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Health and Wellbeing Board

Date: **FRIDAY, 22 SEPTEMBER 2023**

Time: 11.00 am

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

Members:

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

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Ian Thomas CBE
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES FOR ABSENCE**

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

3. **MINUTES**

To agree the minutes and non-public summary of the previous meeting held on 29 June 2023.

For Decision
(Pages 5 - 12)

4. **APPOINTMENT OF CO-OPTEES UPDATE**

Town Clerk and Deputy Director of Public Health to be heard.

For Information

5. **BETTER CARE FUND 2023-25**

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

For Decision
(Pages 13 - 84)

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

Report of Director of Public Health, City of London and London Borough of Hackney.

For Decision
(Pages 85 - 90)

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

Report of the Chair, Healthwatch City of London.

For Information
(Pages 91 - 166)

8. **SUICIDE PREVENTION IN THE CITY OF LONDON ANNUAL REPORT**

Report of Director of Public Health, City of London and London Borough of Hackney.

For Information
(Pages 167 - 206)

9. **MENTAL HEALTH SERVICES FOR PEOPLE WITH SEVERE MENTAL ILLNESS**

Report of Director of Public Health, City of London and London Borough of Hackney.

For Information
(Pages 207 - 214)

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

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

12. **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

13. **CITY OF LONDON SUICIDE AUDIT**

Report of Director of Public Health, City of London and London Borough of Hackney.

For Information
(Pages 215 - 254)

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

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

HEALTH AND WELLBEING BOARD
Thursday, 29 June 2023

Minutes of the meeting of the Health and Wellbeing Board held at Committee Rooms - 2nd Floor West Wing, Guildhall on Thursday, 29 June 2023 at 11.00 am

Present

Members:
Deputy Marianne Fredericks
Gail Beer
Nina Griffith
Dr Sandra Husbands
Ruby Sayed (Deputy Chairman)
Deputy Randall Anderson
Helen Fentimen
Wilde
Matthew Bell
Mary Durcan (Chairman)
Finlay

Officers:

Chris Pelham	-	Department of Community and Children's Services
Chris Lovitt	-	Deputy Direcor of Public Health
Chandni Tanna	-	Media Officer
Simon Cribbens	-	
Ellie Ward	-	Community and Children's Services Department

1. **APOLOGIES FOR ABSENCE**
It was moved by Deputy Randall Anderson, seconded by Mary Durcan and agreed that Deputy Marianne Fredericks takes the Chair until the election of the new Chair of the Board.

Apologies for absence were received from Helen Fentimen and Gavin Stedman (who was represented by Joanne Purkiss).

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

3. **ORDER OF THE COURT**
The Board received the order of the Court of Common Council, dated Thursday 27th April 2023, which appointed the Committee and approved its Terms of Reference.

Members noted that, as the Court of Common Council had approved the Board's Terms of Reference for 2023/24, officers would approach the East London Foundation Trust, St Barts and the Primary Care Network to seek expressions of interest for two co-optees with experience relevant to the work of the Health and Wellbeing Board.

RESOLVED, that – the order of the Court be noted.

4. **ELECTION OF CHAIRMAN**

The Board proceeded to elect a Chair in accordance with Standing Order No. 29. The Town Clerk has received no expressions of interest within 1 full working day of this meeting and the position of Chair was uncontested.

RESOLVED, that Mary Durcan be appointed as Chair of the Health and Wellbeing Board for 2023/24.

On taking the Chair, Mary Durcan thanked past Deputy Chair and Chair Marianne Fredericks for commitment and passion about issues affecting residents and workers in the City of London and Hackney.

5. **ELECTION OF DEPUTY CHAIRMAN**

The Board proceeded to elect a Deputy Chair in accordance with Standing Order No. 30.

RESOLVED, that – being the only Member expressing a willingness to serve, Ruby Sayed be appointed as Deputy Chair of the Health and Welling Board for 2023/24.

6. **MINUTES OF THE PREVIOUS MEETING**

Members considered the draft public meeting of the previous meeting held on the 24th March 2023.

Matters arising

In respect of the request from Members for a report and presentation on the Street Triage Service, the Chair asked if this could be added to the agenda for the September Board. Members also noted the Forward Plan for the Integrated Commission Board, at item 11 on this agenda, which presented an opportunity to engage and co-ordinate the work with mental health partners.

RESOLVED, that - the public minutes and non-public summary of the meeting held on 24th March 2023 be approved.

7. **HEALTHWATCH UPDATE**

The Board received the regular Healthwatch update and, in response to questions, the following points were noted:

Healthwatch had been given assurance of funding for another year and were looking to move the contract onto the next phase. The Assistant

Director, Commissioning and Partnerships at the City of London Corporation and the Health and Wellbeing Board were thanked for their support in this matter.

There has been extensive discussion about future management of the St Leonard's building and Officers agreed to provide an update to the next meeting.

RESOLVED, that – the report be note

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

The Board received a report of the Executive Director, Environment in respect of the Commercial Environmental Health and the Port Health Service Plans for 2023/24. Members noted that the report had been approved by the Port Health and Environmental Services Committee, in accordance with their Terms of Reference. Members noted the enhanced control on Brazilian Chickens, in line with EU Commission recommendation, with 50-100% of consignments being inspected and 100% documentary checks. The officer advised that the Port of London Authority is only one of a few in the UK to do this, as it was advisory. The officer further advised that all animal origins into the UK must be declared and high risk countries are subject to surveillance checks.

Members noted that the hygiene inspections backlog was clearing, with the City Corporation performing better than other boroughs, and the FSA confirmed that the required milestones had been met. The officer advised that if the public have any concerns about a particular restaurant in the City, they should contact the Public Protection Team. RESOLVED, that – the report be noted.

RESOLVED, that – the report be note

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

The Board received a report of the Executive Director, Community and Children's Services in respect of the CQC's launch plan. The report also provided an update on progress and the ongoing approach to local authority and integrated care system assessments. RESOLVED, that – the report be noted.

RESOLVED, that – the report be noted.

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

The Board received a report of the Director of Public Health, City and Hackney and the Executive Director, Community and Children's Services which provided updates on commissioning activities for children and young people and highlighted key strands of work within the Children, Young People, Maternity and Families Integrated Commissioning Workstream. The Executive Director, Community and Children's Services advised that the November Board would receive a presentation on Young People with complex and special educational needs.

RESOLVED, that – the report be noted.

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

The Board received a report of the NHS North East London Integrated Commissioning Board in respect of the NE London Joint Forward Plan. During the discussion, the following points were noted:

1. The new Joint Health and Wellbeing Strategy for the City and its focus on the economic determinants of health, which will provide contextual links to poverty.

2. A change of behaviours in terms of accessing services requires extensive and careful communications and is likely to take some time.

3. The Integrated Care Partnership had agreed that Rough sleepers would be a key group, together with those with learning disabilities and carers.

4. A Workforce Strategy was underway, which would feed into an overarching delivery plan.

RESOLVED, that – the report be noted.

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

The Board received the Director of Public Health's Statutory Annual Report in respect of the health of the local population.
Following the presentation, the following points were noted:

1. Members asked for a breakfast briefing in respect of 'World Aids Awareness Day' in November.
2. Members noted that psycho-sexual services are excellent but there is a waiting list and areas where the commissioning is complex and a single strategy for NE London will aim to address this. The Deputy Director of Public Health suggested the briefing request above could include subject.
3. The level of access to services is better in some community groups than others and the uptake of reversible and long-acting contraception is poor.
4. The good co-production figures, given the community/cultural issues at play. All partners are receptive to change and young people have been consulted as to the best way of communicating and accessing services, rather than enforcing a 'specialist knows best' approach.
5. The commitments made in respect of sex education in schools to ensure it is appropriate.
6. The City and Hackney could do more about the high re-infection rates and prevention work, thereby reducing the need for repeat prescriptions for antibiotics.
7. The offer of flexible medical appointments for working women was commended. The Womens Health Hub has been very successful and was recently visited by the Minister for Women.

8. A 5-Year Strategy is ambitious, noting the funding available. Members noted that the action plan to be presented to the Board in September will contain more detail.

RESOLVED, that – the report be noted.

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

The Board considered a report of the Executive Director, Community and Children's Services which sought approval to commence a formal 12-week consultation on the proposed five-year sexual and reproductive health strategy for the City and Hackney, to commence on 1 July 2023.

RESOLVED, that :

1. The strategy and proposed priorities be noted.
2. The formal 12-week consultation on the proposed five-year sexual and reproductive health strategy for City and Hackney be approved.
3. The process of action planning for the strategy, to run alongside the consultation period be approved.
4. The consultation process shall inform the proposed North East London Sexual and Reproductive Health Strategy.

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

The Board received a report of the Executive Director, Community and Children's Services respect of the options for re-procurement of a city-wide online sexual health service. Members noted that a decision was not required at this stage and that the contact had been widely referred to as an exemplar of digital transformation in health care delivery in the UK.

RESOLVED, that – the report be noted.

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

The Board received a Joint report of the Executive Director of Community and Children's Services and Director of Public Health which introduced the Population Health Hub; a system wide resource to support teams across the City and Hackney in improving population health and reducing health inequalities.

Members noted the City of London Corporation's Committee Report Template which has a prompt in respect of 'Outcomes in the City Corporation's Corporate Plan' and the option to select ' people enjoy good health and wellbeing' under section 2 of the Plan.

RESOLVED, that – the report be noted.

16. **BETTER CARE FUND (BCF) - END OF YEAR REPORT 2022/23**

The Board considered the end of year BCF report, of the Executive Director, Community and Children's Service, which set out how plans were met and funding was allocated.

Members noted that funding was slightly higher for this year and this had been allocated to existing schemes, with some refinements. Plans for this year would be presented to the September Board meeting. The officer advised that a future meeting of the Board would receive a report on virtual wards and discharge from hospital/reducing admissions. Members noted that the care market was facing considerable pressures and all local authorities had been required to produce a market sustainability plan. It was suggested that it would be helpful for the Board to be sighted on this work, as part of the above report. In response to a question, the officer advised that work around commissioning adult placements was underway, funded from this year's BCF. The officer also agreed to investigate the work being undertaken by NE London in this area.

RESOLVED, that – the Better Care Fund End of Year Report 2022/23 be approved.

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

Members noted the following:

1. A meeting had taken place with the Director of Equality, Diversity and Inclusion, who welcomed the report's synergy with the City of London's equality objectives in terms of the London Living Wage and social mobility. The Director agreed to attend the Health and Wellbeing Board when it receives the next iteration of this report.

2. A further meeting had taken place with the Chief Operating Officer, who advised that 15% of the weighting on contractual awards criteria is on responsible procurement, including the London Living Wage. The COO further advised of the complexities in casual staffing structures and the cost and impact implications of the various recommendations would need to be analysed. Therefore, the Health and Wellbeing Board (HWB) might need to take a formal Resolution to the relevant Committee(s) in terms of the next steps.

3. A presentation of the report and its recommendations was made to the Senior Leadership Team (SLT), chaired by the Town Clerk and Chief Executive, on 23 May. The following actions were taken from this meeting:

• The Chief Operating Officer to conduct a health check on the Procurement Code and to feed the 'hidden workers' suggestions into the ongoing review of pay and reward.
• The City Surveyors to review the Facilities Management contract to look at quick wins; i.e. the provision of microwaves and break spaces.
• The Town Clerk and Chief Executive asked for any further suggestion to the next SLT Meeting.

Overall, the report was very well received and Members noted that some of the actions, in terms of reviewing procurement and workplace policies, would need to be undertaken by other partners on the Health and Wellbeing Board. Members noted that they would receive a more comprehensive report at the September Board, at which time consideration could be given to the Resolution, suggested under (2) above. The Deputy Director of Public Health suggested presenting the report to NHS partners who contract out their cleaning and support staff.

18. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**
In response to a question, Members noted that Health Impact Assessments are now carried out on building designs in respect of suicide prevention measures.

The DPH advised that there are no statutory requirements on developers beyond this but the Director of Public Health can be invited to comment.

Members noted that the City and Hackney have gone further than other LA's in terms of design standards for new buildings. The Deputy Director of Public Health suggested that the Building Control Team might be able to assist further, in terms of their regular audits. A Member suggested that the HIA's could be enhanced, with an offer of webinars to developers in terms of designing out suicide, noting again that this would fall within the remit of the Building Control Team.

19. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
There were no urgent items considered in the public session.

20. **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 of exempt information as defined in Part I of the Schedule 12A of the Local Government Act.

21. **NON PUBLIC MINUTES**
The Board considered the draft non-public meeting and non-public summary of the previous meeting held on the [ ]2023.

RESOLVED, that - the non-public minutes of the meeting held on 24 March 2023 be approved,

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

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

There were no non-public items of urgent business.

Committee: Health and Wellbeing Board	**Dated:** 22 09 2023
Subject: Better Care Fund 2023-25	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	1,2,3,4
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**N/A**
What is the source of Funding?	**N/A**
Has this Funding Source been agreed with the Chamberlain's Department?	**N/A**
Report of: Judith Finlay, Executive Director, Community and Children's Services	**For Decision**
Report author: Ellie Ward, Head of Strategy and Performance, DCCS	

Summary

The Better Care Fund (BCF) programme supports local systems to deliver the integration of health and social care in a way that supports person centred care, sustainability and better outcomes for people and carers.

The Fund is based on a pooled budget of funding from Integrated Care Boards (ICBs) and local authorities. Local systems are required to produce plans for the BCF which have to be signed off by local Health and Wellbeing Boards.

The plans are governed by a policy framework and requirements set out by the Department of Health and Social Care (DHSC). Generally, these frameworks and requirements are published after the start of the final year. The latest requirements cover the period 2023–2025 and plans were submitted on 28 June 2023. These plans are now submitted to the Health and Wellbeing Board for approval.

Recommendation(s)

Members are asked to:

- Approve the City of London Better Care Fund Plan 2023–25.

Main Report

Background

1. The Better Care Fund (BCF) was established in 2013 and encourages integration by requiring Integrated Care Boards (ICBs) and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.

2. Each organisation has designated funds they have to include in the pooled budget and it is at their discretion whether they add additional funding to the pot. Neither the City of London Corporation nor the ICB add additional funds to the pot.

3. Every year, local systems agree how the money will be spent within criteria set out by the Department of Health and Social Care (DHSC) and produce plans in accordance with BCF policy and requirements. A key component of the requirements focus on supporting hospital discharge and out of hospital care.

4. The DHSC policy and guidance documents for plans are produced each year but are often published after the start of the financial year. Guidance for plans for 2023-25 was published in April 2023 and the City Corporation plans were submitted on 28 June 2023. All plans have to be approved by the local Health and Wellbeing Board (HWB).

5. Although the plans are submitted after the start of the financial year, local areas are allowed to continue with schemes from the previous year.

Current Position

6. For 2023/24, the pooled budget is £1,303,408, consisting of an NHS contribution of £897,282 and a City of London Corporation (City Corporation) contribution of £406,126. This increases in 2024/25 to £1,387,981 consisting of £952,531 and £435,450 respectively. The City Corporation does not put in any additional funds.

7. A range of schemes are funded through the BCF, as set out in Appendix 2. Of the pooled budget for 2023/24, £347,597 is being spent on City Corporation Adult Social Care Services (not including the Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG)), above the £163,508 required.

8. The City of London schemes in the 2023-24 plan remain broadly the same as the previous year but with a change in the elements of the hospital discharge scheme to reflect changing requirements.

9. Proposed plans are attached as Appendices 1 and 2 and include a narrative plan, which is a joint local system plan for the City Corporation and the London Borough of Hackney, and a City Corporation template with details of income, expenditure and schemes.

10. The template includes five key indicators that the City of London Corporation and health partners monitor.

11. The Health and Wellbeing Board is asked to approve the proposed plans for 2023-25 noting that plans for 2024-25 are subject to change but the Board will be notified if there are any significant changes that need to be approved.

Corporate & Strategic Implications

Strategic implications

The BCF aligns with our corporate priorities of:

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

It also sits within a wider strategic context of health and social care integration and policies driving hospital discharge work.

Financial implications

The City Corporation only contributes required funding to the pooled budget and does not contribute any additional funding.

In terms of expenditure on schemes within the plan, City Corporation schemes are funded above the minimum required from the pooled budget.

Resource implications

None

Legal implications

None

Risk implications

None

Equalities implications

All schemes which are funded through the BCF and commissioned or delivered by the City Corporation are subject to Equality Impact Assessments.

Climate implications

None

Security implications

None

Conclusion

12. The Health and Wellbeing Board is asked to approve BCF plans for 2023-25.

13. Focussing on integration and particularly on hospital discharge and out of hospital services, the BCF plans fund a number of schemes in the City of London.

14. The funding from the pooled budget for City Corporation services is above the minimum required and supports a range of work. The main change from the previous plan is a change to the hospital discharge scheme to reflect changing requirements.

Appendices

- Appendix 1 – BCF Narrative Plan for City and Hackney.
- Appendix 2 – BCF plan.

Ellie Ward
Head of Strategy and Performance

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BCF Narrative Plan 23-25

City and Hackney

Contents

The City and Hackney Place-based Partnership and Health and Wellbeing Boards

The City and Hackney Partnership brings together health and social care organisations who have committed to work together to support improved outcomes and reduce inequalities for our local population. It is one of seven Place Based Partnerships within the North East London Integrated Care System.

The partnership is overseen by the City and Hackney Health and Care Board. The board has agreed a set of strategic focus areas and partners have developed an Integrated Delivery Plan that describes how we will deliver this strategy. The Integrated delivery Plan does not describe the totality of the work underway within each of our organisations. We have taken an outcomes led approach, meaning that we have developed actions that will address population health challenges.

The City of London is overseen by the City Health and Wellbeing Board.

Hackney is overseen by the Hackney Health and Wellbeing Board.

Signing off the BCF Plan

The Hackney BCF plan is jointly written and goes through the following integrated sign off process:

1. BCF Partnership Group - (ICB & LBH Senior Partners)
2. ICB Leadership Team
3. LBH DAS and Head of Finance
4. Hackney Health and wellbeing Board

The City Corporation BCF plan is jointly written and goes through the following sign-off:

1. Internal Integration Programme Board including Senior Leadership from the Department of Community and Children's Services and Finance
2. ICB Leadership Team
3. City of London Health and Wellbeing Board

Stakeholder input into preparing the Plan

- Senior officers at the Councils, NHS NEL and Homerton Hospital
- Hackney Discharge Group
- LBH Housing Needs & Benefits Team
- North East London (NEL) and place-based Homelessness and Health meetings
- City and Hackney Neighbourhoods Health and Care Board
- City and Hackney Health and Care Board

National Condition 1:
Plans to be jointly agreed.

BCF Governance

- There is huge amount of joined up working and cooperation happening within the place-based partnership and BCF funded schemes are fundamental to delivery of the integrated delivery plan.
- LBH Director's within ASC, Finance and BCF Lead meets quarterly with two NHS NEL Directors, Finance and BCF lead to monitor BCF schemes performance and sign-off returns. City of London Corporation staff also meet with NHS NEL leads for monitoring and sign-off.
- There is a bi-monthly Hackney Hospital Discharge Group which is comprised of system partners, including service users, Healthwatch and Age UK, in addition to statutory partners, which includes Head of Benefits and Housing needs. This group monitors any challenges within discharge pathways, and reviews progress against the NHS Discharge Policy and related BCF Metrics. The City of London Corporation has an internal hospital discharge group due to its more complex discharge pathways and its small numbers.
- Hackney DFG Governance includes a weekly adaptations panel to approve all major adaptations and collate soft spend, and a monthly contract meeting with representation from commissioning, housing team (Private Sector Housing) and Home Improvement Agency (HIA). In the City of London, the Assistant Director of People approves all DFG grants and spend is monitored in conjunction with the Capital Finance Team.

Local governance - Hackney

BCF Partnership Board
Chair:Jenny Murphy (AS Commissioning LBH)
Oversees S75 for BCF; BCF Planning and Finances

→

Senior Finance leads ICB & LBH
BCF Officers ICB & LBH
LBH Commissioning AD and Operations Director
Section 75 Lead officer ICB

Hackney Discharge Group
Joint Chair: Jenny Murphy (AD Commissioning LBH & Anna Hansbury Programme Manager Unplanned Care Workstream ICB)
Oversees Local discharge service design; performance and monitoring

→

Homerton Senior Officers
LBH Commissioning
ICB Commissioning
Experts by experience
Age UK

Weekly Stand Up (Discharge)
Joint Chair: Jonathan Carter LBH Discharge Team & Mark Watson LBH Commissioning

→

Discharge Lead for Homerton
IDS Senior officer
Age UK Senior staff
Commissioning
Equipment commissioning lead

Delivery plan big ticket items: preventing and improving outcomes for people with long-term health and care needs

Area	Outcomes	Activities
Enhanced Community Response - 2 hour	• Ensuring that people with long term health needs are better supported in their own home through a more personalised and proactive approach. • An improved health-related quality of life for people with long term conditions • A reduction in the inappropriate use of the urgent -and emergency care system –•Reduced mortality / morbidity from emergency presentations • An improvement in patient experience of urgent care services • Resident knowledge of urgent and community care services and confidence in using them	• Maintain and improve UCR to maximise benefits • ICB and Hackney Council to work in partnership to develop plans for Telecare Response Service that is integrated with urgent and emergency care services with pathways between services • Procurement of End of Life Rapid Response service
Homelessness and vulnerably housed	•A reduction in the number of residents in vulnerable housing •An improvement in the population •vaccination rates •An increased engagement with health, social care and wider services	• Continued delivery of and development of a business case for recurrent funding of Pathway Discharge team, Lowri House step down beds and Routes to Roots Housing Workers.
Discharge	•An improvement in health-related quality of life for people with long term conditions •Making sure more people are able to live independently for longer	•Hackney implementation of improvement plan / recommendations from Discharge Review
Long-term conditions	•A reduction in premature mortality from cardiovascular and respiratory illness •Improved blood pressure control in particular within black population •Improved diabetes outcomes (Blood glucose, blood pressure and cholesterol) •Accurate diagnosis of diseases to enable correct management and treatment in community – (avoid unnecessary hospital admissions)	•Implementation of Blood Pressure Monitoring (BPM) @ Home – Hypertension Specialist Nurse with ACERs •Implementation of 1 year pilot spirometry service to be delivered by ACERs in primary Care

Priority schemes - enabling people to stay well, safe and independent at home

Hackney policy objective 1:

1. **Implement the review of the discharge pathway**

Why: We commissioned PPL to review the current discharge pathway and results will be available at the end of June 2023.

Outcome: further development of an integrated discharge service (and transfer of care hub). Increased capacity of reablement and home care.

2. **Use discharge funding to recruit more permanent staff in the adult social care discharge team**

Why: Many of the Social Work staff and move on team have been funded by short term funding, meaning we have only been able to recruit agency staff.

Outcome: Increased stability within the workforce.

1. **Commission/Recontract discharge services**

Why: Similar to the staffing, short term funding while welcome, has only allowed us to issue short term contracts.

Outcome: Increased stability within the market.This 2 year funding will allow for extended contracts via new procurements. This includes bridging services; accomodation services and other discharge related schemes.

City of London policy objective 1:

1. **Hospital prevention and discharge scheme (scheme number 4 in planning template, includes reablement)**

Why: need is still there, shifting focus to early intervention and prevention. Strengthen social worker and OT within discharge and community.

Outcome: prevent hospital admissions where possible and continue to support Home First approach.

1. **Commissioning Brokerage pilot (scheme number 3 in planning template)**

Why: area identified for development. Strengthen our ability to deliver hospital avoidance support and/or facilitate hospital discharges more rapidly in order to maximise independence.

Outcome: stronger, co-produced and integrated services supporting the individual to maintain their levels of independence within their home environment.

Areas for development - City of London

- DFG - we are developing a Housing Assistance Policy to allow more flexible use of DFG funding for self-funders to access more support with adaptations processes. This is because many people who may need adaptations are self-funders but would benefit from support. The policy will also consider whether a handy person scheme would be appropriate.
The commissioning brokerage pilot will run for one year and be evaluated

Carers - LB Hackney 23-25 Plans

(Funded scheme number: 01)

It's estimated there are over 19,300 people in Hackney providing care for a relative or friend. The BCF supports a carers budget that funds 3 elements, based on strength-based model

1. Prevention, Early Intervention and Outreach service - Provided by Carers FIRST
2. Long Term Targeted Support Service and Carers Assessments - Adult Social Care
3. Long Term Targeted Support Service - Mental Health - East London Foundation Trust (ELFT)

The key features of the service are as follows:

- Carers assessment
- Early intervention and prevention; signposting and advice
- Carers events and training
- Ongoing peer support and carers groups
- Maintaining a carers register
- Carers reviews
- Support planning
- Assigned practitioners for carers; however, this shall change to Lead Worker for LBH ASC and ELFT teams when the Care Act assessment is fully implemented.
- Contingency planning

23-24 Plans for Carers

- LBH will continue to provide support to informal carers
- The current contract is about to enter into its final year. Due to this LBH are reviewing the current model of delivery, with a view to take actions and make improvements where necessary to ensure that the support provided for informal carers continues to meets their needs.
- During the Covid 19 Pandemic, like many other services the delivery model was adapted to meet the needs of the carers. Feedback from carers to date has identified they may wish to have some of these changes extended but this will be considered as part of the service review.

Carers – City of London

Supported under scheme 2

There were 496 City of London residents who self-identified themselves as unpaid carers in the 2021 census. Adult Social Care currently support 37 carers, with universal services supporting over 100 (with some cross-over). All assessments, support plans and reviews are carried out by social workers. The proportion supported by ASC is higher than neighbouring local authorities.

General carers wellbeing support is currently provided through City Connections, by Age UK and BCF funding contributes to this support. During 2022/23 a pilot for more intensive carer support was provided which was successful in identifying an additional 45 carers and providing more carer specific advice and support. This service will now be continued.

Joint commissioning - Hackney

Examples of how LBH and the ICB work together to join up commissioning:

- Published our Market Position Statement (MPS) in 2023: London Borough of Hackney Market Sustainability Plan
- As part of Hackney's Market Sustainability and Improvement Fund work, our BCF Lead officer from the ICB was part of the working group. This was very useful in understanding the intentions of the ICB with their framework agreements in costs for Homecare and Care homes, as well as a shared understanding of both the market feedback and future direction.
- Commissioning across the discharge pathway will be planned together during the year, including any bridging service extension, temp accommodation and other services
- The Homeless pathway was jointly commissioned and will continue to be jointly supported.
- All our BCF hospital discharge services are jointly commissioned, or while led by one agency jointly agreed. (Scheme number 6;8;9;18;19 & 29-58)

Joint commissioning - City of London

- Published our Market Position Statement (MPS) in 2023: City of London Market Sustainability Plan
- Aims of the MPS workstream include supporting choice and quality for those on Direct Payments as well as self funders within the City of London to ensure that they have access to, and can help shape, quality care provision within the City.

We also commission a range of co-produced services to support unpaid carers as part of the BCF funding.

- We develop collaborative working with NEL partner authorities from a commissioning and finance perspective.

National Condition 2:
Enabling people to stay well, safe and independent at home for longer.

Priority schemes - City of London

BCF policy objective 2 - providing the right care, at the right place, at the right time.

- Care Navigator Service (scheme number 1 in planning template)
  - Why - build on existing service to reduce delayed discharge and provide links with reablement team.
  - Outcomes - supports safe hospital discharge for City of London residents and reducing potential delayed transfers of care.

- Carers' support (scheme number 2 in planning template)
  - Why - provide more specific extended support service for carers.
  - Outcomes - better, targeted support for carers. Better links to City Connections or ASC Voluntary sector service that links with acute hospitals and GP surgeries.

Commissioning Brokerage pilot (scheme number 3 in planning template)
  - Why - area identified for development. Strengthen our ability to spot purchase planned and hospital discharge placements and find appropriate services quicker.
  - Outcomes - stronger, co-produced and integrated services and improved partnerships resulting in appropriate services being received quicker and supporting hospital discharge timeframes.
- Neighbourhood Programme (Scheme 18)
  - Why - development of community pharmacy support at a neighbourhood level
  - Outcomes - enhanced pharmacy access
- ParaDoc (Scheme Number 11)
  - Why - Continued implementation and development of our 2 hour community response is a system priority
  - Outcomes - Ensuring that people with long term health needs are better supported in their own home through a more personalised and proactive approach. A reduction in the inappropriate use of the urgent and emergency care system
- GP Care Home Scheme (Scheme 16)
  - Why - Enhanced access to health in care homes continues to be a national and local priority.
  - Outcomes - Providing care to care home residents in their own home environment. A reduction in the use of the UEC system

National Condition 2: Enabling people to stay well, safe and independent at home for longer.

Our local BCF planning template sets out spending on prevention and support for people to remain at home.Those that support entirely this objective include:

- Neighbourhood Programme (Scheme 10)
- Bryning Unit/Falls Prevention Scheme (Scheme 12)
- ParaDoc (Scheme Number 15)
- Integrated Independence Team (Scheme 9, and together with ParaDoc provide a joint falls service)
- GP Care Home visit Scheme (Scheme 23)
- Fit 4 Health (Scheme 24)

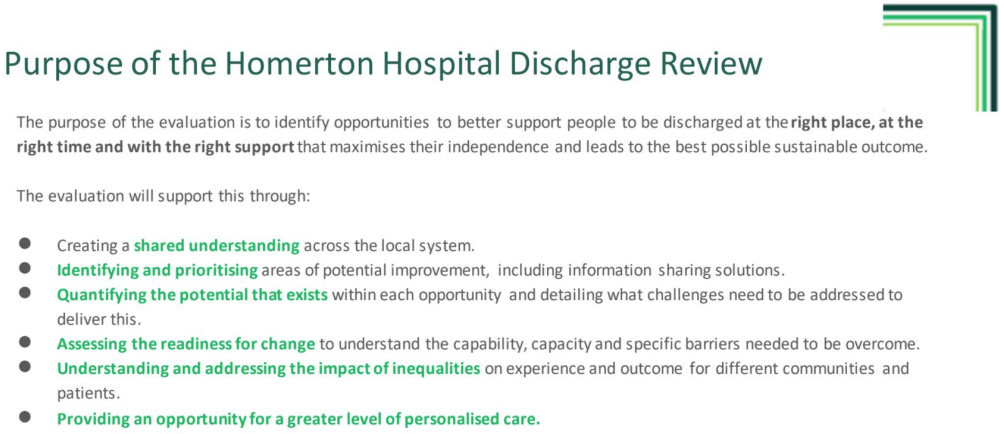
Those that contribute partially to this objective include:

- Support to carers (Scheme 1)
- Funding of equipment services to enable people to stay at home (Scheme 2 &5)
- DFG funding to enable people to stay in their own homes for longer.

National condition 3:
Provide the right care in the right place at the right time

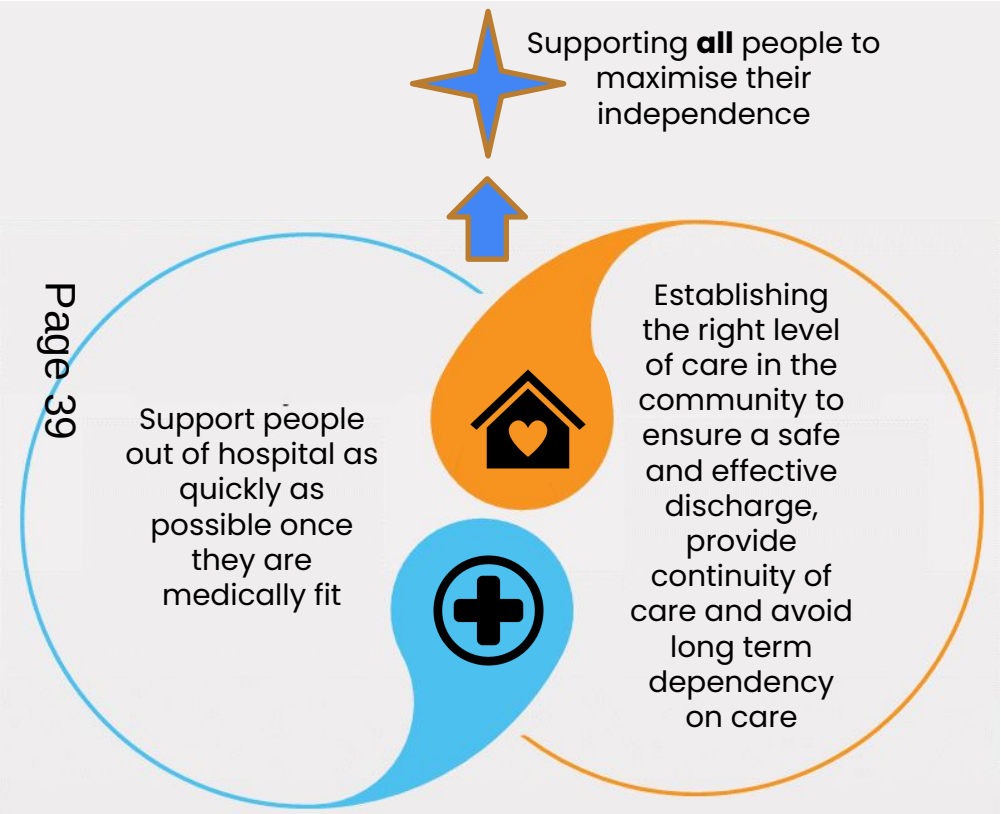
Hospital discharge - Hackney

Hackney partnership has employed PPL, a local consultancy firm to help review and carry out a diagnostic and review of our current hospital discharge pathway with a view of helping the Discharge Group and commissioners use the discharge money where it will have the most impact locally on meeting the national guidelines for safe discharge.



Diagnostic Stage

What is the ‘wicked problem’ we need to solve?



Supporting people out of hospital and establishing the right ongoing care are not mutually exclusive or conflicting.

But in the current climate of increasing demand and financial challenge, these two elements can feel like interconnected but opposite forces. Despite this both objectives are working to a key shared outcome; to maximise a person’s independence and ability to live happy healthy lives.

The next stage of the hospital discharge model must build on the strong foundations of partnership working to create a harmonious relationship between these two key objectives.

The ongoing national funding to support discharge provides an opportunity to do things differently to make this happen.

Where are we now?

Strengths in current practices

- Hospital spells at the Homerton are shorter than the average length of stay in other comparable hospitals, and London and national averages
- Collaboration and team working takes place across a multitude of organisational and system boundaries that in other places and historically have been siloed
- This is made possible by a well tested and developing infrastructure to connect the different parts of the system together
- There are a broad and varied range of services, including a mixture of intermediate services, to help people out of hospital
- This is supported by examples of shared/joint financial mechanisms
- The vast majority of people in hackney return home

Challenges and opportunities

- There is an increasing level of complexity in the needs of people leaving hospital, this is leading to increases in delays of discharging people
- This is driving the need for increasingly complex levels of care being established to support people home, and fewer people returning to their normal place of residence
- There is a risk that this is increasing the level of dependency of people discharged from hospital, reducing independence and creating a financial pressure
- While residential care demand matches capacity, affordability of placements is becoming an increased pressure on the system and are often outside of Hackney
- There is an opportunity to increase the number of people supported through reablement
- Key processes and enablers for people with complex needs can delay discharges including brokerage, equipment and transport

Where do we go next?

Strengthening the community 'pull' out of hospital:

working together to utilise system capacity dynamically to best meet the needs of the patients and get people home as quick as possible, and developing greater intermediate capacity to support independence

Supporting complex cases:

creating quicker decision making and developing more flexible capacity in the system for both interim and long-term care that supports D2A, maximises independence and provides consistency of care

Utilising estates:

bringing staff together around the patient, capitalising on co-location and sharing of space where it will be of benefit to the patients/residents

Co-produced with our staff, patients and communities

Addressing inequalities:

ensuring that our pathways have greater scope for personalisation, helping to support both our diverse communities equally and supporting our vulnerable residents

Data and digital tools:

focus on pragmatic digital and data tools to support better visibility of patients across the system and allow a collective management of cases across teams and organisations

Things to consider from the diagnostic

Those with reablement potential are **able to access care** that supports a journey to/towards independence

Care decisions to be taken **'as close to the patient' as possible**

Utilisation of the voluntary and community sector to support people back home and in a way that is culturally aware

Access to equipment to support people's needs at the right time and in the right place

Developing intermediate care services to meet all needs

Utilising interim care in a way that supports discharge from hospital and flow from interim to long-term care

Flexible utilisation of all intermediate and interim support to ensure patients receive the best care option at the time

New or extended roles to work differently

Greater capacity for specific teams

Co-location of staff at Homerton Hospital, with the appropriate access to resources and IT

An **active and brave approach** to managing risk

'Live' system data sets

A **co-produced approach** to patient choice, and the involvement of families and carers

New **ways of working** together

Skills and training for staff (e.g. Mental Health training)

Collaboration between and integration of key teams

Digital tools to provide a shared visibility of demand across the system and shared case management

Reliability of transport from hospital with more direct access from the community services

Moving on from the diagnostic

Suggested programme plan

Workstreams and associated changes

Working with patients

- Greater communication on discharge updates
- TOCH hotline and information pre-admission

Integrated TOCH

- Implement case load system
- Greater integration of IIT, IDS and Rapid Care
- Integration of neighbourhood and council teams
- Integration of VCSE colleagues

Independence Journey

- Increase reablement and rehab capacity for complex cases
- Establish performance framework to reduce care package
- Develop capacity on wider wellbeing support
- Increase access to equipment
- Support people out of interim beds to back home

Streamlined long-term care assessments

- Implement policy and process for TOCH to deliver restarts
- Reduce panel stages where appropriate
- Implement trusted assessor models

This plan is the outcome of an extensive programme of engagement, including 1:1 interviews, focus groups and a system-wide workshop to improve the patient experience of discharge from the Homerton in Hackney.

Discharge Funding

We have set out in the BCF Spending plan our initial spending plans to support safe and timely discharge.

Our initial plan was to continue to fund the majority of the winter pressure schemes that have been funded through various pots of non-recurrent funding throughout the last few years, in order for us to receive the review done by PPL. This will help commissioners plan how to fund any transformation needed and re-allocate budgets accordingly.

Q1 and Q2 funding will be spent as outlined in the spending plan.

Over the period of Q3 and Q4 we will see a change in funding as we transform the discharge pathway. Areas that we want to review spend include:

- Temporary accommodation post discharge (Scheme numbers 30 to 38)
- Bridging service (Scheme number 39)
- Review Mental health schemes as the roll out (Schemes 53 & 54)
- Increase access to reablement

The funding will help deliver the changes we wish to see which are covered in the previous slide (Slide 26)

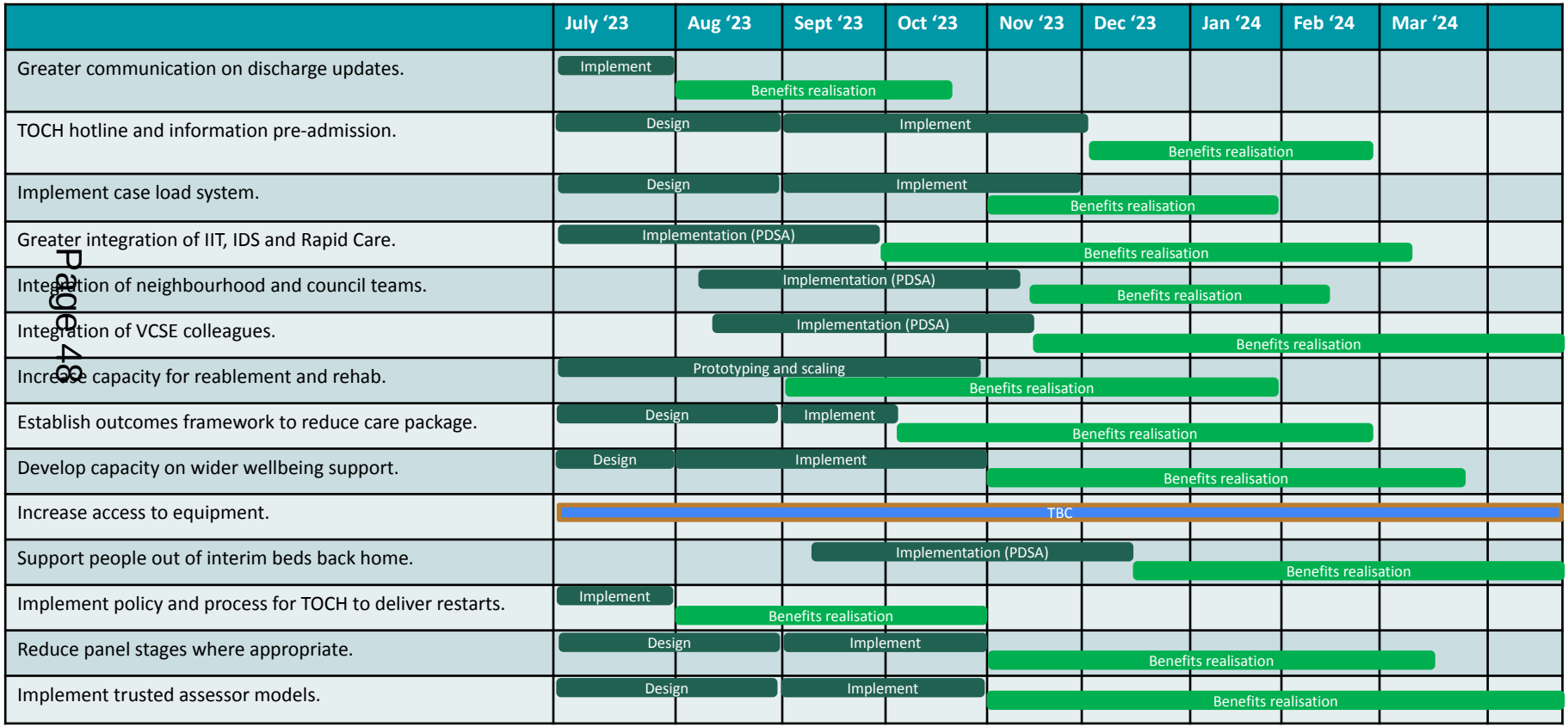
Change		Details of change	Benefits
Working with patients	Greater communication on discharge updates.	• Communications to be provided to patients and families by ward staff and/or TOCH staff as discharge plans develop (e.g. updates from board rounds).	• Greater experience for patients and their families. • Patients maintain agency through being involved in the process. • Increased capacity for the team through reduction in family queries. • Staff have a better working experience, resulting in greater staff retention.
	TOCH hotline and information pre-admission.	• A transfer of Care Hub phone hotline to be introduced to provide updates to families and carers on patient progress. • The hotline would also provide information pre-admission to connect people in to community support, potentially helping to avoid admission.	• Greater experience for patients and their families as they're kept updated and connected to additional support. • Increased capacity for ward staff through reduction in family queries. • Better working experience for staff, resulting in greater staff retention. • Higher utilisation of community assets.
Integrated TOCH	Implement case load system.	• Management of a single case load across all teams, covering all discharge pathways • A proportionate digital tool that will enable this to happen (interim tools may be required)	• Flexible use of staff capacity ensuring a system, pragmatic and practical approach to tackling pressure points collectively • Greater working experience for staff through collaborative approaches to tackling capacity issues
	Greater integration of IIT, IDS and Rapid Care.	• Building on successful collaboration to date to continue to break down barriers between teams • More flexible use of staff across the discharge pathways	• Flexible use of staff capacity ensuring a system, pragmatic and practical approach to tackling pressure points collectively • Greater working experience for staff through collaborative approaches to tackling capacity issues
	Integration of neighbourhood and council teams.	• Integration of NHS neighbourhood representatives with the Transfer of Care Hub • Integration of key council teams (e.g. Move on team) to the transfer of care hub (named individual per team). • To create explicit links with Out of Borough Transfer of Care hubs or discharge functions (named links)	• Smoother patient pathways in to the community, with the right care provided from discharge • Increased experience for patients as they're able to receive tailored support • Better working experience for staff, resulting in greater staff retention
	Integration of VCSE colleagues.	• Identification of VCSE partnerships to support discharge • Integration of VCSE colleagues to transfer of care hub, including organisations linked to key communities.	• Providing a broader range of support for patients, tailored to their care needs and aligned to their cultural/social preferences • Cost effective care

Change		Details of change	Benefits
Independence journey	Increase capacity for reablement and rehab.	• Developing increase capacity for complex cases to go through reablement and rehab; including outcome based contracts and explicit incentives regarding care package reduction. • Thresholds and process aligned to support more complex cases	• Increased independence for the patient, resulting in a better quality of life and long term outcomes. • Reduction in long term care costs as a result of patient independence.
	Establish performance framework to reduce care package.	• Establish a clear and straightforward outcomes framework for care for all internal reablement and rehab support, to promote care reduction (aligned to increasing independence levels) during intermediate care	• Increased independence for the patient, resulting in a better quality of life and long term outcomes. • Reduction in long term care costs as a result of patient independence.
	Develop capacity on wider wellbeing support.	• Develop capacity in cost-effective support focused on wider wellbeing (e.g. house maintenance, daily tasks, social isolation) to recognise and reduce the impact these have on health.	• Reduction in care costs. • Culturally sensitive and personalised support, resulting in an improved patient experience.
	Increase access to equipment.	• Increase access to equipment- available to all staff that are 'leading' discharge planning (ward staff, transfer of care staff, neighbourhood teams).	• Reduction in lost bed days due to equipment. • Greater experience for staff as less cumbersome process in place.
	Support people out of interim beds back home.	• Support people in interim beds to return back to usual place of residence through collaboration in the transfer of care hub. • This could be facilitated by community in-reaching and support from other groups.	• Increased patient flow through the system. • Reduction in lost bed days caused by delay in bed availability.
Streamlined long term care assessments	Implement policy and process for TOCH to deliver restarts.	• Develop and implement policy and processes to allow all transfer of care hub staff to restart packages of care, allowing a streamlined approach with effective risk management.	• More efficient and effective use of team • Less delays due to reduced process points
	Reduce panel stages where appropriate.	• For cohorts of patients where appropriate risk share can be identified and implemented, reduce panel stages in care package delivery.	• Reduction in lost bed days due to reduced assessment process time.
	Implement trusted assessor models.	• Streamline and align long term care assessments wherever possible • Implement trusted assessor models within Hackney – allowing wider staff roles to assess patients, dependant on their needs • Implement trusted assessor models for out of borough patients – agree with key borough social care teams that a trusted assessment can be used for certain levels of need/cohort of patients.	• Reduction in lost bed days due to reduced assessment time. • More efficient and effective use of team; including reduced duplication of assessments

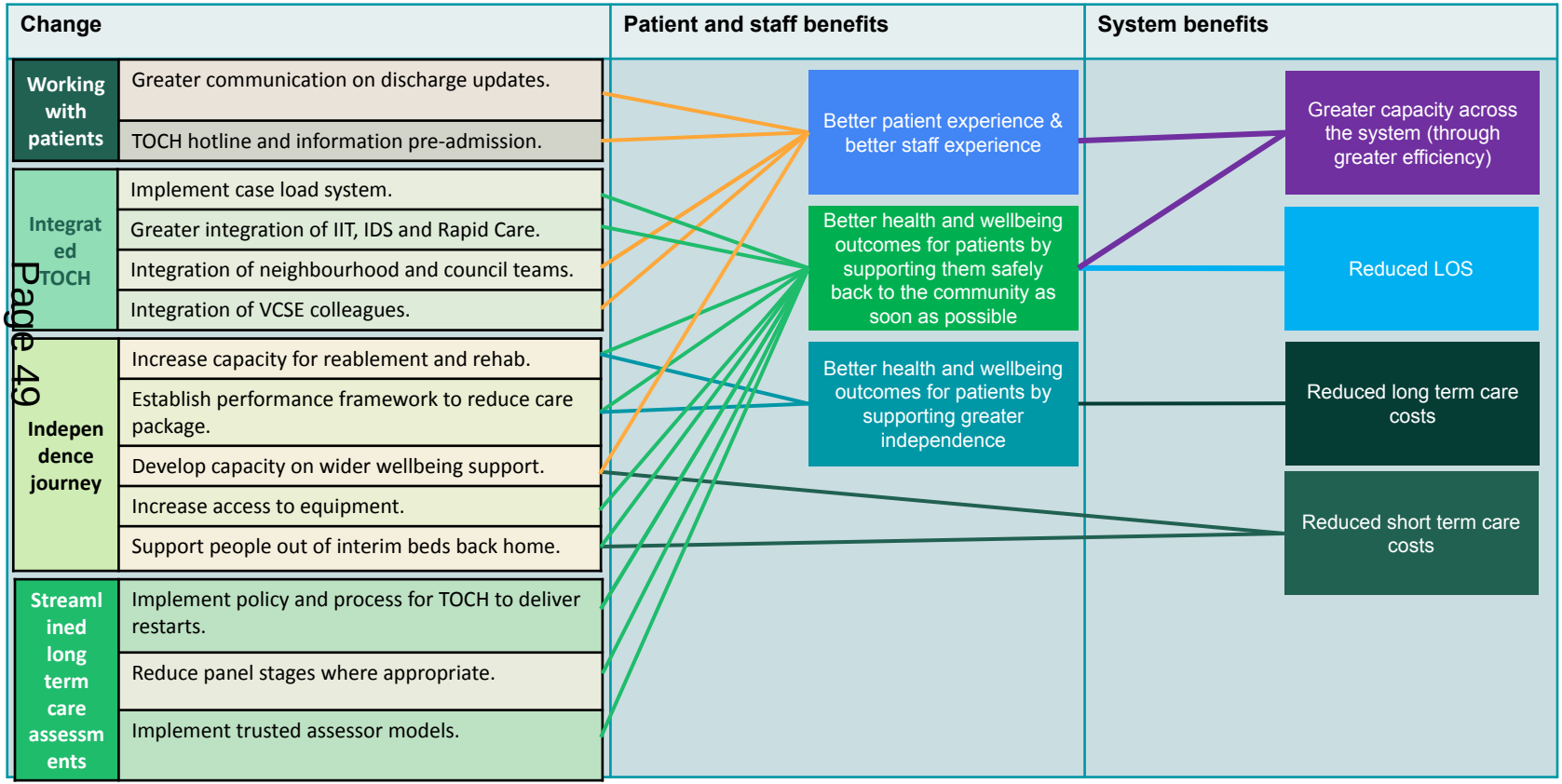
Provisional timelines

Benefits realisation

Implementation



Benefits map



Hospital discharge - City of London

There were 107 hospital discharges in 2022/23 through the following pathways:

- Pathway 0 - 53
- Pathway 1 - 41
- Pathway 2 - 7
- Pathway 3 - 6

Our Discharge scheme provides an intensive discharge to assess offer and includes reablement and domiciliary care. As can be seen above, we adopt a home first model wherever possible and have a rapid response service that can provide up to 72 hours of care to facilitate Discharge to Assess etc. However early discharge planning means that we have often assessed people, at least initially, before they leave hospital. The providers of the rapid response service also provide our reablement service and this has added flexibility to meet people's needs.

The Care Navigator plays a key role in facilitating safe hospital discharge and the rapid response service has been strengthened to respond to the more complex cases which are discharged into the community as part of early discharge.

We have excellent performance on the 'still at home 91 days after discharge' metric (each quarter is always more than 95%) and we are also able to avoid hospital admissions with the use of our rapid response service.

The Adult Social Care Discharge Fund will be used to further support early discharge planning and our home first approach. The ICB allocation has been agreed by all partners across NEL and does meet the needs of the City.

Whilst it is low, that is partly because the City of London Corporation are not providing some of the infrastructure or step down capacity that their patients will benefit from – so for example they do not have an integrated discharge hub, but patients are managed through the Homerton or Royal London (or UCLH) hubs, likewise City do not directly procure step down beds but will access beds procured by other boroughs.

High Impact Change Model self-assessment
London Borough of Hackney

1	Early discharge Planning	We continue to identify who needs support early to ensure appropriate pathway in advance.
2	Monitoring and responding to system demand and capacity	We continue to have a joint approach to developing step down facilities, integrated health and social care support and work with Age UK. We are jointly planning step down care facilities, with LBH as the lead commissioner using intelligence from front line staff on weekly stand up calls and complex cases being fed back to commissioners. **Area to develop:** we need to develop stronger real-time data about demand and capacity - we hope taking an NEL wide approach this will become easier, along with the fortnightly reporting.
3	Multi-disciplinary work	Our review has concentrated on this and the future development of a transfer of care hub.
4	Home First (Discharge to assess)	The review also looked at this - we have built capacity in the market and have a resilient homecare market supported by a bridging service. THe bridging service is under utilised and is not particularly a reablement model - we wish to increase the numbers of people being discharged home first with a reablement package.
5	Flexible working patterns (Formally 7 day working)	The services operate 7 days per week

6	Trusted assessment	During COVID this worked well although more homes are now requiring that they conduct their own assessments. The difficulty for Hackney is we don't have many care homes in borough so a trusted assessor model for care homes is difficult to pursue.
7	Engage and Choice	Extensive work was carried during 2021-22 using social marketing techniques to co-design patient and family/carer information leaflets, posters and prompts for staff to promote the idea of discharge home to your own bed if possible. Materials have been printed and delivered to Homerton Hospital in July 2022 and again in 2023. Rapid change in staff has led to them not being used consistently and a refresh on getting the message across throughout the hospital is needed this year.
8	Improve discharge to care homes	We work on an individual basis with local care homes to improve relationships and processes which support discharge from hospital. Each care home also has an aligned GP and there is a DES Supplementary Care Home service for our nursing homes which helps to reduce unnecessary hospital admissions and support flow of information post discharge.Market developments with the Fair Cost of Care have improved the availability of care homes as new fees have been agreed.
9	Housing and related services	Extensive work has gone into this area jointly supported by Adult Social Care, NEL ICB and LBH Housing teams. We have established a Pathway Homeless team for homeless citizens, a step up and down accommodation based service and Routes to Routes link workers. We have also completed an evaluation of the first year of service. We also have a number of temporary housing with care flats available as part of our discharge pathway, 2 accessible flats for working age adults with mobility issues and, Ageing Well funding is supporting an early intervention hoarding project pilot.

High Impact Change Model self-assessment City of London

1	Early discharge planning	We proactively manage early discharge planning in a number of ways: - Identification of cases through the care navigator and co-ordinating of the planning across social care, primary care services and the voluntary sector. Also allows identification of carers - Social workers visit people whilst still in hospital to facilitate a return home without D2A where appropriate - Involvement of OT at earlier stage as part of discharge planning and more equipment is purchased through a more efficient route - Expanded service with new homelessness social worker with link to ASC team (Schemes 1,2 and 4,19 and 20)	Next steps: Care navigator service to be recommissioned in 2024 as part of City Connections contract
2	Monitoring and responding to system demand and capacity	There are no acute hospitals within City of London boundaries	Next steps: N/A
3	Multi-disciplinary work	We are proactively involved in: - Practice MDTs - Social Worker and Care Navigator attends - Neighbourhood MDMs - Team Manager and Deputy Team Manager attend. Social workers present complex cases with multi disciplinary agreement on who will lead on the case and assign actions to different partners. This has improved working relationships and accountability (Schemes 1,2 and 4,19 and 20)	Next steps: Continue to engage with MDMs and range of health professionals.

4	Home First (Discharge to assess)	A rapid response service is in place providing up to 72 hours of assessment and then onward pathway. Also prevents admissions to hospital by providing care interventions. (Scheme 4)	Next steps: Keep under review
5	Flexible working patterns Discharge scheme.	Our hospital discharge service model provides a full discharge service 9-5 Monday to Friday with a clear expectation that there is flexibility outside of these hours subject to demand. Friday pressure points are expected and ASC cover enables weekend discharge arrangements to be secured. Our Rapid Response provider can support pre-arranged weekend discharge. (Scheme 4)	Next steps: Continue with discharge service model and rapid response provision.
6	Trusted assessment	There are two strengths based practitioners and 1.6 occupational therapists (OT) plus an additional 0.6 OT funded through iBCF. (Scheme 6)	Next steps: Consider training all staff in team to be trusted assessors
7	Engagement and Choice Discharge scheme. LA discharge fund. ICB discharge fund.	The strengths-based approach is used as part of early discharge planning to promote engagement and choice around the appropriate pathway. (scheme 4, 19 and 20)	Next steps: Continue to develop and implement a strengths-based approach.

8	Improve discharge to care homes	There are no care homes within City of London boundaries and all of our care home provision is spot purchase. This is built into early discharge planning with commissioners. Our brokerage pilot is designed to improve the efficiency of the process of purchasing placements, especially when placements are rapid. The pilot will also strengthen quality assurance. (Scheme 3)	Next steps: evaluation of pilot
9	Housing and related services	We are reviewing our DFG process and developing a Housing Assistance Policy to make best use of our DFG as many people are self funders. None of our hospital discharges have needed a DFG but we have undertaken some deep cleans and provided equipment to facilitate discharge. We work with our housing service on urgent adaptations to our own stock and our OT is involved in this. Our early intervention project can provide things that facilitate a return home e.g. a microwave, supporting a better discharge pathway. (Scheme 5)	Next steps: DFG review and development of Housing Assistance Policy

Disabled Facilities Grant (DFG) in Hackney

Aim

The Disabled Facilities Grant (DFG) provides funding to enable disabled residents to live in their homes as safely and independently as possible.

The local authority Occupational Therapists ot@hackney.gov.uk carry out assessments and make recommendations for a range of adaptations such as wet floor showers, ramps, stair lifts, ceiling track hoists and through floor lifts. The adaptations are then sent to the Private Sector Housing Team (PSH) pshgrantsfolder@hackney.gov.uk who arrange for the works through the commissioned Home Improvement Agency (HIA)

London Borough of Hackney (LBH) has a **Housing Grants and Assistance DFG policy** which is underpinned by the council's vision of "building to make Hackney a place for everyone" and objectives set out in Hackney Community Strategy 2018-2028 such as helping disabled people to stay active and healthy, both physically and emotionally. The policy uses the powers set out under the Regulatory Reform Orders to provide more flexibility in the delivery of the DFG. The policy was signed off by housing authorities in LBH.

Key inclusions in the policy

- Joint working with health to prioritised assessments and adaptation delivery for residents discharged from hospital - which include works such as deep cleaning and boiler replacements.
- The £10,000 is not means tested, and this will be reviewed in September 2023
- Relocation grants of maximum £20,000
- Innovative adaptations designs for Hackney's 'period' housing stock

DFG - City of London

As noted in the HICM self-assessment, we provide deep cleaning, decluttering and aids and minor adaptations to facilitate discharge. To date no major adaptations have been required to facilitate discharge. Most of our DFGs come from housing association stock in the City of London - the private sector is very small and most owner occupiers would be self-funders and do not approach in the first place.

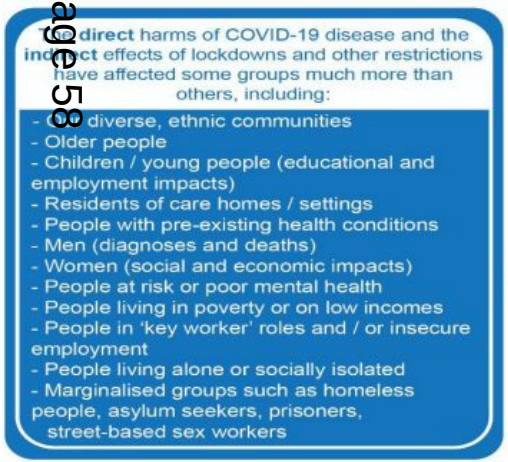
The OT works well and closely with our housing department to support appropriate adaptations in our own stock.

DFGs are held and managed within our ASC Team and the use of an external support agency. Through our other work such as the ADMs and MDTs and general collaboration with health, where appropriate, there is joint working around adaptations.

There were 9 DFG cases in 2022-23. 1 was for an under 18 year old, 1 was for the 19-64 age range, and 7 were for 65 and overs. 5 had been completed, 1 was closed, 3 remain open.

However, we want to do more. The City of London is reviewing its DFG process as part of its ASC Transformation and Change Programme. The review includes analysing and learning from good practice, identifying how we can increase awareness and take-up of the DFG, especially with regards to the use of assistive technology and infrastructure and developing a Housing Assistance Policy to help encourage greater uptake and use surplus DFG funding more effectively to meet wider needs (e.g. self funders).

Tackling Health Inequalities in City and Hackney



The breadth and depth of the impacts of COVID-19 emphasise the need for collective, system-wide action to address health inequalities that have been starkly exposed by the current pandemic.

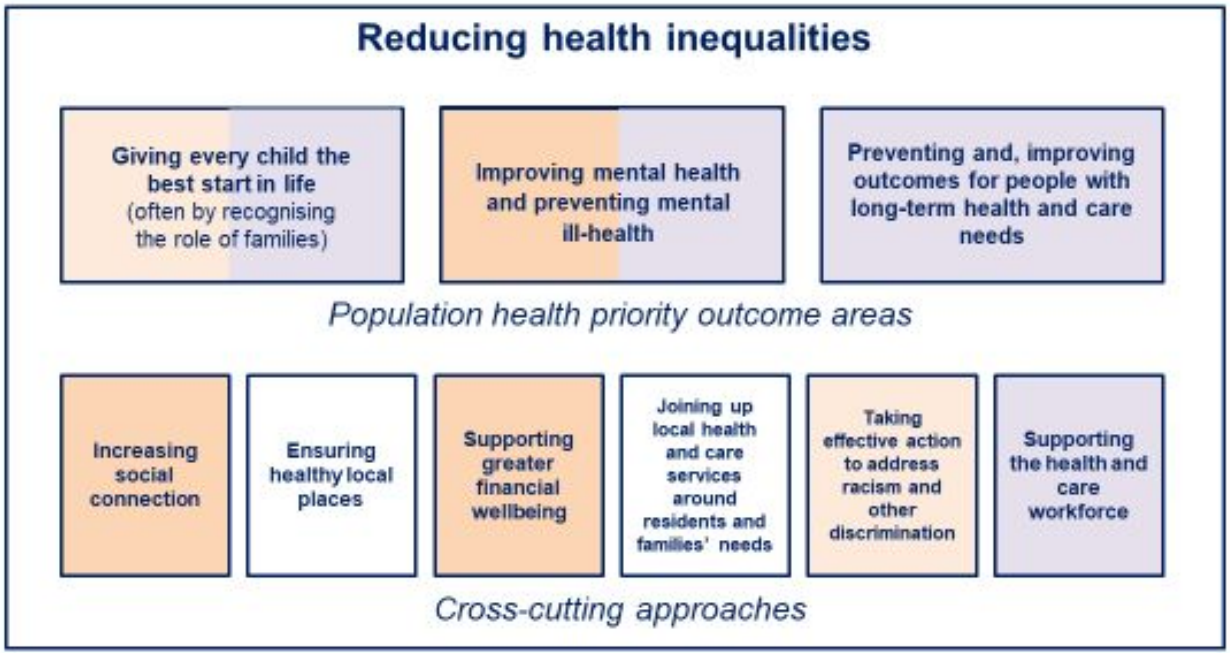
The City and Hackney Place-Based Partnership and both Health and Wellbeing Boards have adopted a population health approach that aims to improve physical and mental health outcomes, promote wellbeing, and reduce inequalities.

The City and Hackney Health Inequalities Steering Group has been convened to ensure our collective efforts have maximum impact, and that we make best use of our combined resources, through collaboration and a partnership approach.

Ten broad areas for local system-wide action to tackle health inequalities in City and Hackney

Act: Health Inequalities Steering Group leadership and mobilisation of system resources	1. Inequalities data and insights	Routine collection and analysis of equalities data and insight to inform action
	2. Tools and resources	Develop / enable system-wide adoption of tools to embed routine consideration of health equity in decision-making
	3. Tackling structural racism and systemic discrimination	Adopt a partnership position and action plan to tackle racism and wider discrimination within local institutions
	4. Community engagement, involvement & empowerment	Build trust and adopt flexible models of engagement to work in partnership with residents to improve population health
Sponsor: Led from elsewhere, but Health Inequalities Steering Group role to champion, facilitate partnership working, ensure focus on reducing inequalities	5. Health (equity) in all policies	Ensure wider policies and strategies explicitly consider and address health inequalities
	6. Anchor networks	Anchor institutions collectively use their local economic power to lead action on reducing social inequalities
	7. Strengths-based, holistic approach to service provision	No wrong door access to support residents to address wider health and wellbeing needs, include building a preventative approach across all public services
	8. Staff health and wellbeing	Build on COVID-19 risk assessments to provide ongoing support for wider staff wellbeing needs
Watch: Monitor progress of existing partnership work to tackle inequalities	9. Tackle the digital divide	Pool system resources to address the 3 dimensions of digital exclusion: skills, connectivity, and accessibility
	10. Tailored, accessible info about services & wider wellbeing support	Produce information in community languages that is culturally appropriate and responsive to local diverse needs

Strategic focus areas for the City and Hackney Place-based Partnership



=Hackney HWB focus area

= Hackney HWB specific 'lenses': (approaches to reducing health inequalities)

= NEL ICS four partnership priority areas

= reflecting LTP response / long term C&H partnership ambitions / Neighbourhoods Programme vision

Equality and health inequalities

National priorities (e.g. Core20Plus5), local data on health needs, insight on what is important to residents, and insights from the voluntary sector have informed partnership decisions on non-recurrent funding to support projects that need investment to address health inequalities.

Where any new BCF schemes are developed or commissioned an Equality Impact Assessment (EIA) is carried out. None of the schemes in the BCF are identified as having a negative impact on any protected characteristic groups. Several of the services (e.g. CoL care navigator scheme) are universal and available to those who require it.

The following BCF schemes play a core part in reducing health inequalities and disparities for the local population, taking account of people with protected characteristics:

- DES Supplementary Care Homes Service for older adults (CoL scheme 16 , LBH scheme 23)
- Neighbourhood approach to population health that addresses the variation seen between populations at the 30-50,000 level (CoL scheme 18, LBH scheme 10)
- End-of-life care through St Joseph's Hospice and Marie Curie Rapid Response End of Life service (CoL scheme 10/22, LBH 14/54)
- Adult Cardiorespiratory Enhanced and Responsive Service (ACERS) and Asthma services aim to reduce inequalities in management of long-term conditions CoL 7/9, LBH 11/13)

Equality and health inequalities - BCF

- The Homelessness Pathway team and Lowri House step-down accommodation which supports the more at risk homeless and disenfranchised population often missing out on any healthcare. (LBH Scheme 21; 22 & 29).
- As part of the PPL discharge report, we asked the review team to consider equality of access to discharge services. During the transformational work to redesign discharge services in the Homerton and LBH we will conduct an Equality Impact Assessment (EIA) to ensure equal access (LBH)
- Carers support service is now provided by Tower Hamlets Carers Centre who can provide a more culturally appropriate service to reach carers on the east of the City of London who were often hidden. The service has now engaged with 45 new carers, 38 of whom are from more the east of the City (CoL scheme 6)
- Rough sleepers: Strength-based Practitioner post in the rough-sleeping homelessness service and access to primary care services. Some of our IBCF money has established integrated health and care work for rough sleepers which has been continued with specific rough sleeping funding (CoL scheme 6)

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Complete:
Health and Wellbeing Board:	City of London		Yes
Completed by:	Ellie Ward		Yes
E-mail:	ellie.ward@cityoflondon.gov.uk		Yes
Contact number:	2073321535		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Fri 22/09/2023	<< Please enter using the format, DD/MM/YYYY	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Member	Mary	Durcan	mary.durcan@cityoflondon.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Ms	Zina	Etheridge	zina.etheridge1@nhs.net	Yes
	Additional ICB(s) contacts if relevant	Ms	Nina	Griffith	nina.griffith@nhs.net	Yes
	Local Authority Chief Executive	Mr	Ian	Thomas	ian.thomas@cityoflondon.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)	Ms	Judith	Finlay	judith.finlay@cityoflondon.gov.uk	Yes
	Better Care Fund Lead Official	Ms	Ellie	Ward	ellie.ward@cityoflondon.gov.uk	Yes
	LA Section 151 Officer	Mr	Mark	Jarvis	mark.jarvis@cityloflondon.gov.uk	Yes
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	ICB BCF Lead for City	Ms	Cindy	Fischer	Cindy.fischer@nhs.net	

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

#REF!

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	#REF!
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: City of London

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£37,091	£37,091	£37,091	£37,091	£0
Minimum NHS Contribution	£893,101	£943,650	£893,101	£943,650	£0
iBCF	£323,659	£323,659	£323,659	£323,659	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£45,376	£74,700	£45,376	£74,700	£0
ICB Discharge Funding	£4,181	£8,881	£4,181	£8,881	£0
Total	**£1,303,408**	**£1,387,981**	**£1,303,408**	**£1,387,981**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£234,089	£247,339
Planned spend	£529,913	£548,298

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£163,508	£172,763
Planned spend	£347,597	£379,292

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	25.8	38.0	38.0	77.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	865.0	847.7
	Count	14	13.72
	Population	433	1464

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.7%	94.2%	94.2%	93.3%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	0	410

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	96.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: City of London

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month.
The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.
Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. **Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.**	We do not have block contracts for residential or nursing care - these are spot purchased and our average

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!! | **Demand - Hospital Discharge**

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BARTS HEALTH NHS TRUST	Social support (including VCS) (pathway 0)	1	1	1	1	1	1	2	2	2	2	2	2
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST		0	0	0	0	0	1	2	2	2	2	2	1
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	1	1	0	0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	0	1	1	0	1	2	2	2	2	1	1
OTHER		0	1	1	1	0	2	2	2	2	2	2	1
BARTS HEALTH NHS TRUST	Reablement at home (pathway 1)	0	0	1	0	0	1	2	2	2	2	2	2
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	1	0	0
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	1	0	0	0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	1	0	1	2	1	2	1	1	0
OTHER		0	0	0	0	0	0	0	0	1	0	0	0
BARTS HEALTH NHS TRUST	Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
BARTS HEALTH NHS TRUST	Short term domiciliary care (pathway 1)	0	0	0	0	0	0	2	1	2	1	1	1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST		0	0	0	0	0	0	0	1	1	1	0	0
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	1	1	2	2	2	1	0
OTHER		0	0	0	0	0	0	0	0	1	0	0	0
(Please select Trust/s.....)	Reablement in a bedded setting (pathway 2)												
BARTS HEALTH NHS TRUST		0	0	0	0	0	0	0	1	1	1	1	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	1	0	0	0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	1	1	1	1	0
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)												
BARTS HEALTH NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
BARTS HEALTH NHS TRUST		0	0	0	0	0	0	0	0	1	0	0	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
HOMERTON HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	1	1	0	0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	1	1	0	0
OTHER		0	0	0	0	0	0	0	0	1	0	0	0
Totals	Total:	1	2	4	4	1	8	15	17	28	21	14	8

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0	0	0
Reablement at home	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	1	0	1	0	1	1	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Reablement at Home	Monthly capacity. Number of new clients.	1	1	1	1	1	1	1	1	1	1	1	1	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Short term domiciliary care	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2	2	2	0%	100%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	1	1	1	1	1	1	1	1	1	1	1	1	0%	100%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	0	0	0	0	0	0	1	1	1	0	0	0	0%	100%	0%

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Urgent Community Response	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Reablement at Home	Monthly capacity. Number of new clients.	1	1	1	1	1	1	1	1	1	1	1	1	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%

Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	1	1	1	1	0	0	0	100%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Other short-term social care	Monthly capacity. Number of new clients.	1	1	1	1	1	1	1	1	1	1	1	1	0%	100%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: City of London

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
City of London	£37,091	£37,091	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£37,091**	**£37,091**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
City of London	£45,376	£74,700	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS North East London ICB	£4,181	£8,881	Yes
Total ICB Discharge Fund Contribution	£4,181	£8,881	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
City of London	£323,659	£323,659	Yes
Total iBCF Contribution	**£323,659**	**£323,659**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
				Yes
Total Additional Local Authority Contribution	**£0**	**£0**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS North East London ICB	£893,101	£943,650
Total NHS Minimum Contribution	**£893,101**	**£943,650**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£893,101**	**£943,650**	

Yes

	2023-24	2024-25
Total BCF Pooled Budget	**£1,303,408**	**£1,387,981**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: City of London

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£37,091	£37,091	£0	£37,091	£37,091	£0
Minimum NHS Contribution	£893,101	£893,101	£0	£943,650	£943,650	£0
iBCF	£323,659	£323,659	£0	£323,659	£323,659	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£45,376	£45,376	£0	£74,700	£74,700	£0
ICB Discharge Funding	£4,181	£4,181		£8,881	£8,881	£0
Total	**£1,303,408**	**£1,303,408**	**£0**	**£1,387,981**	**£1,387,981**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£234,089	£529,913	£0	£247,339	£548,298	£0
Adult Social Care services spend from the minimum ICB allocations	£163,508	£347,597	£0	£172,763	£379,292	£0

Checklist

Column complete:

Yes	Yes	#REF!	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	#REF!	Yes	Yes

!!! Critical errors detected !!!

This is usually due to cutting and pasting into cells - Please start over from the last working copy of this template or contact the BCF Team for support: england.bettercarefundteam@nhs.net

									Planned Expenditure									
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	CoL-Care Navigator Service	To ensure safe hospital disharge for City of London residents	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£60,000	£63,396	100%
2	CoL-Carers' support	To provide specialist indpendent support, information and advice for	Carers Services	Other	Provides specialist independent	50	55	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£14,352	£15,175	100%
3	Brokerage pilot (one-year)	To provide a more efficient and effective commissioning of placements including for	Residential Placements	Other	Commissioning	12	12	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	New	£50,000	£52,830	100%
4	CoL-Discharge Scheme	To prevent hospital admissions and provide an intensive discharge to assess	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£223,245	£235,881	100%

5	Disabled Facilities Grant	To support Diasbled people to live more independently in their own homes	DFG Related Schemes	Adaptations, including statutory DFG grants		10	10	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG	Existing	£37,091	£37,091	100%
6	iBCF	Meeting adult social care needs by delivering a targeted, preventative,	Care Act Implementation Related Duties	Other	Adult social care support				Social Care		LA			Local Authority	iBCF	Existing	£323,659	£323,659	100%
7	Adult Cardiorespiritory Enhanced and	ACERS Respiratory Service is a 7 day service, that provides care and support to anyone	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£22,760	£23,446	12%
8	Bryning Day Unit/Falls Prevention	The Bryning Unit is a multidisciplinary team running a weekly programme	Prevention / Early Intervention	Other	Physical health and wellbeing				Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£14,186	£14,613	100%
9	Asthma	This service will offer asthma expertise in the community in order to train health	Community Based Schemes	Other	Education and training of HCP and patients.				Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£1,405	£1,447	1%
10	St Joseph's Hospice	Community-based and inpatient palliative care services	Personalised Care at Home	Physical health/wellbeing					Other	Charity	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£85,597	£88,472	27%
11	Paradoc	The service provides an urgent GP and paramedic response service to patients	Urgent Community Response						Primary Care		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£20,961	£21,592	100%
12	Adult Community Rehabilitation Team	To provide specialist inter-disciplinary and uni-disciplinary rehabilitation to	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£162,846	£167,915	87%
13	Adult Community Nursing	To provide an integrated, case management service to patients living within the	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£217,454	£224,222	68%
14	Pathway Homelessness Hospital Discharge	Multidisciplinary hospital discharge team for homeless individuals. Also provides	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Other	Works across acute and mental health	NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£1,513	£0	1%
15	Pathway Charity Franchise Fee	Direct Support from Pathway's Support Service	Enablers for Integration	Other	Data, evaluation, workforce development,				Other	Works across acute and mental health	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£540	£0	100%
16	DES Supplementary Care Homes	GP enhanced services within older adults care homes.	Personalised Care at Home	Physical health/wellbeing					Primary Care		NHS			NHS	Minimum NHS Contribution	Existing	£5,475	£5,595	2%
17	GP out of hours home visiting service	Primary Care out of hours for patients requiring home visits. Delivered by a social	Personalised Care at Home	Physical health/wellbeing					Primary Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£10,680	£10,914	3%
18	Neighbourhood - Community Pharmacy	Community pharmacy	Integrated Care Planning and Navigation	Other	Community pharmacy				Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£2,087	£2,152	3%
19	Local authority discharge funding	Support hospital discharge	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£45,376	£74,700	16%
20	ICB discharge fund	Support hospital discharge	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	ICB Discharge Funding	Existing	£4,181	£8,881	2%
21	System pressures	Respond to system pressures	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£0	£12,010	100%
22	Out of hours rapid response end of life care service	Rapid response overnight support, information and crisis internvention to	Personalised Care at Home	Physical health/wellbeing					Other	Charity	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	New	£0	£3,990	100%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: City of London

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	116.2	58.1	58.1	44.0	The indicator values for 2023-24 are based on the data from 22-23. There was under achievement across all quarters from last year's plan so we have used the similar figures this year. Q1 is actual data.	The following services funded are by the BCF and aim to support people living with long-term conditions and/or provide an urgent community response: • Neighbourhoods Programme • Adult Community Nursing Service • Adult Cardiorespiratory Enhanced + Responsive Service (ACERS) • Paradoc	Yes
	Number of Admissions	9	3	3	-			
	Population	9,721	9,721	9,721	9,721			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	25.8	38	38	77			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	0.0	865.0	847.7	The latest baseline data was reviewed in conjunction with local schemes to provide an improvement for 23-24 based on the estimated 2022-23 data.	Paradoc and the Integrated Independence Team comprise our urgent community response which includes a joint falls service. In addition to providing an urgent response if someone has fallen, they will also complete a falls assessment and make onward referrals as necessary. The Telecare Response service also provides	Yes
	Count	0	14	13.72			Yes
	Population	0	433	1464			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	91.6%	94.1%	94.2%	93.4%	The 2023-24 plan is based on trends from the last 12 months of activity, which does show average increases in overall acute hospital activity (denominator). The number and proportion of patients being discharged to their normal place of residence has accelerated in 2022-23. and this reflected, in line with local plans and	We have no local care homes or intermediate care beds which has reinforced our Home First approach. The Discharge scheme and Care Navigator Service are key to enabling people to return home in addition to other community health services funded via the BCF	Yes
	Numerator	98	96	97	108			
	Denominator	107	102	103	116			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	91.7%	94.2%	94.2%	93.3%			

	Numerator	99	97	98	98	ambitions.		Yes
	Denominator	108	103	104	105			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	0.0	300.5	420.7	410.2	We do well at keeping people independent in the community but we do have an aging population and long life expectancy. Admissions to residential homes vary given our small population size, and 2022-23 was higher, therefore we have reflected that	We have a strength-based assets approach designed to help people maximise their independence for as long as possible. We can provide complex care at home but when needs become too great or complex then residential care can be more	Yes
	Numerator	0	5	7	7			Yes
	Denominator	1,731	1,664	1,664	1,706			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	100.0%	90.0%	91.7%	96.0%	We anticipate similar numbers to 22-23 of those receiving reablement and aim to maintain good performance with some improvement.	We have a commissioned reablement service which provides good quality support and has an appropriate level of capacity.	Yes
	Numerator	6	9	22	24			Yes
	Denominator	6	10	24	25			Yes

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: City of London

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes	Slide 4 Planning Template completed		
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes	Joint approach & Joint Commissioning - Slides 9, 16 Health inequalities Slide 42-45 Changes to local priorities related to Equality Slide 44-45		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes	Slide 41		
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	Prevention & support projects & Expenditure Slide 18 Capacity - template -Capacity and demand tab and expenditure tab		

Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes	Slide 34 We have not been identified as an area of concern for discharge.		
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes	Slide 18 HICM 37-39		
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	Carers Slide 14 Reablement - Slides 10, 34		
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes			

Committee(s) Health and Wellbeing Board	**Dated:** 22 September 2023
Subject: The health and wellbeing of the City's hidden and essential workers	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	*2) People enjoy good health and wellbeing.* *3) People have equal opportunities to enrich their lives and reach their full potential.* *5) Businesses are trusted and socially and environmentally responsible*
Does this proposal require extra revenue and/or capital spending?	Not at this stage
If so, how much?	To be determined
What is the source of Funding?	N/A
Has this Funding Source been agreed with the Chamberlain's Department?	N/A
Report of: Sandra Husbands	For Decision (on a resolution)
Report author: Froeks Kamminga, Chris Lovitt	

Summary

The hidden workforce are those essential staff in routine, manual and service occupations who often work during anti-social hours and without whom businesses could not function. Published reports have confirmed that shift workers often have significantly worse health and wellbeing with increased health inequalities.

Reports, presentations and updates have been undertaken to the Board and other bodies within the Corporation over the last six months to raise awareness on the issue of health inequalities for people who are employed in the hidden workforce, and present recommendations for change. The Health and Wellbeing Board is now requested to consider adopting a formal Resolution to the City of London Corporation in relation to two key recommendations for third party employment contracts relating to a) immediate sick pay -also known as Safe Sick Pay and b) death in service benefits.

Recommendations

Members are asked to:

- Note the actions taken or planned since the last update
- Consider adopting a Resolution for consideration by the relevant committees of the City of London Corporation

Main Report

1. Background

1.1. Business Healthy is an innovative partnership hosted and run by the City of London Corporation which aims to “bring together businesses in the City to ignite a positive change in the health and wellbeing of their workforce.”

1.2. Since 2019 Business Healthy has been working to better understand the health and wellbeing needs of the so called “hidden workforce”. The hidden workforce are those essential support staff in routine, manual and service occupations such as cleaners, maintenance workers, construction workers and security staff who often work during anti-social hours and without whom businesses could not function. Published reports have highlighted that shift workers often have significantly worse health and wellbeing with increased health inequalities.

1.3. A report was presented to the Health and Wellbeing Board In March 2023 with a number of recommendations for consideration by the Board, its members and the City of London Corporation. This report built on a research report[1] commissioned by Legal & General, a key business member of the ‘Hidden Workers’ project team convened by Business Healthy, into the lived experience of a number of essential workers. It suggested a number of management and procurement recommendations to improve health and wellbeing outcomes for hidden and essential workers, often contracted via third party contracts. These relate to sick pay, death in service benefits, shift work and access to online healthcare, to name a few.

1.4. Both the research report and the report to the Board were well received and several follow up actions were assigned to officers.

1.5. At the June 2023 Board a verbal update was provided on actions taken since the March meeting, a summary of which is presented here:

1.5.1 A meeting took place with the Director of Equality, Diversity and Inclusion, who welcomed the report’s synergy with the City of London’s equality objectives in terms of the London Living Wage and social mobility. The Director agreed to attend the Health and Wellbeing Board when it receives the next iteration of this report. Further engagement will now be deferred until a new Director of Equality, Diversity and Inclusion is in post.

1.5.2 A presentation of the report and its recommendations was made to the Senior Leadership Team (SLT), chaired by the Town Clerk and Chief Executive, on 23 May. The following actions were taken from this meeting:

1.5.3 The Chief Operating Officer to conduct a health check on the Procurement Code and to feed the ‘hidden workers’ suggestions into the ongoing review of pay and reward.

1.5.4 The City Surveyors to review the Facilities Management contract to look at quick wins; e.g. the provision of microwaves and break spaces.

[1] https://group.legalandgeneral.com/media/o1wfq1qp/2829476_hidden-workers-report_v9-0-22-final.pdf

1.5.5 The Town Clerk and Chief Executive asked for further suggestions to be brought to the SLT Meeting.

1.6. Subsequently, a meeting was held with the Chief Operating Officer (COO) who confirmed that 15% of the weighting on contractual awards criteria is on responsible procurement, including the London Living Wage. The COO further advised of the complexities in casual staffing structures and that the potential cost and impact implications of the various recommendations would need to be analysed. Therefore, the Health and Wellbeing Board (HWB) might need to take a formal Resolution to the relevant Committee(s) in terms of the next steps.

2. Current Position

2.1. Following this update at the June Board Meeting, the Members requested that they would receive a more comprehensive report at the September Board, at which time consideration could be given to the Resolution that was suggested by the COO.

2.2. A key observation by Members was that, in terms of reviewing procurement and workplace policies, this should also to be undertaken by other partners on the Health and Wellbeing Board. To support this, the Deputy Director of Public Health suggested presenting the report to NHS partners some of whom have contracted out their cleaning and support staff.

2.3. This engagement with NHS partners will take place on 14 September at the Place Based Delivery Group that is chaired by Member Nina Griffiths. A verbal update can be provided to the HWB on agreed next steps

2.4. In addition, work within the 'Hidden workers' project team continues and one of the key business partners, L&G, in collaboration with PwC, is planning a symposium in London and Leeds on 8 November to focus on and promote Safe Sick Pay[2]. Part of this event will be a VIP breakfast meeting to which City of London Corporation representation has been requested.

2.5. Engagement has been initiated with the Responsible Procurement Manager (Operations) to assess the existing guidance on ethical procurement, and undertake a review of existing contracts, especially within the Integrated Facilities Management Contract, to scan whether any of the existing suppliers are applying immediate sick pay, and/or any of the other suggested recommendations from the research report.

3. Recommendations for discussion

3.1. To request an update on the health check on the Procurement Code and the reflection of 'hidden workers' suggestions into the pay and reward process.

3.2. Following on the previous activities and suggestions, the Board considers adopting a series of Resolutions and asks that these be considered by the appropriate committees of the City of London Corporation:

[2] See for more information on Safe Sick Pay: SSP campaign

The board is requested to consider the following as resolutions:

a) The Corporation to note the potentially detrimental impact that low paid shift work can have on the health and wellbeing of staff including those from the hidden and essential workforce.

b) For the Corporation to continue to support studies which seek to identify potential actions that can address health inequalities in the essential and hidden workforce.

c) For the Corporation to note the recommendations for sick pay and death in service eligibility, without a qualifying period, for workers and to request that further work is undertaken to assess the likely cost and benefits and human resources implications of implementation.

4. Corporate & Strategic Implications

- *Strategic implications*

  Following through on recommendations in the Hidden Workers report will contribute to the following strategic priorities:

  Contribute to a flourishing society

  People enjoy good health and wellbeing.

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

  Support a thriving economy

  Businesses are trusted and socially and environmentally responsible.

- *Financial implications*

  The financial implications and cost/ benefits of adopting the recommendations for sick pay and death in service benefits without a qualifying period would need to be determined if the resolutions were accepted.

- *Resource implications*

  Determining the costs benefit, human resources and wider implications of adopting the recommendations would need further work to determine the likely resource implications.

- *Legal implications*

  None directly. Indirectly, following through on recommendations may lead to review of contracting and procurement policies, especially for outsourced services.

- *Risk implications*

  None

- *Equalities implications*

  The HWB is specifically tasked with promoting good health and wellbeing for its local population and for tackling health inequalities. Active follow up to the recommendations of the Hidden Workers report will contribute to addressing health inequalities among people working in routine, manual and service roles. Further work on the intersectionality of poorer health outcomes amongst the hidden and essential workforce with many of the workers being from ethnic minorities is needed.

- *Climate implications*

  No specific implications but environmental issues are part of the wider determinants of health.

- *Security implications*

  None

5. Conclusion

5.1. To continue the important work to address health inequalities among people working in routine, manual and service occupations, the Board is requested to consider adopting a series of resolutions for consideration by the City of London Corporation that will seek to improve the health and wellbeing of the hidden and essential workforce.

Froeks Kamminga
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Committee: Health and Wellbeing Board - For information	**Dated:** **01/09/2023**
Subject: Healthwatch City of London Progress Report	**Public**
Report author: Gail Beer, Chair, Healthwatch City of London	

Summary

The purpose of this report is to update the Health and Wellbeing Board on progress against contractual targets and the work of Healthwatch City of London (HWCoL) with reference to Quarter 2 2023/24

Recommendation

Members are asked to: Note the report.

Main Report

Background

Healthwatch is a governmental statutory mechanism intended to strengthen the collective voice of users of health and social care services and members of the public, both nationally and locally. It came into being in April 2013 as part of the Health and Social Care Act of 2012.

The City of London Corporation has funded a Healthwatch service for the City of London since 2013. The current contract for Healthwatch came into being in September 2019 and was awarded to a new charity Healthwatch City of London (HWCoL). HWCoL was entered on the Charities Commission register of charities in August 2019 as a Foundation Model Charity Incorporated Organisation and is Licenced by Healthwatch England (HWE) to use the Healthwatch brand.

HWCoL's vision is for a Health and Social Care system truly responsive to the needs of the City. HWCoL's mission is to be an independent and trusted body, known for its impartiality and integrity, which acts in the best interests of those who live and work in the City.

1 Current Position

The HWCoL team has continued to operate from the Portsoken Community Centre. Through hybrid working – both at the office and home working – and maintained output of up-to-date information in a rapidly changing environment. The new team operating out of Portsoken are developing a good rapport with local people and community groups.

The communication platforms continued to provide residents with relevant information on Health and Social care services via the website, newsletters, bulletins

and social media. The Healthwatch City of London website has been updated to the Drupal 9 hosting site which allows for more functionality.

The recruitment of new Trustees to the Board remains challenging, the team are in conversations with one possible candidate, however another Trustee to increase diversity on the Board and to ensure representation of communities of the City would be welcome.

2 Extension of the HWCoL contract

HWCoL are pleased to report that the City of London Corporation have agreed to a year's extension of the current contract, at the increased funding level agreed last year. The extension contract is currently being written by the City of London Corporation. HWCoL are not anticipating any changes to the deliverables in our current contract.

3 Annual report

In July HWCoL published its Annual Report from 2022/23, the report highlights our achievements over the past year, an overview of our projects and events. Some of the highlights include:

- Successfully negotiating with St Bartholomew's Hospital to carry out ECGs and echocardiograms at the Neaman Practice, saving residents having to journey to UCH.
- Supporting and campaigning for the Foot care service and contributing to the securement of additional clinics (provided by Hoxton Health) at both the Neaman Practice and the Portsoken Community Centre.
- Supporting the development of the London Ambulance Service five-year strategy, as noted in our last report; and
- Continued working with the Neaman Practice to ensure the practice team were responsive to service users.

The report is available on the HWCoL website and is attached as an appendix to this report.

4 Annual Survey

The annual survey of residents and stakeholders was undertaken throughout July the aim of which is to determine the levels of awareness and engagement with Healthwatch City of London.
The survey was promoted to residents across the City of London via the newsletter, bulletins, and website with added promotion on social media.

Stakeholders received a separate survey via email. The aim of this survey is to give insight into how partners view the organisation's effectiveness and how well HWCoL works in partnership with key stakeholders.

Response to both surveys was disappointing with 18 responses to the community survey, which is around the same as last year, but only three responses to the stakeholder survey.

However, the responses received were very positive, with 100% of respondents stating that they feel Healthwatch is very effective in its role, and that our communications are very informative and useful.
It also highlights the need to increase the visibility of Healthwatch across the City of London and that residents would like more information on the meetings that are attended on their behalf.
The outcomes from the survey will be used to shape the communications and engagement strategy that is currently being reviewed.
The full report from the survey has yet to be reviewed by the Board but will be distributed at the next Health and Wellbeing Board.

5 Areas of concern

HWCoL remains concerned about the engagement with City residents and subsequent decision-making processes and the impact on City residents by NHS North East London and the ICB.

HWCoL attend meetings on behalf of City residents to ensure representation. Specifically, the Residents Involvement Committee which now has a detailed action plan to represent and involve residents from across City and Hackney. More support from the City of Corporation is now evident with the strategy and projects officer attending many of the meetings too, however there is concern that funding for patient involvement and engagement across the City has been given to Hackney CVS and is taking place without our involvement. We have contacted Hackney CVS to discuss their plan for engagement. HWCoL will continue to monitor the level of engagement with City of London residents.

5.1 St Leonards Hospital site Redevelopment

There is no change to this area. As reported previously HWCoL were involved in the scrutiny of the St Leonards redevelopment project, this project was put on hold last year, and there is yet to be an update on its status. The services offered at St Leonards play an important part in the delivery of care to City residents. Without a clear strategy there is some uncertainty of the future of the site and the services within it and the likely impact on residents. The HWCoL team will ask for un update from the ICB.

5.2 Neaman Practice

The next quarterly meeting with the Neaman Practice is scheduled for early September. A new Practice Manager has been recruited; we will be closely scrutinising the handover of roles. HWCoL have been made aware of duplication of prescribed medicines by the Portman Pharmacy. The Neaman Practice are aware of the problem and have begun to reject some requests from the pharmacy and are calling patients to double check they have the correct amount of medication.

The Practice is now working more closely with the Shoreditch Park and City PCN, utilising and accessing system wide services, such as the Better Together initiative. They also now hold a weekly coffee morning for patients. HWCoL will attend the

coffee mornings on a regular basis to talk to patients about their experiences of the Practice, this will be fed back to the Practice in the quarterly meetings.

5.3 Digital exclusion

Barts NHS Trust have recently launched a patient portal, Patients Know Best, and there is an increasing emphasis from the Neaman Practice on patients using the NHS App, and appointments booking via their website. This is good news for many patients but, is an area of concern for patients who are unable to access these digital options, with a risk of them becoming excluded. HWCoL are working on a project to look at the extent of digital exclusion across City residents and will be holding a face-to-face event to discuss concerns. HWCoL understands that the City of London Corporation have undertaken some research into digital exclusion and have requested to view the findings. HWCoL have also had discussions with the Older Persons Reference Group about the issues faced.

5.4 Mental Health Service Provision and Social Isolation

Discussions are currently underway with ELFT and the City and Hackney Public Health to address Social Isolation, its extent across the City, current service provision and what needs to be put in place to address the issue. HWCoL are hoping to undertake this project with colleagues at City Connections and MIND.

5.5 Over prescribing at the Portman Pharmacy

HWCoL have been made aware of over dispensing of repeat prescriptions by the Portman Pharmacy. Dr Paul Gilluley, Chief Medical Officer at NHS North East London has been made aware of this as have the Neaman Practice. NEL have the medicines optimisation team looking into the situation and the Neaman Practice are monitoring and have also requested a meeting with the pharmacy to discuss.

6 Public Board Meetings

HWCoL held a Public Meeting in June on the topic of mental health service provision across the City. Jed Francique, Borough Director for City & Hackney, ELFT was our speaker for the event who gave an overview of access to services and service provision to City Residents.
Unfortunately, there was low attendance at the event, it was held on the hottest day of the year, and as an in-person event. The team are exploring new ways of increasing attendance at events with greater promotion through leafleting and the possibility of hybrid meetings.

7 Communications and Engagement

7.1 Patient Panels

The ‘Patient Panels’ series will recommence in September 2023.
The first of the series will be held with the North East London Cancer Alliance on 28th September and will enable residents to find out more about the cancer screening programme in the City and answer any questions residents may have.

Residents will be consulted on panel topics, to ensure HWCoL are addressing the real concerns of service users. The panels will also be used to gain greater

understanding and insight on projects that HWCoL are undertaking, for example Digital Exclusion and Social Isolation and inform the need for further work. The results will also be shared with key stakeholders to assist in shaping changes to services.

7.2 Communications and Engagement Strategy
A review is currently underway of the communications and engagement strategy. The review will take into account and use the feedback gained from the annual survey. The strategy will be presented at our Annual Public Meeting in October. The Board are currently working with a local resident with marketing skills to determine what more can be done to engage a broader spectrum of local residents. The preliminary results of the recent survey, suggest there is more to be done in this area.

7.3 Annual General Meeting
In October Ian Thomas, Town Clerk will be our main speaker at HWCoL AGM. This will be held at St Giles Church, Cripplegate on 19th October at 10am.

8 Projects

City and Hackney COVID rehabilitation Service Project
The aim of this project was to improve access to Long COVID services for residents, particularly those from underrepresented populations, living in City & Hackney.

The City & Hackney COVID Rehabilitation (CoRe) Service provides an established multi-disciplinary, community-based, therapy-led assessment and rehabilitation outpatient service for individuals experiencing the impact of symptoms associated with Long COVID.

The service currently offers flexible rehabilitation options in keeping with current NICE guidelines for managing the long-term effects of COVID-19, including input from a GP, physiotherapy, occupational therapy, psychological therapy, and speech and language therapy.

The CoRe service also provides care-coordination in navigating any employment and financial impact of Long COVID. By helping individuals understand what support is available to them and guiding them through the complex process of application forms, patients have avoided eviction, managed rent payments, bought food, paid for travel to appointments, and were provided with access to digital devices to facilitate engagement with healthcare.

Since its establishment in January 2021, it has become apparent that the demographics of patients accessing the City & Hackney CoRe Service does not accurately reflect the population of City & Hackney, with underrepresentation from marginalised groups including Black, Asian and other ethnic minorities.

However, it was crucial to understand the scale of the impact of Long COVID in the community and the degree of unmet need amongst the local population. For this purpose, the City & Hackney Long COVID 'deep dive' survey was initiated as a collaboration between the City & Hackney CoRe service, Healthwatch City of London, and Healthwatch Hackney.

The set of recommendations devised from the report are designed to enhance support structures for Long COVID patients. The primary focus of these include Awareness and Education, Enhanced Referral Process and Care Coordination, Support for Self-Management, Collaboration and Partnerships, and Inclusive Support Services.
It is hoped that the implementation of these strategies by the CoRe Service and partner organisations promises to improve care coordination, patient empowerment, and foster stronger collaboration with relevant stakeholders.

The full report from the project is attached as an appendix to this report.

9 Enter and View programme

Healthwatch services have a statutory function to carry out Enter & View visits to health and care services to review services at the point of delivery.
The team at HWCoL have now received full Enter and View Training and are now authorised to complete visits. A training session for new volunteers is scheduled for late September.

The first enter and view visit will take place, in association with Healthwatch Tower Hamlets, at the Goodman's Fields practice in mid-September. A report will be given to the HWB at the next meeting.

Other settings to be visited this year are the Neaman Practice, Barts Health and Moorfields Eye Hospital.

11 Q4 Performance Framework (Contractual Obligations)

There has been no significant change in performance as measured by the Key Performance Indicators.

12 Work with NHS North East London ICB

In Q2 HWCoL supported the 'Big Conversation' led by NHS NEL. The project aims to bring together organisations working across health and care, including local government; the voluntary, community and social enterprise sector; the NHS and wider partners enabling them to plan and deliver joined up health and care services.

The Big Conversation is about listening to people in local communities, and understanding their views about health, care, and wellbeing in north east London. There will is an online questionnaire and local events across NEL hosted by Healthwatch. HWCoL hosted an event in July at the Golden Lane Community Centre and a focus group specifically for Older People in August.

13 Volunteers
HWCoL have increased our volunteer base to 18 volunteers.
Projects volunteers are working on include:
PALS - provision, ease of access and effectiveness. A report on this will be submitted at the next Health and Wellbeing Board.

Dentistry – NHS accessible places; all the NEL Healthwatch will undertake this research to present a full picture for the NEL ICB.
Enter and View at Goodman's Field Surgery in September.

A volunteer team meeting is scheduled for mid-September with and Enter and View training session scheduled for late September.

14 Planned activities in Quarter 3 2023/24

In support of the delivery of the business plan during Q3 the team at HWCoL will:

- Refresh and reinvigorate the communications and engagement strategy.
- Refresh and reinvigorate the volunteer strategy.
- Recruit additional Trustees.
- Hold the Annual General Meeting where we will be joined by Ian Thomas, CBE; Town Clerk City of London Corporation.
- Hold Patient Panels on Cancer Screening and Mental health and wellbeing.
- Carry out an Enter and View visit at Goodmans Fields Surgery
- Attend the OPRG open meeting.

11 Risks

Trustees review the Risks and Issues Log at Board meetings. The Risk Log identifies financial pressures, and some concerns over security in the new office as issues rather than risks along with data security, non-compliance General Data Protection regulations as key risks. HWCoL currently lack a Data Protection Officer (DPO) and HWCoL is in the process of securing access to a DPO. Advice has been sought from Healthwatch England, who are in the process of developing training for both officers and Board members, this however, will not be available until later in the year. HWCoL will explore online training in the meantime.

12 Conclusion

With the new team in place HWCoL is actively increasing presence in the City, especially in the east of the City. The team will engage with GP Practices on the edge of the City who serve some City residents, namely Goodman's Fields Surgery and increase collaboration with Barts Health and UCLH.

Gail Beer
Chair
Healthwatch City of London
E. gail@healthwatchcityoflondon.org.uk

Rachel Cleave
General Manager
Healthwatch City of London
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Together

we're making health and social care better

Annual Report 2022–23

healthwatch City of London

Contents

"In the last ten years, the health and social care landscape has changed dramatically, but the dedication of local Healthwatch hasn't. Your local Healthwatch has worked tirelessly to make sure the views of local people are heard, and NHS and social care leaders use your feedback to make care better."

Louise Ansari, Healthwatch National Director

Message from our Chair

Gail Beer
Chair Healthwatch City of London

Welcome to our annual report for 2022/23. It has been another busy year here for us at Healthwatch City of London.

Over the past year, as the City has opened back up, we have been able to start our patient panel series, that focus on the topics you want to discuss, we has some excellent speakers at our Public Board meetings and have represented you at various system and local committees and Boards.

The North East London Integrated Care System came into effect in July, we have been

Working with NEL Healthwatch

Earlier in the year we facilitated a discussion between the Neaman Practice and Barts Health, the result of which ECG and Echocardiograms are now offered at the Practice. This is a huge benefit to patients. We hope to hear more about this at our APM. Have you used this service yet? Let us know what its like. Still having trouble accessing services? tell us about it and we can ask the right questions of the right people.

> “getting involved is important as it makes sure that not only do we have our say but that we are helping shape how services are delivered for us and to us.”
>
> Gail Beer, Chair Healthwatch City of London

Thanks to our Board and Team for working hard

Thanks to Sean

Here’s what you could include:

About us

Healthwatch City of London is your local health and social care champion.

We are here to represent everyone living, working and studying in the City of London to ensure your health and social care services are reflective of what you need.

Our vision

For Health and Social Care services to be truly responsive to the needs and requirements of the residents, students and workers of the City of London.

Our mission

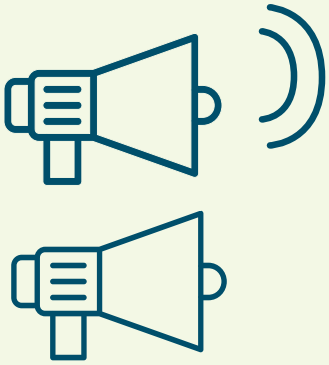
To be an independent and trusted body, known for its impartiality and integrity, which acts in the best interests of those who live and work in the City of London.

Our values are:

- Respecting and encouraging diversity
- Valuing everyone's contributions
- Maintaining integrity
- Creating inclusiveness

Our year in review

Reaching out



This past year we have shared 10 monthly newsletters, held 3 patient panels, 1 webinar, hosted 5 Board meetings in Public and held our Annual General Meeting.
We have undertaken XX surveys and worked with our partners across the Healthwatch North East London and the voluntary sector.

Health and care that works for you

We're funded by our local authority. In 2022-23 we received
[£x,xxx]
which is [x% less / more] than the previous year.

We currently have
1 Chair
3 Trustees
3 Board Associates
3 staff members

Do you want to get involved?

We have many volunteering opportunities, so please get in touch today.

https://www.healthwatchcityoflondon.org.uk/
020 3745 9563
info@healthwatchcityoflondon.org.uk

Our Team

Gail Beer – Our Chair

Gail has over 40 years' experience in healthcare. A Barts trained nurse, her association with the City goes back a long way. After working extensively in London Hospitals, including the Royal London, Gail moved into management, becoming an executive director on the board of Barts and the London. Leaving Barts, Gail worked as an independent consultant before moving into 2020health, a Westminster-based think tank. She has returned to the NHS and is currently at Guy's and St Thomas' as a director working on special projects.

Gail has numerous publications in her name on a wide range of health-related subjects and has undertaken several TV and radio interviews as an expert commentator. As a long term City resident, she feels strongly that the voice of local residents and workers must be heard and that holding health and social care providers to account is an essential part of the Healthwatch role.

Rachel Cleave General Manager

Rachel became the General Manager in October 2022 having previously been the Communications and Engagement Manager.
Rachel has over 20 years' experience in Communications. Her experience spans a range of areas, including event management, internal communications, website management, production and design of publications, budget control and project management. She has worked in the public and private sector.
Rachel is a Governor at her local Primary School, and the Secretary of the Parents Association.

> We are only too aware of the challenges there are in designing and delivering services across the City where there are differing priorities, and providers of care. "
> Gail Beer, Chair Healthwatch City of London

Our Team

Lynn Strother - Trustee

Lynn managed the first Healthwatch City of London contract and offers a wealth of knowledge and understanding of Healthwatch. She also has experience and knowledge of the NHS, Social Services and Older Peoples Charities, having worked in these sectors for several years. Lynn is a member of the London Ambulance Service Public and Patient Council. She is also a member of the Patient Involvement Collaborative at Kingston Hospital.

Malcolm Waters - Trustee

Malcolm Waters retired in 2019 after 41 years in practice at the Chancery Bar in London. He was appointed a QC in 1997. In his professional life, he specialised in retail financial services and mutual institutions, taking a particular interest in the law relating to unfair contract terms and the various ways in which consumers can obtain redress if they have been treated unfairly by financial institutions. He has a flat in the Barbican and is a patient of the Neaman Practice.

Steve Stevenson - Trustee

Steve has been a City resident since 1988. He was a member of the City of London's Common Council from 1994 to 2009, serving on the community services committee covering housing, social services and health. Steve has considerable experience of patient engagement and involvement first as a member of the Community Health Council and then at Links. He has been a member of the City of London's health and social care scrutiny committee since 2012. Steve was the sole carer for his wife who had Alzheimer's from 2000 to 2014. Steve joined the board in October 2014.

Do you feel inspired?

We are on the lookout for trustees, so please get in touch today.

https://www.healthwatchcityoflondon.org.uk/

020 3745 9563

info@healthwatchcityoflondon.org.uk

Our Team

Janet Porter - Board Associate

Janet Porter has lived in the Barbican since 2005. She is a business journalist who retired as executive editor of Lloyd's List in 2018, and now chairs the shipping publication's editorial board, as well as continuing to write about the maritime industry. Janet was born in London and has an economics degree from London University.
As a resident of the City of London, she is keen to ensure that health and social care services in the Square Mile are world class and meet the needs of the local community. Janet is an authorised Enter and View representative

Stuart Mackenzie - Board Associate

Stuart MacKenzie is retired, and a Barbican resident since 2005. He held principal consultant and senior European marketing roles in leading UK and US management, high technology and product design consultancies. He has also had public sector experience, conducting studies and holding seminars in the medical equipment industry, as well as undertaking freelance consultancy projects in the biotech and food sectors. He has a degree in industrial design and engineering.
He is interested in improving the user/service provider interface and the quality of communications in the NHS and social care.

Dr Cynthia White – Board Associate

Cynthia joined Healthwatch City of London as an Associate Board Member in January 2019. She Chairs the City & Hackney Older People's Reference Group, sits on the City of London Adult Safeguarding Sub-Committee and represents the OPRG on the City and Hackney Safeguarding Adults Board. Cynthia has been a Barbican resident since 1980 and is well known across the City for her voluntary work championing patient and public involvement in Health and Social Care and co-production in policy-making and the design and delivery of services

Our Team

Liesa Sandt - Communications and Engagement Officer

Liesa has recently graduated from Swinburne University of Technology in Victoria, Australia with a Bachelor's degree in Health Science and a focus in Health Promotion.
Liesa moved to London at the beginning of January 2023 and took up a volunteer role at Healthwatch Greenwich.
She is particularly passionate about promoting the health and wellbeing in the community and ensuring that everyone has the ability to easily access and engage with information related to their health and the health services around them.

Habiba Shaikh - Volunteer and Project Officer

Before joining Healthwatch City of London, Habiba supported Healthwatch Greenwich as a Volunteer, helping with patient engagement, projects, and volunteer management.
Habiba has twelve-years' experience in HR based in the Middle East. She has worked in the Healthcare, Retail and Education sectors and held strategic and operational leadership HR positions at organisations dealing with various health and regulatory bodies.
Habiba has a degree in Business Administration from Pune, India and started her career as a call center associate, and worked her way up to HR manager.

Our thanks to....

Sean Lee was a Trustee from February 2021, left Healthwatch City of London in February 2023. Sean helped to set up the accounting and budgetary procedures and brought a new perspective to the team.

Teri Anderson left Healthwatch City of London in February 2023. Teri was the Communications Assistant and was instrumental in setting up our social media channels.

Salma Khatun who left in December 2022, was the Administrative Assistant, helping to organize our webinar and patient panels.

Introducing our Patient Panels

This year we introduced our Patient Panels where we held sessions based on issues that are currently concerning the community.

We were joined by health professionals in the related field to have the opportunity to engage with and listen to people who live, work and study in the City of London.

Advocating for better foot care

We heard from patients in the City of London that they struggled to get appointments for their podiatry (foot) issues, alongside a general confusion in where to go to access foot care.

Based on your experiences, we heavily campaigned on increasing the current access to podiatry health in the City of London and increased the access to information surrounding where to go to access podiatry health services.

With that campaigning, there is now an additional foot clinic in the City of London funded by the City of London Corporation.

Patient Participation and Resident Engagement

We held our second patient panel at the Golden Lane Community Centre in November with Charlotte Pomeroy from NHS North East London and Nina Griffiths the Director of Delivery from the City and Hackney place based partnership.

The event discussed patient participation and resident engagement across the Integrated Care System.

London Ambulance Engagement Strategy Survey

In January, the London Ambulance Service (LAS) NHS Trust asked Healthwatch's across London to seek the views and feelings from people who have used the London Ambulance Service.

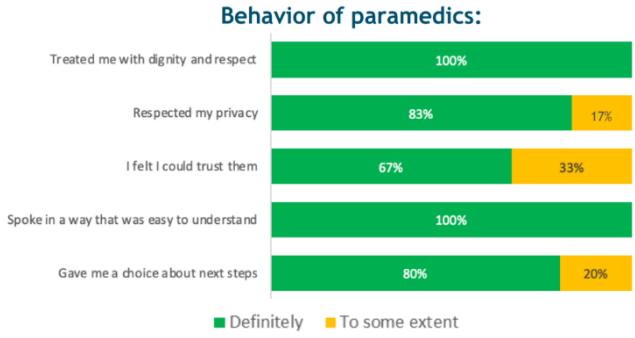
These views and experiences will be looked at to shape their organisational strategy for 2023 – 2028.

Our Five Questions

1. What is LAS getting right?
2. How can LAS improve emergency care?
3. How can LAS enhance urgent care?
4. How should LAS work with other parts of the healthcare system to improve care?
5. How can LAS do more to contribute to life in London

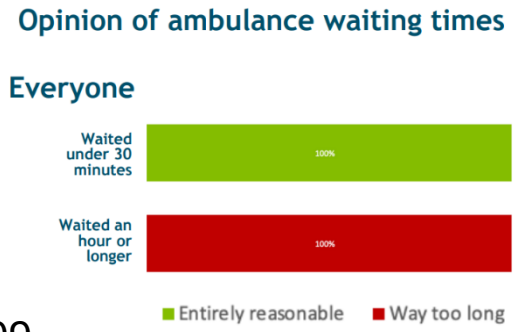
The Results

The survey results found that patients had a **very good** experience with paramedics, with positive experiences of paramedics surrounded being treated with **dignity and respect, respect of privacy** and spoke in a way that way **easy to understand**.



Feedback also showed that the average waiting time for an ambulance was 21 minutes and the average journey to hospital took 30 minutes.

In the survey, all patients agreed that it was **entirely reasonable** to wait for an ambulance for a period of under 30 minutes however, waiting an hour or longer was **way too long**.

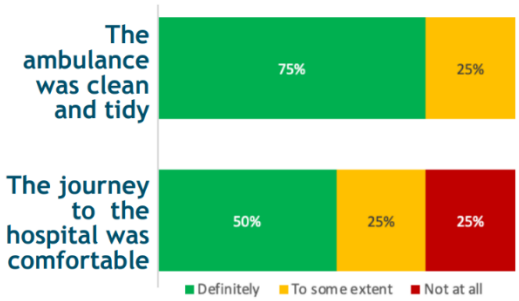


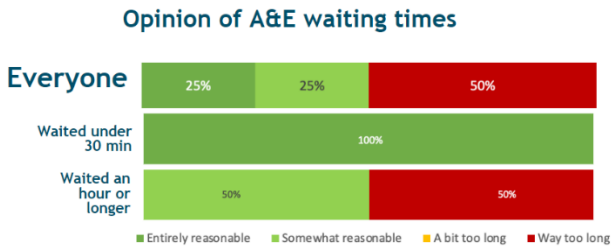
London Ambulance Survey

The Results

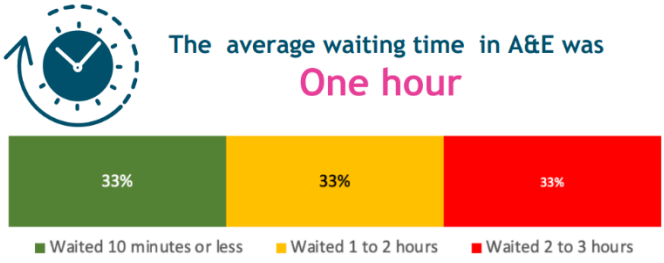
75 percent of patients found that the ambulance was clean and tidy while 50 percent of patients found that the journey to the hospital was **definitely** comfortable, however, 50 percent of patients showed that that was not a shared experience, with 25 percent sharing that it was **to some extent** and 25 percent of patients shared that it was **not all their** experience.

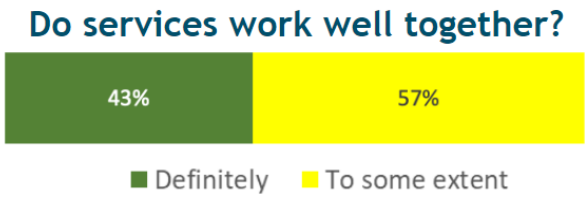
The opinion on A&E waiting times differ from ambulance waiting times. Half of patients believe that it is **somewhat reasonable** to wait an hour or longer, while half of patients believe that it is **way too long**.



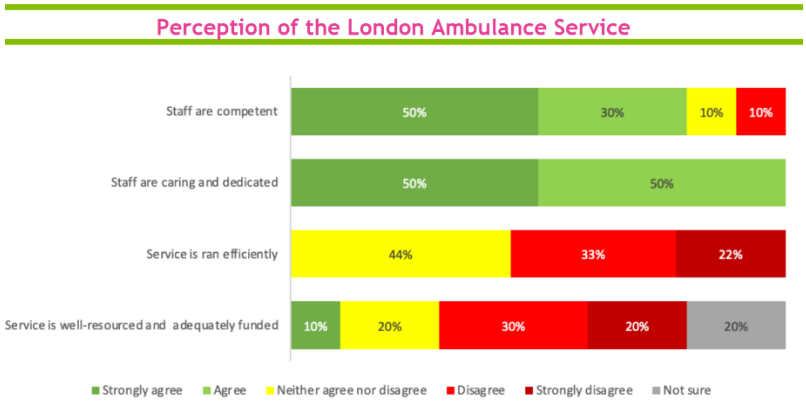


The average waiting time in A&E was one hour, with one third of patients waiting two to three hours, one third of patients waiting one to two hours and another third of patients waiting ten minutes or less.





The perception of the London Ambulance Service showed that the majority of patients had a positive experience of staff but believe that the service is not ran efficiently or adequately funded.



Our Board Meetings in Public

This year we held five Board Meetings in Public where we discussed our updates and future plans. At each meeting we were also joined by guest speakers who gave presentations and updates on their current work.

May Public Board Meeting

In our May public Board Meeting, we were joined by Dr Chor from the Neaman Practice and Abimbola Musa from the Health Inequalities Lead from the Shoreditch Park and City PCN. Dr Chor joined us to give an update on the action plan that was created to improve the patient experience at the Neaman Practice.

Abimbola Musa joined us to address the work that is being conducted to address Health Inequalities and the progress that has been made in applying our recommendations made in our July 2021 Shoreditch Park and City PCN resident engagement project

July Public Board Meeting

In our July meeting we were joined by speakers from Bart's Health NHS Trust, who Spoke of their updates to their Engagement, Participation and Experience 2022-25 Strategy.

We were also joined by the City of London Corporation, our commissioners who spoke of working with us.

Our Public Board Meetings

October Annual General Meeting

For our Annual General Meeting, we had our theme of Local Voice, Local Care.

To address this, we were joined by three guest speakers, Rajiv Jaitly, Non Executive Director at North East London Integrated Care Board who spoke of how the Integrated Care Systems work.
Charlotte Pomeroy, Chief Participation and Place Officer at NHS North East. Charlotte Pomeroy joined us to address how they are ensuring participation in the City of London.
Eeva Huoviala, Head of Public Engagement and Personalised Care Lead (City and Hackney), also joined us to address working with people in the City of London, as the local voice.

December Public Board Meeting

In our December meeting we were joined by the London Ambulance Service, Susan Master from the Neighbourhood programme and Dr Chor from the Neaman Practice.

February Public Board Meeting

In our February meeting, we were joined by the Director of Cancer Nursing for Screening and Diagnostics who walked us through information surrounding the virtual wards that are being utilised by the cardiology department at Barts Hospital.

Representing you

We work in partnership with local Health and Social care providers to ensure that your voice is heard. It is imperative that the City has a voice at the heart of decision making, and we ensure that speak up for what the City needs. During 2020-21 we represented you on the following boards and committees, and also attend meetings on your behalf:

Neaman Practice Patient Participation Group
The group discuss the services delivered by the Practice, and how improvements can be made for the benefit of patients.

North East London Integrated Care Board NHS North East London is responsible for planning and buying health services across north east London to meet the population's needs, making sure all parts of the local health system work effectively together.

City of London Health and Wellbeing Board
This board aims to align the City's approach to the NHS Outcomes Framework, the Adult Social Care Outcomes Framework and the Public Health Outcomes Framework through improving the integration of services - positively influencing the health of everyone who lives and works in the City, enabling them to live healthily, preventing ill health developing, and promoting strong and empowered groups of individuals who are motivated to drive positive change within their communities and businesses.

Health and Social Care Scrutiny Committee
This committee fulfils the City's health and social care scrutiny role in proactively seeking information about the performance of local health and care services and institutions, challenging the information provided to it by commissioners and providers of services for the health service and testing this information by drawing on different sources of intelligence.

Integrated Care Communications and Engagement Enabler Group
This group supports and facilitates effective engagement with key stakeholders in the Integrated Care System (ICS) in the City of London and Hackney.

City and Hackney Safeguarding Committee
This committee oversees the discharge of the City of London's and Hackney's responsibilities for safeguarding those adults who have been identified as requiring support and protection.

City of London Adult Safeguarding Sub-Committee
This committee oversees the discharge of the City of London's responsibilities for safeguarding those adults who have been identified as requiring support and protection.

Healthwatch in London Network Meeting
This network aims to share updates on issues from across London, enable project working on areas that affect people across boroughs and the sharing of best practice.

Neaman Practice Quarterly Meeting
The group discuss any issues raised via Healthwatch City of London regarding delivery of services by the Practice, and how improvements can be made for the benefit of patients.

Community Insights Meeting
This is made up of the seven Healthwatch who are part of the North East London ICS, to share insight and to enable project working across NEL.

Shoreditch Park and City Neighbourhood Forum
The Neighbourhoods programme Neighbourhoods brings residents, voluntary sector, health, education and care services together in City & Hackney's Neighbourhoods, to work together on what matters to local people and address health inequalities

Representing you

North East London Integrated Care Board Healthwatch Meeting A meeting with the Chair of the Integrated Care Boards and NEL Healthwatch
Neighbourhood Providers Alliance Group A meeting for all service providers and voluntary groups who are part of the Shoreditch Park and City Neighbourhood.

Our Webinars: Advice and information

This past year, we started our webinar series where we brought together experts in the field to talk to you about topics that are both important to your health and wellbeing as well as gives you the opportunity to ask important questions that you may have.

One of these webinars was based on our Christmas theme, surrounding how to Stay Safe over Christmas.

Christmas can be a difficult time for many regarding the increased feeling of loneliness and in addition with the cost of living crisis, it was important to us to discuss. We were joined by colleagues from MIND, the Samaritans and City of London Corporation who spoke about who you can talk to get help and how you can access services.

Finance and future priorities

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Our income and expenditure

Income		Expenditure	
Annual grant from Government	£3,377,309	Expenditure on pay	£2,089,576
Additional income	£219,929	Non-pay expenditure	£776,448
		Office and management fee	£283,362
Total income	**£3597,238**	**Total expenditure**	**£3,149,386**

Additional income is broken down by:

- **£4,000 funding** received from Healthwatch England for work on a project
- **£800 funding** received from a local charity to support their project

Next steps

In the ten years since Healthwatch was launched, we've demonstrated the power of public feedback in helping the health and care system understand what is working, spot issues and think about how things can be better in the future.

Services are currently facing unprecedented challenges and tackling the backlog needs to be a key priority for the NHS to ensure everyone gets the care they need. Over the next year we will continue our role in collecting feedback from everyone in our local community and giving them a voice to help shape improvements to services.

We will also continue our work to tackling inequalities that exist and work to reduce the barriers you face when accessing care, regardless whether that is because of where you live, income or race.

Top three priorities for 2023-24

1. List your top three priorities for next year
2. These could include tackling health inequalities further
3. Or plans to reach areas of the community you currently don't hear from.

Statutory statements

Healthwatch City of London, Portsoken Community Centre
20 Little Somerset Street, London E1 8AH

Healthwatch City of London uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

The way we work

Involvement of volunteers and lay people in our governance and decision-making

Our Healthwatch Board consists of seven members who work on a voluntary basis to provide direction, oversight and scrutiny to our activities. Our Board ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community. Throughout 2022/23 the Board met 11 times and made decisions on matters such as organisational design, budget setting, objectives and priorities as part of the business plan and using insight from public forums..
We ensure wider public involvement in deciding our work priorities.

Methods and systems used across the year to obtain people's experiences

We use a wide range of approaches to ensure that as many people as possible have the opportunity to provide us with insight about their experience of using services. During 2022/23 we have been available by phone, email, provided a webform on our website and through social media, as well as attending meetings of community groups and forums.

We are committed to taking additional steps to ensure we obtain the views of people from diverse backgrounds who are often not heard from.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. We will publish it on our website and print copies to distribute to stakeholders and at events.

Responses to recommendations

We had 0 providers who did not respond to requests for information or recommendations. There were no issues or recommendations escalated by us to Healthwatch England Committee, so no resulting reviews or investigations.

Taking people's experiences to decision makers

We ensure that people who can make decisions about services hear about the insight and experiences that have been shared with us.

In our local authority area for example we take information to the Health and Wellbeing Board, the Health Scrutiny and Insight Committee and the City and Hackney Adults Safeguarding Board.

We also take insight and experiences to decision makers in NHS North East London For example, we attend the Integrated Care System Board and the Integrated Care Partnership Board alongside the other seven Healthwatch in North East London. We also share our data with Healthwatch England to help address health and care issues at a national level.

Enter and view – N/A

This year, we made [number] of Enter and View visits. We made [number] recommendations or actions as a result of this activity.

Location	Reason for visit	What you did as a result
GP Practice - Willowbank	Patients raised safety concerns	Wrote a report with recommendations – the service followed up on these and patient safety improved.

Healthwatch representatives

Healthwatch City of London is represented on the City of London Corporation Health and Wellbeing Board by Gail Beer, Chair Healthwatch City of London. During 2022/23 our representative has effectively carried out this role by producing and presenting a quarterly report to the Board and by raising issues on Health and Social Care at the Board meetings.

Healthwatch City of London is represented on North East London Integrated Care Partnerships by Rachel Cleave and North East London Integrated Care Boards by Rachel Cleave.

2022–2023 Outcomes

Project / activity	Changes made to services

Healthwatch City of London

Portsoken Community Centre
20 Little Somerset Street
London E1 8AH

www.healthwatchcityoflondon.org.uk

t: 020 3745 9563

e: info@healthwatchcityoflondon.org.uk

@HealthwatchCoL

Facebook.com/CoLHealthwatch

@HealthwatchCity

Linkedin.com/HealthwatchCityofLondon

Listening to your experiences

Services can't make improvements without hearing your views. That's why over the last year we have made listening to feedback from all areas of the community a priority. This allows us to understand the full picture, and feed this back to services and help them improve.

How we've made a difference this year

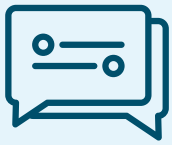
Spring

From running advice lines to delivering medication, our volunteers helped combat COVID-19.

We quickly alerted regulators about care homes using 'Do not attempt to resuscitate' forms without consent.

Summer

With online appointments becoming the norm, our top tips helped professionals and patients get the most out of digital appointments.



We supported the #BecauseWeAllCare campaign which saw 54,000 people come forward to tell us about issues they faced with services.

Autumn

Teaming up with the British Red Cross, we called for improvements to make leaving hospital safer during the pandemic.

We urged the Government to act after reporting a 452% increase in people struggling to see an NHS dentist.

Winter

We held a webinar on How to Stay Safe over Christmas

To support the COVID-19 vaccination programme we talked to different communities to understand their hesitancy towards the vaccine and published guidance to improve trust.

10 years of improving care

This year marks a special milestone for Healthwatch. Over the last ten years, people have shared their experiences, good and bad, to help improve health and social care. A big thank you to all our Healthwatch Heroes that have stepped up and inspired change. Here are a few of our highlights:

How have we made care better, together?

Vaccine confidence

Our research exploring vaccine confidence with people from different backgrounds provided vital lessons for public health campaigns.

NHS admin

We highlighted the negative impact poor NHS admin can have and recommended five principles for services to improve people's experiences.

Patient transport

NHS England announced improvements to non-emergency patient transport services thanks to public feedback.

Waiting list support

After we and other organisations called for an urgent response to hospital waiting lists, and better interim communication and support, the NHS set out a recovery plan to address the backlog.

NHS dentistry

We continued to voice public concerns that improvements to NHS dentistry are too slow, leaving thousands of people in pain.

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healthwatch Hackney

healthwatch City of London

Not the person I used to be

City & Hackney Long COVID

Deep Dive Report

COMMUNITY VOICE

CoRe

“I’m not the person I used to be…”

-Hackney resident

Contents

Executive Summary

Long COVID refers to the signs and symptoms that persist or develop after an acute COVID-19 infection. This report highlights the impact of Long COVID on individuals' mental and physical health, as well as their ability to work and engage in daily activities.

As of February 2023, it is estimated that 2 million people in the UK have symptoms associated with Long COVID. The City & Hackney CoRe Service offers a multi-disciplinary, community-based rehabilitation service for individuals experiencing Long COVID symptoms.

The service provides various therapies and support, including input from GPs, physiotherapy, occupational therapy, psychological therapy, and speech and language therapy.

The report identifies several of the barriers faced by individuals seeking support for Long COVID. These include a lack of information from trusted sources, isolation, cultural and language barriers, financial challenges, and a feeling of being a burden on resources.

The findings from the report indicate that while most respondents sought help from their GPs, there were challenges in the referral process and accessing appropriate care.

However, GPs were generally praised for their support and proactive approach to treating Long COVID. Peer support and clear communication were also identified as important factors in improving the overall experience for individuals with Long COVID.

Based on the findings, the report proposes a robust set of recommendations devised to enhance support structures for Long COVID patients. The primary focus of these include: Awareness and Education, Enhanced Referral Process and Care Coordination, Support for Self-Management, Collaboration and Partnerships, and Inclusive Support Services.

It is hoped that the implementation of these strategies by the CoRe Service and partner organisations promises to improve care coordination, patient empowerment, and foster stronger collaboration with relevant stakeholders.

Furthermore, our hope is that by implementing these recommendations local and national integrated care partnership organisations will be better able to support individuals living with Long COVID, improve their overall well-being and amplify their voices both locally and nationally, to improve and best shape future services.

Background

Post COVID-19 Syndrome (Long COVID)

Long COVID is commonly used to describe signs and symptoms that continue or develop after acute COVID-19.

As of March 2023, the Office of National Statistics (ONS) estimated that 1.9 million people in the UK had symptoms associated with Post-COVID Syndrome, more commonly known as 'Long COVID' (ONS, 2023). Long COVID is considered a Long-Term Condition, in keeping with the Department of Health's (DoH, 2012) definition of *'a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies'.*

This condition significantly impacts a person's mental and physical health, impeding one's ability to maintain employment, self-care, and relationships. The latest ONS report (March, 2023) states that 1.5 million people (78.9%) expressed that Long COVID symptoms had adversely affected their day-to-day activities, with 381,000 (25.4%) reporting being "*limited a lot*".

There is currently no recommended pharmacological treatment or curative intervention for the condition itself, but some symptoms may be managed following existing guidelines specific to those symptoms. The recommended approaches for managing Long COVID include self-management, supported self-management and multidisciplinary rehabilitation (NICE, 2022).

The mainstay of long-term condition management typically involves self-management strategies, often provided by a multi-disciplinary team. Long COVID significantly impacts mental health, with 67% of patients from the City & Hackney COVID Rehabilitation (CoRe) Service reporting moderate to severe depression.

Most self-reported cases of long COVID fall within the age range of 35-69 years (ONS, 2023). This aligns with the CoRe demographic data, which most frequently

features referrals in the 25–54-year age range, representing a predominantly working-age population.

Case definition, Symptoms & Physiology

Long COVID is commonly used to describe signs and symptoms that continue or develop after an acute COVID-19 infection. Three main categories help define symptoms related to COVID-19 infection (NICE 2020):

Acute COVID-19 Infection:

- Signs and symptoms of COVID-19 from initial infection up to 4 weeks

Ongoing symptomatic COVID-19:

- Signs and symptoms of COVID-19 from 4 to 12 weeks

Post-COVID-19 syndrome:

- Signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are *not explained by an alternative diagnosis*

Current research data suggests that the risk of Long COVID is mitigated by vaccination. Furthermore, we know that ongoing symptoms from an acute COVID-19 infection bear no relation to the severity of the initial infection itself. The symptoms of Long COVID are very real and often severe, significantly affecting a person's life, arising from a complex interplay between mind and body.

There are over 200 recorded symptoms linked with Long COVID, the most commonly reported being fatigue, breathlessness, 'brain fog', issues with memory and concentration, muscle pain, and chest pain and/or tightness. This list, however, is not exhaustive. Patients have reported a wide range of distressing symptoms that significantly diminish their quality of life.

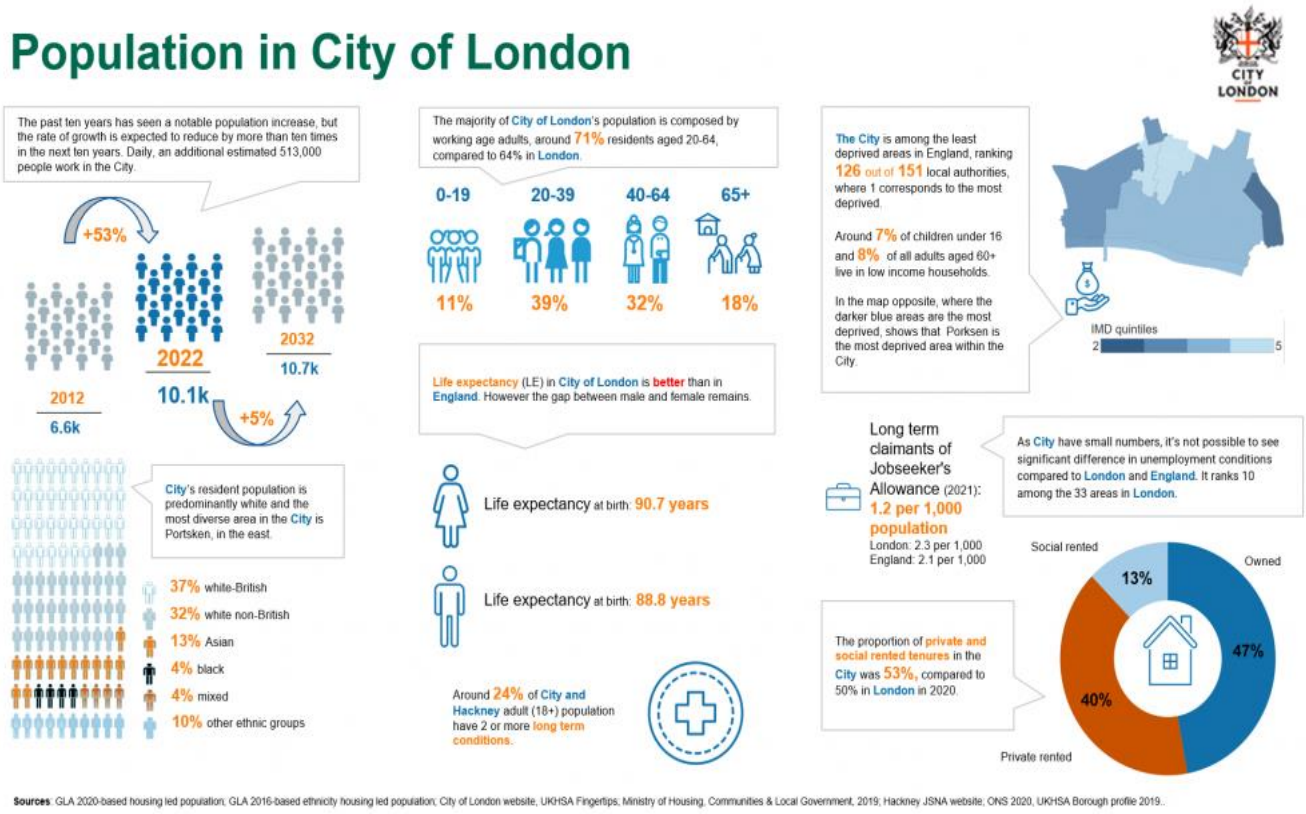
Image: Range of symptoms as described by Long COVID patients at an online introduction to the CoRe service.

City of London Population Statistics

The City of London is home to approximately 10,000 residents. Of these, 25% are aged 60 years and above. The largest age bracket is the 25-29 years group, with 10% of the population falling into it. The population is nearly evenly split between males and females, with a ratio of 53% males to 47% females.

In terms of ethnicity, around 38% identify as white British, 30% as other white, and 30% as non-white. The non-white breakdown is as follows: 4% black, 7% Arab, 2% Bangladeshi, 2% Chinese, 4% Indian, 1% Pakistani, 5% other Asian, and 5% other ethnicities.

It is estimated that 7% of children under the age of 16 and 8% of adults over the age of 60 reside in low-income households. Approximately 80% of the population are registered with the Neaman Practice, while the remaining 20% access their Primary Care in the neighbouring boroughs of Tower Hamlets and Islington.



Hackney Population Statistics

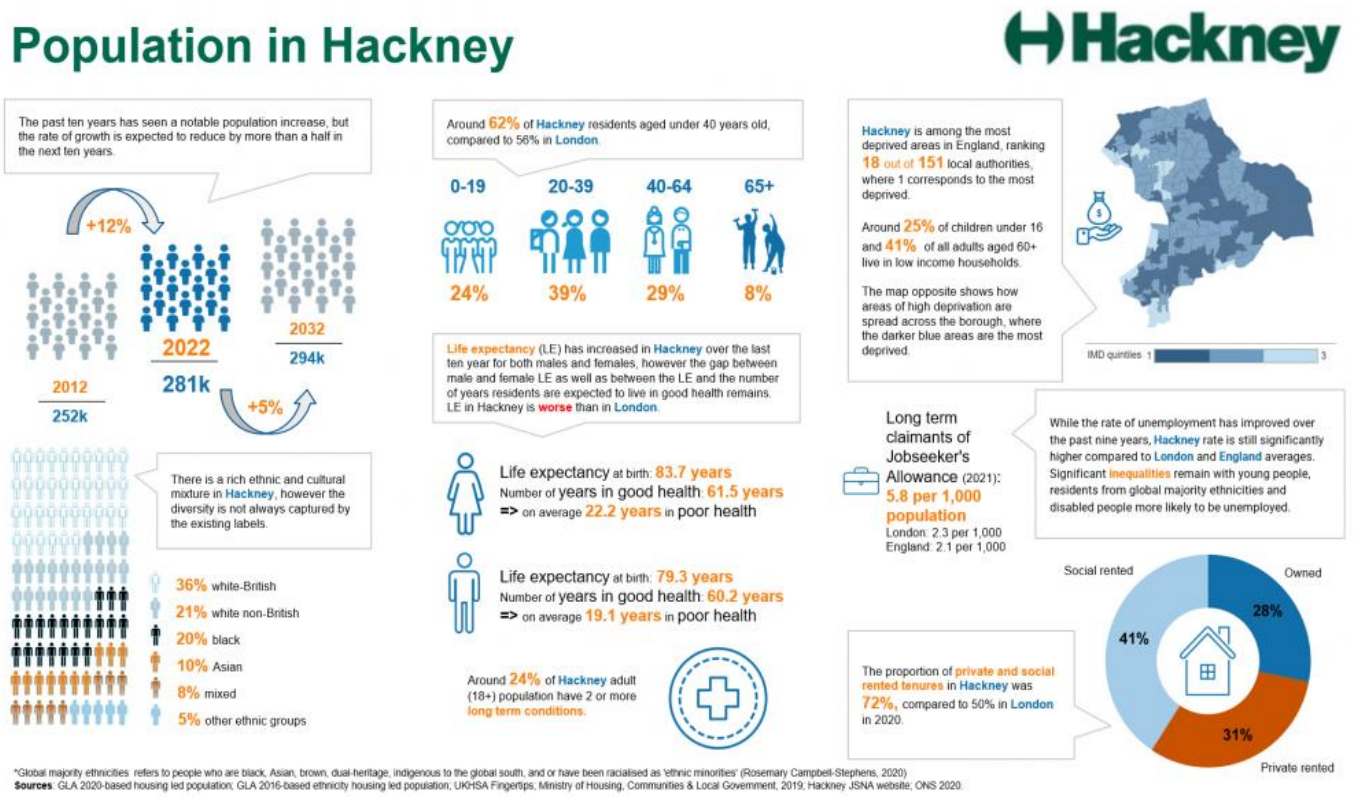
Based on recent growth rates, the estimated population of Hackney in 2023 is estimated to be 261,000. As of mid-2021, Hackney covered an area of 19 square kilometres (7 square miles) and had a population density of 13,647 people per square kilometre (km^2), a figure that has increased by 407 people per km^2 over the past decade.

According to 2021 census data, 53.1% of Hackney residents identified their ethnicity within the 'White' category. The proportion of the population who identify as 'White' is largely consistent with London (53.8%) but is far below the average for England as a whole (81%). This is reflective of the relative ethnic diversity of the population of London and Hackney.

The second most common high-level ethnic group in Hackney is 'Black', with 21.1% of Hackney residents identifying in this category. Hackney has a significantly higher proportion of residents who identify as 'Black' than the average for both London and England where the figures are 13.5% and 4.2% respectively.

English is spoken as the main language by 80.1% of people in Hackney and spoken either well or very well by 15% of the population. 4.0% reported having poor English language skills, and the remaining 0.8% spoke no English at all. A diverse range of communities are present in the borough, including the Charedi Orthodox Jewish, Turkish and Kurdish, Irish, Caribbean, Vietnamese, South Asian and African communities.

While Hackney's rich cultural mix brings a lot of positives to community life, poor integration can negatively affect community cohesion, perception of safety, utilisation of local services and, ultimately, physical and mental health outcomes. In addition, a lot of migrant communities are often overrepresented in deprived areas which puts them at an increased risk of poor health and wellbeing (Diverse communities – cityhackneyhealth.org.uk)



[Population Infographics - City and Hackney Health and Wellbeing Profile (cityhackneyhealth.org.uk)]

City & Hackney COVID Rehabilitation (CoRe) Service

The City & Hackney COVID Rehabilitation (CoRe) Service provides an established multi-disciplinary, community-based, therapy-led assessment and rehabilitation outpatient service for individuals experiencing the impact of symptoms associated with Post COVID Syndrome/Long COVID (i.e. symptoms persisting beyond 12 weeks from initial infection).

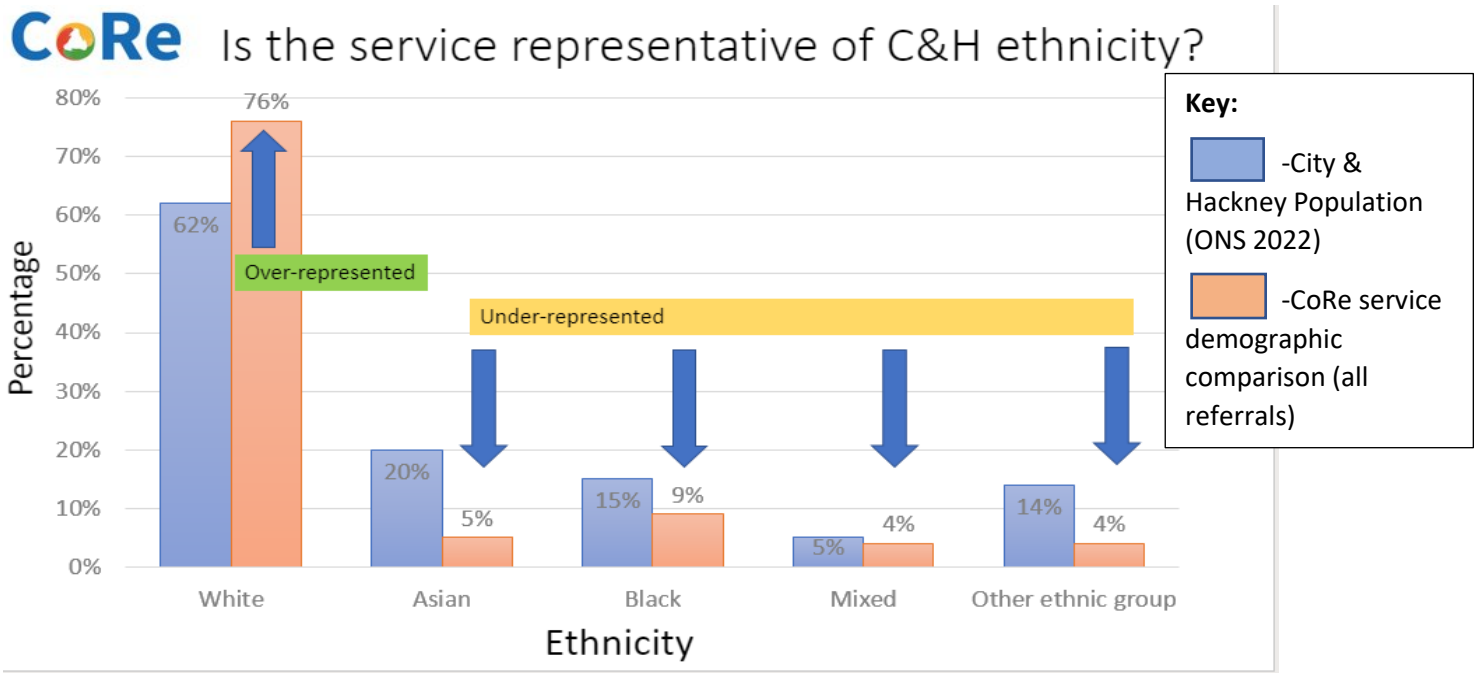
Adults over the age of 18 registered with a City & Hackney GP are eligible to receive the service. A dedicated pan-London service for children and young people is in place, in addition to three other local services supporting North-East London (NEL) residents in Barking, Havering & Redbridge, and Tower Hamlets, Newham, and Waltham Forest.

The service currently offers flexible rehabilitation options in keeping with current NICE guidelines for managing the long-term effects of COVID-19, including input from a GP, physiotherapy, occupational therapy, psychological therapy, and speech and language therapy. These provide continuity of care and a sense of 'safety' under the supervision of a specialist team (a factor frequently praised in patient satisfaction feedback).

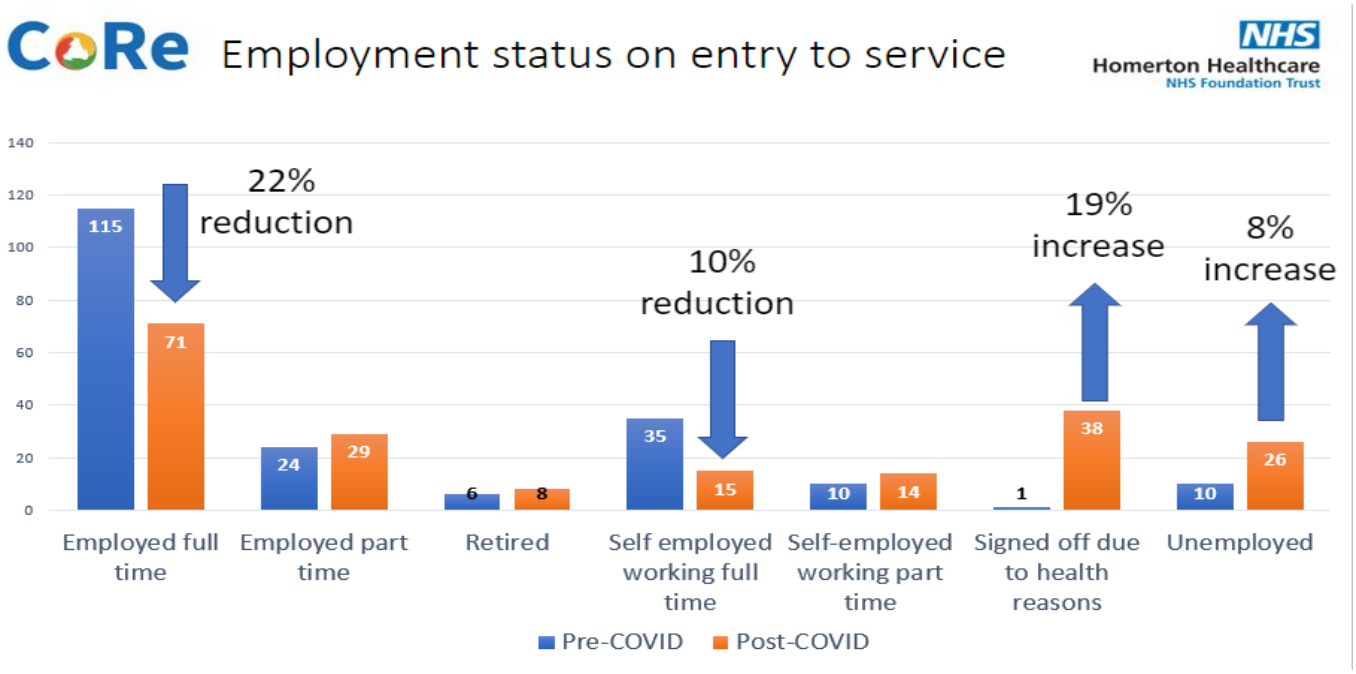
The CoRe service also provides care-coordination in navigating any employment and financial impact of Long COVID. By helping individuals understand what support is available to them and guiding them through the complex process of application forms, patients have avoided eviction, managed rent payments, bought food, paid for travel to appointments, and were provided with access to digital devices to facilitate engagement with healthcare.

Rationale

Since its establishment in January 2021, it has become apparent that the demographics of patients accessing the City & Hackney CoRe Service does not accurately reflect the population of City & Hackney, with underrepresentation from marginalised groups including Black, Asian and other ethnic minorities:



In line with NHS England Post-COVID-19 Proactive Case Finding guidance (2022), the CoRe service has been exploring community mobilisation and engagement, with the appointment of a dedicated Long COVID engagement lead.



The Long COVID engagement lead has focused efforts on listening to patient feedback, co-producing service improvements, building links with primary care services, local authority, and community partners as well as voluntary sector organisations in City & Hackney. This is done with the aim of improving access to Long COVID services for residents, particularly those from underrepresented populations, living in City & Hackney.

However, it was crucial for us to understand the scale of the impact of Long COVID in the community and the degree of unmet need amongst the local population, especially considering the data gap in this area within national Long COVID data. For this purpose, the City & Hackney Long COVID 'deep dive' survey was initiated as a collaboration between the City & Hackney CoRe service, Healthwatch City of London, and Healthwatch Hackney.

We were eager to hear from patients and residents of City & Hackney regarding their experiences of living with Long COVID. Our aim was to use our platform to amplify their voices both locally and nationally, with the intent of improving and shaping future services.

This applies not only to the direct provision of Long COVID clinical services but also to the broader services frequently required, given the severe effects of Long COVID on patients' lives.

Method

Online Survey

The online questionnaire was designed to explore issues surrounding:

- Residents' experience of Long COVID symptoms
- Residents' awareness of Long COVID services
- The impact of Long COVID in daily function
- Barriers faced by residents in seeking support

The main survey contained 31 questions and was disseminated electronically via email and social media platforms. The CoRe service and Healthwatch teams utilised our respective organisational communications teams and linked in with local authority and community partners to disseminate the survey widely through their communications networks.

We collaborated with NEL communications team to design an interactive flyer to help publicise the survey on social media, using a QR code to enable easier access to the survey.

We were mindful of digital exclusion and made every effort to minimise the impact of technological barriers by offering a telephone service for residents to call for support to complete the survey.

Furthermore, we personally attended various community events, with laptops to support residents in completing surveys in-person. We also linked up with partners to support the reach of the survey into key inclusion populations.

In total, we received 282 survey responses.

Focus Groups

The main survey also offered residents the opportunity to participate in a one-to-one interview, providing them with a platform to share a more detailed account of their experience of living with Long COVID, as well as any barriers they had faced in accessing care or support.

Initially, we received 91 responses from residents volunteering to participate in one-to-one interviews. However, due to limited capacity, we decided to offer the opportunity to share feedback in a focus group format instead.

Focus group participants were offered a £20 high street voucher, as a token of recognition for their valuable time.

To maximise accessibility for all residents within the two catchment areas, a face-to-face focus group event was held in the City of London and another in Hackney. Owing to high demand, a virtual session was also conducted via Zoom.

In total, we engaged with 22 participants via the focus groups.

Findings

Online survey

During November 2022 – January 2023, 282 people responded to our survey on Long COVID.

Overall Findings

Most survey respondents had tested positive for COVID-19 and sought medical support either from their general practitioner (GP) or by visiting the hospital.

Nearly two-thirds of the respondents (61%) had received a diagnosis of Long COVID, having experienced symptoms such as fatigue (57%), difficulty concentrating (54%), muscle ache (45%), memory problems (41%), and shortness of breath (40%).

Encouragingly, almost two-thirds of respondents (62%) indicated that they knew how to seek support, although only half of them had initially reached out to their GP. Additionally, around two-thirds of respondents (67%) were aware of the City and Hackney COVID Rehabilitation Service (CoRe).

Furthermore, over two-thirds of the participants (69%) were aware of the symptoms associated with Long COVID, while 31% admitted they had not received information about these symptoms.

People reported that the most significant impacts of Long COVID symptoms on their daily lives were difficulty with socialising (41%), inability to work (37%), needing to make adjustments at work (35%), inability to study (35%), and difficulties with caring responsibilities (29%).

60% of paid employees believed that their employer would be supportive if they disclosed their Long COVID condition, while 15% felt they would not; and a

considerable portion of respondents (28%) identified language as a potential barrier when seeking or using services.

Further barriers to seeking support mentioned included: financial challenges (35%), caring responsibilities (34%), previous negative experiences when seeking help (24%), lack of information or confidence in available services (both at 22%), and employment-related concerns (21%).

Findings by Age

We observed distinct variations in responses across different age groups. Individuals in the later working age bracket (50-59) were notably more likely to have tested positive for COVID-19. On the other hand, those in the mid-working age range (40-49) were clearly more inclined to have sought consultation with their general practitioner (GP).

The youngest respondents (aged 21-29) stood out as the group most inclined to have visited the hospital, while showing the lowest likelihood of contacting NHS 111 for medical support.

Individuals in the mid-working age range (40-49) emerged as the group with the highest likelihood of being diagnosed with Long COVID.

Surprisingly, the youngest respondents (aged 21-29) were more than twice as likely as the oldest respondents (60+) to possess knowledge about how to seek support. However, despite being diagnosed with Long COVID, the youngest respondents were significantly less likely to consult with their general practitioner (GP) compared to other age groups.

The oldest respondents (aged 60+) were notably more likely to have sought support from the Post/Long COVID clinic, as well as being the most frequent users of online services.

Respondents of mid-to-late working age (40 – 59) were most aware of Long COVID symptoms while the oldest respondents (aged 60+) were the least aware of City and Hackney COVID Rehabilitation Service (CoRe) services.

Focus Groups

1) Reported symptoms and impact on daily life

Physical symptoms

People reported a vast array of symptoms, emphasising the multifaceted nature of this condition. Some of the physical symptoms frequently mentioned included extreme fatigue, heart irregularities, a general sense of weakness, difficulty standing up due to dizziness, chronic body pain, and breathlessness.

In addition to physical symptoms, several participants reported cognitive and sensory symptoms such as brain fog, difficulty concentrating, changes in smell and touch, sleep disturbances and numbness in the hands and feet.

Some had to relearn basic tasks, such as walking, indicating a long and challenging recovery process. This wide-ranging list of symptoms underscores the complexity and severity of long Covid.

> *"I was feeling exhausted. Brain fog, lack of sensitivity in my feet and in hands, and just exhaustion, sheer exhaustion…"*

> *"I was in bed at home for about six months (…) I had a lot of issues with my heart racing (…) I couldn't get out of bed, had terrible pain in my body (…) strange symptoms like skin stuff, numbness, brain fog and breathlessness. I've very slowly taught myself to walk again."*

Impact on lifestyle and mental health

People reported that their symptoms were impacting many areas of daily life, such as difficulties with employment, daily routines such as housework or moving around, and ability to socialise.

> *"Lost job as not fit for work. I'm not the same person I used to be."*

> *"I have to sit on the floor to load the washing machine and have to do the dishes in short spells as I'm too tired to stand for long periods of time."*

They also reported a lack of understanding and support in the workplace, especially as society had transitioned' back to normal' following the initial COVID breakout and lockdowns.

People felt their needs for adjustments, such as remote working, had at times been ignored or denied, as the general societal attitude was that everything had returned to normal. This misconception presents a serious challenge for those experiencing Long COVID.

Many told us that they felt wary or concerned about the prospect of re-integrating into busy workplaces and social spaces, where COVID safe measures were no longer in place. We heard concerns about lack of mask wearing and ventilation, meaning some people felt more comfortable working from home.

> *"I feel right now that people want to ignore COVID, in business situations and in meetings, they don't want to talk about it."*

> *"'Everything is back to normal' - but for quite a large proportion of people it isn't (…) there's a feeling in society that everything is fine and that gives you less of a reason to [speak up] and push for your symptoms."*

People reported depression, anxiety, and despair at ever recovering, concurring that friends and family had struggled to comprehend them and maintain their support as the illness persisted over time and initial support often waned as these close relationships expected a swifter recovery.

People shared experiences of feeling misunderstood and pressured by friends, family, and colleagues, leading to feelings of guilt for not being able to function as expected.

> *"My friends, my family, my relationships, they look at me and they think: 'oh God, Mum, surely, you're over this fight, over this virus by now. You can't still be suffering from Long COVID'. They expect me to bounce back, to be the way that I used to be. And I wonder if I ever will."*

> *"Friends & family really expect you to be able to function and I feel guilty sometimes that I can't."*

Several participants told us that they had been battling depression because of the impact of the illness and its symptoms on their lives, leading to feelings of hopelessness at their lowest points.

> *"Depression is another thing that I found has kicked in for me (…) we don't know when it's going to end. And if we're ever going to feel the way we did."*

> *"It feels like a constant struggle, just everything is."*

2) Barriers to seeking/accessing service/support:

Lack of information from trusted sources

Due to the initial lack of information and awareness about 'long COVID' some, referring to themselves as 'first-wavers', did not know who to contact for help or whether to even seek medical attention. Consequently, they often relied on family and friends for support in the early stages of their illness.

Although there is now an increased understanding of the condition, research is still ongoing. Long COVID is still a comparatively new condition and there is still a great need for readily accessible information in keeping with new developments.

It is vital that this information is provided by trusted sources, as many people told us that in the absence of trusted information, they were likely to turn to contradictory information provided by the media.

> *"It wasn't immediately [that I realised I had long Covid] I didn't go too deep immediately because I really didn't have the understanding of what long COVID was about."*

> *"I got COVID when it first started. At first it was new so it was very hard for me to know what was wrong. I was ill for close to seven months and couldn't get appropriate treatment. And eventually, it became well known to everyone and I got some kind of treatment from my GP."*

This initial confusion was exacerbated by misinformation around adverse reactions to the COVID-19 vaccine. Some people with long COVID symptoms mistakenly attributed their ongoing health issues to the vaccine instead of the virus itself, which delayed them in seeking professional medical support. This underlines the importance of providing accurate evidence-based information from trusted sources.

> *"I thought maybe this might be the effect of the vaccine. During that period, a lot of people had said they felt fatigued after taking the vaccine. So, I just thought it was that and I persisted for a very long time [before seeking help]."*

> *"The idea of having COVID really didn't pop up in my mind. My first thought was that 'maybe I'm reacting to the vaccine?'."*

Some people independently researched their symptoms via the internet and informal channels. They used a variety of sources, including the NHS website, advice from health professionals, online forums such as Reddit, and social media platforms like Twitter.

People felt these platforms were particularly useful for gathering information on 'Long COVID', and some participants even adopted some of the self-treatment methods discussed there. However, the advice people told us they researched

was often conflicting, contradicting NHS and government advice, which inhibited their motivation to access appropriate healthcare.

> *"I contracted COVID-19 twice and did not access support initially but just waited it out, hoping it would go away. I looked on the NHS website which stated it might take up to 12 weeks for symptoms to improve."*

> *"I got COVID-19 in 2020 – my mum is a GP and I spoke to her friend who was a volunteer on the COVID helpline. She informed me that no one was getting better from COVID-19."*

> *"I turned to the internet to find support, at the time the Reddit forum was the only place that had the most information on Long COVID and people sharing their own self-treatment methods which I was drawn to."*

Some expressed a sense of distrust in the UK government's approach and information on COVID-19 and Long COVID messaging and therefore a distrust in NHS advice by association. NHS online information was criticised for being 'out-of-date', which led some to seek private health care.

> *"I didn't bother with the NHS advice as I don't feel the UK government's ideology on COVID-19 and Long COVID is not going to lead to good public health management, and the NHS advice is aligned with the government."*

> *"The UK government's messaging on COVID-19 and Long COVID has been dangerous – implying that people shouldn't be worrying about it and carry on with their lives."*

> *"NHS information was out of date and irrelevant compared to the latest research found elsewhere."*

> *"Through research I found out who in the NHS was working on Long Covid, what specialists there were, but accessed them privately."*

Isolation

Some people told us they did not immediately attribute their condition to the virus. This was particularly true for those who were isolated when their symptoms developed.

Without the chance to discuss their symptoms with friends or family, they were less likely to identify their illness as 'Long COVID'. Consequently, people sometimes waited longer before seeking medical attention, due to a lack of understanding and recognition of their condition.

> *"I didn't go [to my GP] immediately (…) When I was first diagnosed, I was isolated for a long time."*

> *"At the start of my journey I didn't go to the GP (…) I really didn't engage much with people during that period. So, I never really thought [it was Long COVID] (…) but eventually I went to the GP."*

We heard that a lack of social support groups had had a negative impact on people's ability to seek support.

> *"I think of my mum in this area, there really isn't anywhere here, where I live, where she can go and connect with people and start talking about COVID. What local groups are there? If you're not in an area that's of your culture…"*

Lack of understanding of the referral process

Diagnosing Long Covid is a process of elimination. When a patient reports symptoms it is important to establish, by simple blood tests, chest X-rays, ECGs etc, whether there is any other underlying cause of symptoms.

We heard a perception from patients that undergoing the tests would delay referral to the CoRe service by several months. We would not expect a referral to take longer than a month, or two at the most. However, there was a sense that patients felt discouraged by the process and there was a risk that they might disengage.

Residents told us that it was often difficult to explore the full range of symptoms experienced in a regular 6-minute GP appointment slot.

> *"I remember having a conversation with my GP. When [Long COVID] wasn't a thing, they thought it was chronic fatigue. And there was nothing they could do for chronic fatigue."*

> *"I've just given up now, because when you've said something three times and you only have six minutes in a GP session, how much more do you do? All you then do is focus on one individual illness, rather than saying 'can you have a look at this whole set please?'"*

> *"I remember one GP saying you won't get diagnosed with Long COVID until all the other things have been taken off the table. So, then my head is like 'well you're never going to get diagnosed then are you'."*

Although feedback about GP services was generally positive (see below section on GP contact), feedback about other clinical services was less so. People reported that secondary care services seemed to lack an understanding of the condition.

We were told that clinical staff specialising in other areas seemed to give advice that didn't fit with Long COVID or gave no advice at all. Often patients were left feeling there was nothing that could be done and that they should 'stop moaning' or 'try harder'.

> *"There's a real problem with the attitude of nearly all the [secondary care] clinicians I've come into contact with. The neurologist I saw said to me, "at least it's not dementia, and you're still relatively high functioning", despite what I would consider being a huge drop in function. 'Stop moaning', that was the tone of the conversation."*

> *"My renal consultant was telling me I need to "try harder" He said that graded exercise needed to increase, which is the worst thing that everyone knows now [about Long COVID], it's the worst thing to do. And this was a consultant, telling me I'm not trying hard enough and I need to exercise harder."*

People agreed that more training around how to understand and communicate with those living with Long COVID was important for clinical staff that don't specialise in the condition.

Patients feeling they are a burden on resources

Most people we spoke with had been living with Long COVID for a long time. They described feeling guilty for not improving despite healthcare professionals' efforts and being a burden due to their ongoing needs. Some felt "*fobbed off*" or forgotten.

> *"It's a feeling like you need too many resources because you have all the checks done and then they might come back normal because they haven't necessarily got the right tests yet to be able to pick stuff up and pinpoint it. I definitely feel a bit like a burden now."*

> *"I do feel a bit forgotten about because aside from yourselves in these groups, I feel that we're sort of left to get on with it. You know, we walk around with this label of Long COVID but there's not much help and support out there for us."*

People suggested further training for medical professionals around better communication with patients, feeling that the language used often felt disheartening and the tone dismissive. We heard that medical professionals did not always acknowledge the impact that symptoms were having on their lives and that a more empathetic approach was needed.

There was also a feeling that clinicians sometimes spoke about the prognosis in a way that left patients feeling there was no possibility their condition could ever improve.

> *"I was utterly dismissed, told it was the menopause and told to 'deal with it'"*

> *"We don't want to be fobbed off! They may not be able to offer me all the support but I do have a real condition and I want to feel supported."*

"I feel like somehow there needs to be training in how to work with patients in a way that recognizes [these needs] and gives us hope."

Barriers due to culture and wider society

Some patients told us of the challenges they faced when accessing Long COVID support, due to cultural, linguistic, and societal barriers. In cultures where the medical profession is highly respected, we were told that patients often struggle to assertively communicate their symptoms.

Others pointed out the reluctance among older people, especially those from immigrant and minority ethnic communities, to seek access to healthcare services, vaccinations, or discuss their health problems openly, suggesting that certain attitudes amongst this population make it harder to admit when they have health issues.

One participant, who told us she worked as a nurse in emergency services, noted that many older patients had opted not to receive the COVID vaccine. She wondered whether this refusal stemmed from a cultural disinclination to engage with health care and observed that she had sadly lost many older Afro-Caribbean patients to COVID.

"If I describe my mum, she'll say she's fine unless her arms and legs are chopped off. There's a whole thing in her generation, when she came over (…) it's a different language, you've got to be brave, bold, all these things (…) that make it harder to say "actually, I think I've got something wrong with me."

Some suggested that their communities had been more severely impacted by the pandemic, due to a higher prevalence of certain conditions like diabetes. They felt this was especially significant for people of South Asian heritage, who statistically have a higher disposition for such health conditions.

Social status was also seen as a factor that influenced the impact of the pandemic on different communities, and people expressed concern about limited access to community support.

"I'm of South Asian origin. There are probably, statistically, much higher comorbidities where COVID might have a disproportionate impact. For example, being diabetic and having other sorts of things at the same time (…) So those things add complications."

We reminded participants that one of the aims of the consultation was to better understand why certain communities (such as those of Black, Asian and minority ethnic origin) were underrepresented in accessing Long COVID services, compared to other groups.

Some suggested that the discrepancy might perhaps be attributed to the proactive approach (or lack of) of certain GPs, rather than cultural factors. They proposed that it was not necessarily about ethnicity but more about specific GPs and the areas they served, where some were actively identifying the need for referral while others were not.

"It's not necessarily about ethnicity, probably more about the GPs and those particular areas, who have actually said 'you know what, you need to get this' while the other GPs aren't doing it?"

Barriers due to language

Language was identified as a barrier to accessing initial support through GPs. Those for whom English is a second language found it challenging at times to clearly express their symptoms.

Similarly, we know many people find it difficult to communicate in a clinical setting, including those living with autism or learning difficulties. Notably, we heard from patients that were offered longer appointment times or translation services, and that this helped overcome some of these barriers.

"Not being able to, for whatever reason, describe things in a manner that a professional can understand. Especially if people don't have English as a first language."

Barriers due to finance

People also emphasised the struggles they had faced in feeling marginalised due to their economic status. They expressed the sense felt by members of their communities of not being able to access treatment because they could not afford to take time off work, for fear of losing an income relied on for survival.

The cycle of poverty is such that they cannot afford to be sick as it means less food on the table and challenges in paying bills, leading to sacrifices in personal health to sustain their homes and families.

> *'we've got to keep going because we can't afford to take the time off work, because we need to earn the income. And if we take the time off work, we're going to be laid off'.*

These fears were borne out by accounts of unsupportive employers. Some reporting the experience of forced resignations, due to being unable to keep up with the demands of work, which deeply impacted their mental health, self-image, and financial stability. Some expressed a further sense of guilt, and uncertainty about the future.

> *"I found that work wasn't very supportive to me at the time and said, If I'm not fit for work, then I can't work there anymore. So, I had to resign."*

> *"I feel guilty that I can't go back to work."*

3) GP contact – The Good News

When asked about their first contact in seeking medical support for Long COVID, all participants told us they had sought help from their GP, although some experienced symptoms for some time before doing so. The GPs were overwhelmingly reported to be supportive.

Some reported their GP's efforts to secure small, incremental health improvements for them, commended their GP's willingness and thoughtful

approach. Others noted the proactive attitude of their GP in securing appointments, recognising the challenge for some to do so due to their ill health.

One patient mentioned their GP setting up the last appointment of the day for them, allowing for an extended discussion of their symptoms. The GP would even arrange double appointments if the participant had missed one. Another praised their GP for being patient despite their increased irritability caused by their illness.

Overall, people's GPs were highly praised for their consideration, patience, and proactive approach to treating the condition.

> *"My GP keeps referring me to things to try and get some small incremental improvements for me. And he's very willing and thoughtful."*

> *"When I was first ill my GP would make appointments to call me, he said: "I will make an appointment to make sure I see you in a week's time", so I didn't have to try and do it [when I was too unwell to organise my own appointments]."*

> *"He would always give me the last appointment so that we would talk for an hour or longer. He was incredibly thoughtful and considerate. If I missed an appointment he phoned back and say: "I'm making another appointment with you. So, we'll have a double appointment". In terms of a GP, I could not praise him enough."*

> *"The GPs have been very considerate. They're patient, because I found myself becoming very irritable, very unlike myself, I became very difficult to relate with."*

4) Peer support

When discussing peer support with participants, we gathered valuable insights. Some expressed a preference for online sessions to minimize the risk of infection, emphasizing the importance of timing for these sessions.

Additionally, participants mentioned that incentives like local vouchers would serve as a welcome motivator to attend. In terms of content, conciseness was emphasized, especially for individuals with memory issues.

The inclusion of speakers or peers with long-term experience was seen as highly valuable by the participants.

> *"Having [peer support] online is better. You can get multiple bouts of COVID. I don't particularly feel comfortable in close proximity [to people]."*

> *"With regards to peer support groups (…) give them something back (…) so you're getting something back as well as attending. Otherwise, why else are you there? (…) because everyone's time is so limited."*

> *"I've been in this session for seemingly not much time but my brain… I am knackered! The concentration I've had to put into listening to everybody and you guys is off the charts! (…) it's harder than just a normal peer support group."*

> *"…part of it has to do with how long you've had Long COVID. Quite a few people in the group that I was in are 'first wavers'. We're all sort of hitting the three-year mark (…) [we] found management tools and skills to cope with the condition as best [we] can. There may be a case for sharing that with newcomers."*

5) General Practitioner & Healthcare Professional perspective

We felt it important to obtain a primary care healthcare professional perspective, given that general practitioners currently serve as the single point of access to the Post-COVID service in City & Hackney.

We sought feedback from GP practices within all 8 neighbourhoods in City & Hackney, through a short online survey on their experience of managing Long COVID patients, referral pathway and sources of Long COVID information.

With the acknowledgment of time constraints faced by general practitioners, we disseminated a short e-survey to all GPs through the NEL practitioners'

newsletter, City & Hackney practitioners forum, and directly to practitioners' inboxes and primary care network contacts.

Referral Process

The majority of GPs told us that the referral process is time consuming, with long forms to be completed. We heard that given the current stress and work levels GPs are experiencing, the current referral process is not practical. This could result in some GPs not referring patients.

> *"Referral process is the most tedious process than any other. It takes me 30-45 mins for one patient. Totally unacceptable with current stresses. Leaves the GP overwhelmed with the process, instead of trying to focus on the needs of the patient."*

> *"Referring patients is long-winded and requires a lot of information and investigation gathering. A lot of the time this is appropriate and forms part of the assessment process whilst seeing if patient fulfils long-covid criteria. For other patients who are more frail / complex, getting the information together takes too long and delays the referral."*

We also heard from some GPs that the referral process can lead to patients being rejected as unsuitable for the services.

> *"Discouraged in general, given rejection rate when trying to refer. We are aware of the investigations required but it's an administrative burden, the odd test result sometimes doesn't get through."*

> *"The referral process is long and arduous, seems as though it is not unusual to have referrals bounce back (has never happened to me)."*

However, this is often the result of GPs failing to follow the full referral process, as the Long COVID service is unable to accept patients that may have been incorrectly referred.

This raises a concern, that we heard from residents in the focus group phase of this survey, that the referral process seems to take a very long time. This could be due to GPs not following the correct referral process, which delays the patient gaining access to the Long COVID service.

However, some practitioners felt the referral process had improved and that patients have benefited from accessing the Long COVID service.

> *"Referral pathways now seem quite clear information now available."*

> *"I referred a patient with breathlessness to long covid clinic that was helpful, he saw physiotherapists and felt satisfied with the level of follow up The form is far too long however."*

Resources

We wanted to gauge the efficacy and reach of clinician focused Long COVID resources currently available. Practitioners told us they sought Long COVID information from online sources, healthcare journals such as the BMJ and through personal study.

Also, 33% of GPs asked had accessed and viewed the Long COVID information videos available on the NEL Community of practice resources website and social media.

It should be noted that these videos were designed for both patient-viewing as well as healthcare professionals, indicating the need to highlight the key aim of these resources and encourage practitioners to share them more widely among patient-facing areas.

Others were either unaware of these resources or, commonly, despite being aware did not feel they had the time to watch the videos, given their workload pressures.

We also heard that the videos were "*scattered across websites*" and would be more easily accessible if held in one place.

Ongoing Support

We heard from GPs that more information about what CoRe services offer could be helpful. Feedback from the CoRe team about individual patients could also help GPs to offer them ongoing support.

> *"Not sure I have had much feedback from long covid team once the patients are under them?"*

> *"Is there enough psychological support?"*

> *"Once patients get there, they seem to be very happy with the support they receive. I do have one patient who has been severely affected by Long Covid and I have found both Joanna and Louise very helpful in thinking about her management. With regards to patients with non-Covid fatigue, fibromyalgia etc, I imagine that they would receive similar support via the CFS service?"*

Practitioners felt integration with other linked specialties would be beneficial.

> *"It's great that this is MDT. It would be great if there was a way of also integrating, e.g. cardiology, since POTS is so common as well as respiratory and neurology, etc. Also, this was a while back so may have changed now, but think it would be useful to screen for post-exertional malaise. Thanks"*

The CoRe service continue to work closely with City & Hackney primary care network colleagues and local healthcare commissioning bodies, to update and reform Long COVID resources in supporting easier access to the service.

This is being done in conjunction with feedback from general practitioner and HCP colleagues, to ensure resources are responsive to their learning needs while also feasible alongside their workload pressures.

Follow-up Patient Engagement & Co-design

Having analysed the data from the four focus groups carried out with survey participants, we took the survey findings back to patients with a view to consult and co-produce key recommendations to be incorporated within the final report. Our aim was to use this platform to amplify the patient voice and use people's experiences to help improve services for Long COVID patients in a meaningful way.

This face-to-face consultation gave us the opportunity to collaborate directly with Long COVID patients in identifying key areas requiring further support and focus. These were:

- Social, financial & housing support
- Employment support
- Resources for self-management
- Transparency in communication between different clinical specialties when treating patients with Long COVID
- Visibility & awareness of Long COVID in the community
- Language and attitude of clinicians towards patients
- Reliable sources of information and resources

(See Appendix 3 for full consultation feedback)

Conclusion

This project was undertaken to address the underrepresentation of marginalised communities accessing the City & Hackney Covid Rehabilitation (CoRe) Service, identified with the appointment of the Long COVID engagement lead.

Both the survey and the subsequent focus groups reached over 300 people across the area, listening to patient feedback, co-producing service improvements, building links with primary care services, local authority and community partners as well as voluntary sector organisations in City & Hackney. This project has helped to identify the unmet need with regards to Long COVID service provision and the associated services required to help Long COVID services across the population

A comprehensive engagement approach was implemented, involving both a survey and 4 subsequent focus groups, reaching over 300 people. This approach encouraged the receipt of patient feedback and facilitated the co-design of service improvements. Importantly, it also cultivated a deeper connection between Long COVID patients, primary care services, local authority bodies, community associates, and voluntary sector organisations in City & Hackney.

This initiative has helped to identify areas of unmet need in relation to Long COVID service provision, identifying additional services required to complement the delivery of Long COVID care across the population. These findings establish a foundation from which we can take further steps to improve service provision and, ultimately, the wellbeing of our community.

Recommendations

The recommendations aim to improve awareness, streamline care coordination, empower patients with self-management tools, and foster collaboration with relevant stakeholders. By implementing these recommendations, the CoRe Service and partner organisations can enhance their capacity to support Long COVID patients and effectively eliminate the barriers reported.

Awareness and Education:

1. Improved information from 'trusted' sources. NHS website and locally, City and Hackney public health information.
2. Clearer published information on patient pathways
3. Information campaign to GP surgeries and secondary care providers across City and Hackney with online webinars and leaflets in surgeries and hospitals.
4. Information produced in other languages.
5. Workplace education – information pack for employers, detailing workers rights and support recommendations. Provide resources to employers and unions about Long COVID and its impacts, including the need for flexibility and possible accommodations.
6. Provide up-to-date information about Long COVID and available support services on a centralised website, making it easily accessible for patients, healthcare professionals, and the general public.
7. Offer training and education programs for healthcare professionals, including GPs and specialists, to enhance their understanding of Long COVID, its diagnosis, and management and Promote transparent communication among clinicians about Long COVID patient's care. Training to include support for healthcare professionals to take a respectful and understanding approach towards CoRE patients (recognise challenges faced by those who may not appear visibly unwell but are nevertheless struggling with the condition).
8. Emphasise guidelines and protocols for healthcare professionals on diagnosing and managing Long COVID, including specific criteria for referral to the CoRe service.

9. Consider allocating a Long Covid Care Coordinator for patients as a single point of contact for patients.
10. Long Covid volunteer champion – responsible for sharing and promoting communications to communities, engaging local orgs and residents in information sharing conversations. Gathering and feeding back insights.
11. Provide guidance to Long COVID patients on how to navigate the benefits system, especially to those experiencing job loss or reduced hours due to their condition.

Enhanced Referral Process and Care Coordination:

1. Single care plan shared between care providers.
2. Streamline the referral process for Long COVID patients, ensuring that it is efficient, timely, and well-communicated to healthcare professionals.
3. Improve sharing of information between primary care providers, specialists, and other healthcare professionals involved in the care of Long COVID patients, facilitating a multidisciplinary approach to treatment and rehabilitation. This could look like a single care plan shared between care providers.
4. Consider allocating a Long Covid Care Coordinator for patients as a single point of contact for patients.

Support for Self-Management:

Co-design resources and tools for self-management of Long COVID symptoms, including guidance on lifestyle modifications, coping strategies, and techniques for managing physical and mental health challenges.

Collaboration and Partnerships:

1. Proactively target communications and information to under-represented communities. Go to where communities are rather than expecting them to come to us – share information through VCS orgs, lunch clubs, libraries, community centres, healthcare facilities, and online platforms, wellbeing groups. Recruit a volunteer to distribute comms material.
2. Outcomes appraisal – 6/12 months following report publication follow up on work by actively seeking patient feedback to measure outcomes and identify ongoing areas for improvement.

Inclusive Support Services:

1. Develop peer support programs including older individuals, men, those going through menopause, and cultural groups less likely to seek help (support groups; exercise classes; workshops on relevant topics that promote and support social inclusion and engagement).
2. Expand existing peer support groups – consider using non-clinical local settings.

Next Steps

It is hoped that the findings and recommendations of this report, on the experience of Long COVID patients in accessing rehabilitation services, will serve to influence service providers, commissioning groups and healthcare trusts to better address the discrepancies in engagement which triggered this research and increase inclusion by working on more efficient collaboration between partners to better serve the health needs of the population in City & Hackney. If implemented, these recommendations will lead to better coordinated services, providing increased access to services and support for our diverse communities.

It is our hope that the insights gained from this report, coupled with the recommendations put forth, will enable service providers, commissioning groups, and healthcare trusts to better tackle the identified discrepancies in engagement that prompted this study.

To foster increased inclusivity, it is crucial that we cultivate a more efficient, collaborative environment among all involved partners. This will not only enhance the level of service provided but also ensure it better aligns with the health needs of the population in City & Hackney.

We believe the adoption of these recommendations will contribute to a significant improvement in the coordination of services which will, in turn, pave the way for broader accessibility to services and support, thereby more effectively meeting the needs of our diverse communities.

Appendix

Online Long COVID survey of 231 City & Hackney residents - Summary of findings:

During November 2022 – January 2023, 231 people completed our survey on Long COVID. This section summarises key findings – see here for findings in full.

Overall Findings

- A broad majority of respondents (84%) have tested positive for COVID-19.
- When seeking medical support for COVID-19 infection, the GP (48%) and hospital (40%) are the most common services used.
- Just under two thirds of respondents (61%) have been diagnosed with Long COVID.
- Symptoms most mentioned are fatigue (57%), difficulty concentrating (54%), muscle ache (45%), memory problems (41%) and shortness of breath (40%).
- Just under two thirds of respondents (62%) know how to seek support.
- When seeking support following diagnosis of Long COVID, the GP, at 54% is clearly the most commonly used service.
- Over two thirds of respondents (69%) are aware of the symptoms of Long COVID.
- The greatest impacts on daily life are difficulty with socialising (41%), inability to work (37%) or having to make working adjustments (35%), inability to study (35%) and difficulty with caring responsibilities (29%).
- Around two thirds of respondents (67%) are aware of the City and Hackney COVID Rehabilitation Service (CoRe).
- 60% of paid employees feel their employer would be supportive, while 15% feel they would not be.
- A sizeable minority (28%) feel that language may present a barrier, when seeking or using services.
- Disincentives, or barriers to seeking support include money issues (35%), caring responsibilities (34%), previously poor experiences when seeking help (24%), a lack of information or confidence in services (both at 22%) and employment issues (21%).

Findings by Age

- Respondents of later working age (50 – 59) are significantly most likely to have tested positive for COVID-19.
- Those of mid-working age (40 – 49) are clearly most likely to have consulted with their GP. The youngest respondents (aged 21 – 29) are by some margin, most likely to have visited the hospital., and also least likely to have contacted NHS 111.
- Those of mid-working age (40 – 49) are most likely to have been diagnosed with Long COVID.
- The youngest respondents (aged 21 – 29) are over twice as likely, to know how to seek support, compared with the oldest (60+)
- Following a diagnosis for Long COVID, the youngest respondents (aged 21 – 29) are by far, least likely to consult with their GP. The oldest respondents (aged 60+) are by some margin, most likely to have received support from the Post/Long COVID clinic, and also most likely to have used online services.
- Respondents of mid-to-late working age (40 – 59) are most aware of Long COVID symptoms.
- The oldest respondents (aged 60+) are by some margin, least aware of City and Hackney COVID Rehabilitation Service (CoRe) services.
- The youngest respondents (aged 21 – 29) are noticeably most likely to consider language as a potential barrier

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Committee	Dated:
Health and Wellbeing Board	22/09/2023
Subject: Suicide prevention in the City of London Annual Update	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	1,2,12
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**£**
What is the source of Funding?	
Has this Funding Source been agreed with the Chamberlain's Department?	**N/A**
Report of: Sandra Husbands, Director of Public Health	**For Information**
Report author: Claire Giraud, Senior Public Health Practitioner	

Summary

In 2017, the City of London Corporation established a multi-agency suicide prevention group, in accordance with best practice recommendations, and published a Suicide Prevention Action Plan containing numerous initiatives aimed at reducing the number of suicides in the Square Mile. This report provides an update on the suicide prevention action plan as well as on the number of attempted suicides and suicides occurring in the City of London.

Suicide figures for the City should be interpreted with caution, as they are extremely low – this means that any variations may not be statistically significant (i.e. the figures may be due to chance fluctuation); and additionally, recording practices have changed during the reporting period, which may impact upon the figures.

Recommendations

Members of the Committee are asked to:

- Note the progress made on the Suicide Prevention Action Plan
- Note the most recent data for suicide in the City of London

Main report

Background

1. Suicide is the act of intentionally ending one's own life. It is often the end result following a complex range of risk factors, mental illness and significant negative life events; however suicide is preventable, rather than an inevitable event. In the UK, suicide is one of the most common causes of death in people under the age of 50, with 5,691 reported people dying in this way in 2019. It is estimated that each suicide further impacts between 6 and 60 people. Within the UK, suicide shows significant gender and social inequalities, and is associated with stigma for families affected by it.

2. Over the last 8 years, a number of key policies and reports have been published to improve suicide prevention nationally and locally. In the City, a local audit, suicide prevention action plan and multi-agency suicide prevention group was established in accordance with best practice recommendations.

3. Public Health England (PHE) recommended several priority action areas to include in local suicide prevention plans:
    - Reducing risk of suicide in men
    - Preventing and responding to self-harm
    - Mental health of children and young people
    - Treatment of depression in primary care
    - Acute mental health care
    - Reduce suicides at known 'high risk' locations
    - Reducing isolation
    - Bereavement support for those affected by suicide

Overview for the City of London

4. Between 1st of September 2022 and 31st of August 2023, there have been 6 suicides, with a total of 162 attempted suicides.

5. Between 1st of September 2022 and 31st of August 2023, there had been a total of 150 incidents whereby the subject had contemplated suicide or had suicidal thoughts.[1]

[1] We have yet to achieve consensus on the definitions of these terms, creating a challenge for interpreting these data. The City of London suicide prevention steering group have identified this as an issue and aim to achieve consistency in future.

Emerging Trends throughout 2022

Timing and Location

6. Data from the City of London refers to events occurring within its geographic area. The majority of incidents will therefore involve individuals resident elsewhere in London and the country.

7. Over 67% of the attempted suicides occurred during the night and the peak days were Wednesday, Saturday and Sunday.

8. Bridges remain the most common location type for suicide attempts within the City, with 86% attempted suicides occurring on bridges. The second most common location was on the street (5%).

9. The qualitative analysis shows that 45% of individuals had a direct journey from their home address to the incident location, meaning it only required one mode of transport and one direct route.

10. The analysis also demonstrated that one of the individuals stated they worked in the City; however for 97% of individuals this was either not known or not recorded.

Demographics at the end of 2022

11. Data from the City of London Police is provided in the table below, and covers the period subsequent to the previous City Suicide Prevention Annual Report in 2022. The data covers both completed and attempted suicides. Please note that the most recent data from the coroner was not available for this report.

12. ***Age range:*** Unlike in 2018, in 2019, 2020 and 2021, in 2022 there was a mixed aged range for attempts: five individuals aged under 18 (5%), 56% were aged 18 to 29 years of age, 19% in their 30s, 12% in their 40s, 7% in their 50s and one individual in their 60s (1%).

    Completions were also mixed in 2022 (between ages 27 and 45).

13. ***Gender***: Males represented 60% of attempted suicides, females represented 39% and trans represented 1%.

14. ***Home Address:*** The majority of individuals travelled into the City from their home address where suicide was completed or attempted.

Summary for Period 1 January 2021- 31 August 2023

Month	Attempt			Contemplating			Complete suicide		
	2021	2022	2023 to date	2021	2022	2023 to date	2021	2022	2023 to date
Jan	< 5	8	12	< 5	9	11	< 5	0	0
Feb	< 5	7	18	7	7	15	0	0	0
Mar	16	7	13	< 5	14	14	0	0	< 5
Apr	9	6	8	9	5	12	< 5	0	< 5
May	11	8	13	9	10	12	0	0	0
Jun	17	13	19	19	16	9	< 5	0	< 5
Jul	17	13	16	15	11	18	0	0	< 5
Aug	12	18	14	9	16	15	0	0	< 5
Sept	10	15		15	13		< 5	< 5	<5
Oct	13	15		6	7		< 5	0	
Nov	11	13		11	10		0	< 5	
Dec	11	6		12	14		0	0	
Total	127	129		119	132				< 10

*data up to September 2nd 2022

15. Increases in suicide rate are associated with periods of economic and political uncertainty.[2] This could explain why the City of London saw a corresponding rise in 2021 and again in 2023.

[2] De Bruin et al, 2019. *New insights on suicide: uncertainty and political conditions.* Applied Economic Letters. doi.org/10.1080/13504851.2019.1686453

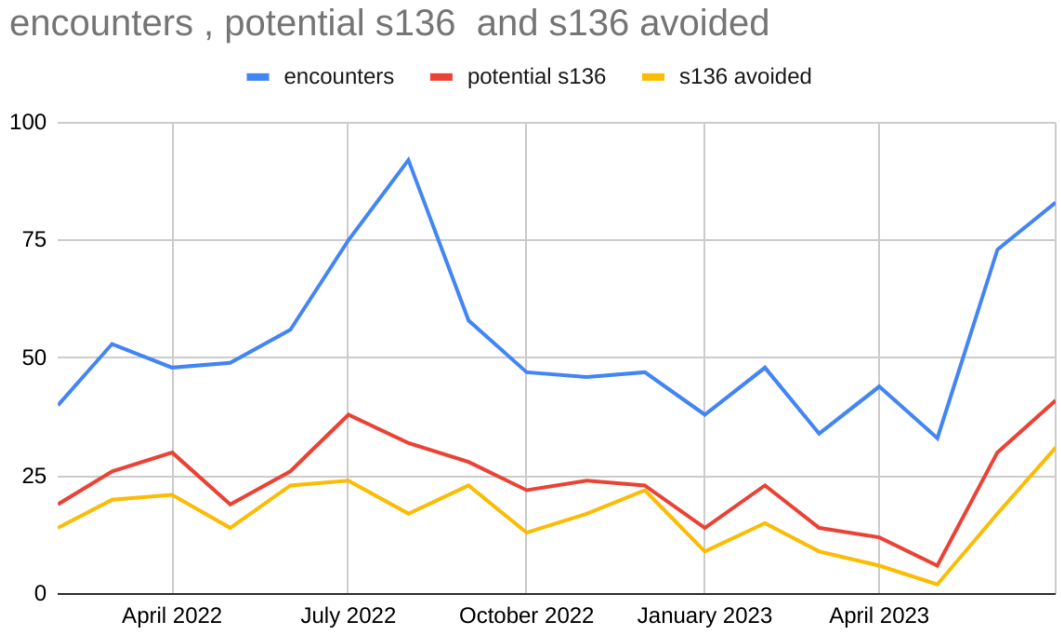
Mental Health Street Triage

16. The Mental Health Street Triage (MHST) was operating 7 days a week from 5pm to 3am since May 2018.

17. The number of daily operational hours expanded in response to a rise in incidents from July 2021 to October 2022.

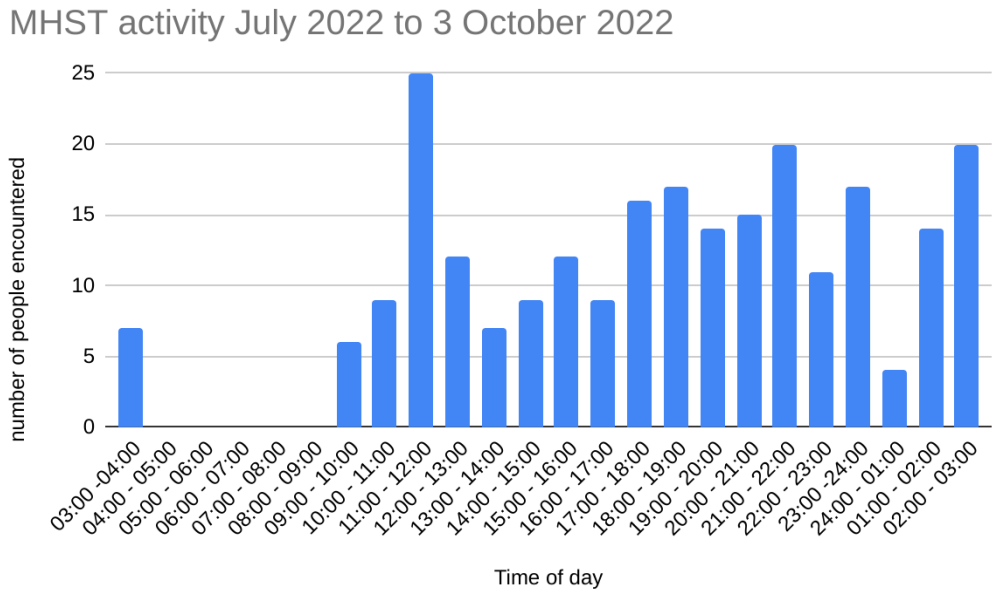
18. In 2022, after the operating team reported lower activity levels during the expanded hours, new core hours for the service became 3pm to 3 am. This new model started on October 4th 2022.

19. MHST Activity levels February 2022 - July 2023:

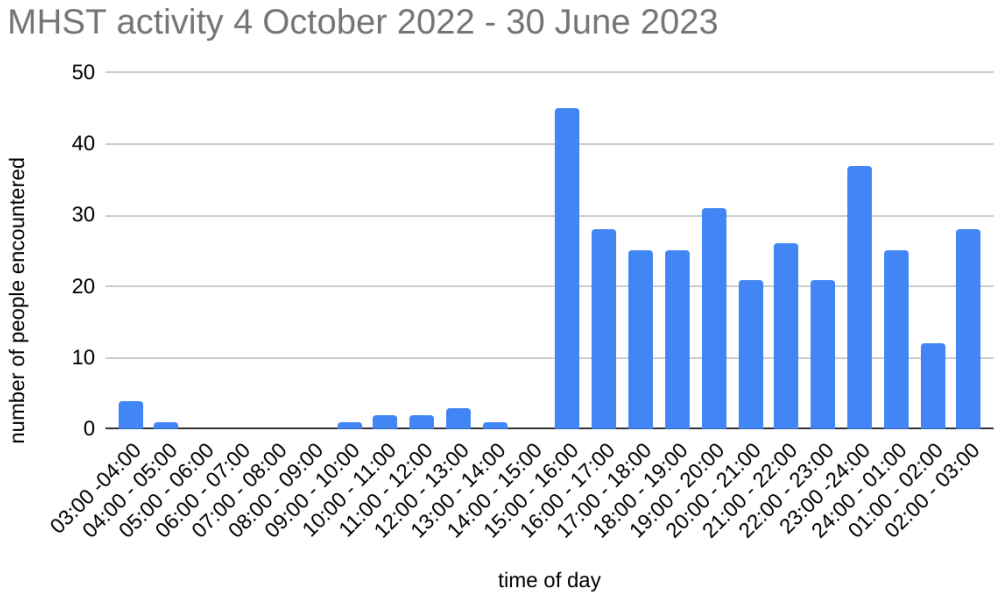


The graph above shows activity levels over the past 18 months, with daily shift patterns changing from 18 to 12 hours per day in October 2022. In both 2022 and 2023, there is an increase in activity in the summer months.

20. MHST activity level per hour July 2022 to 3 October 2022 (expanded hours)



21. MHST activity level per hour October 2022 to June 2023 (12-hour model)



22. Overall the service has seen more activity since the 12 hour model was established, with the first hour of the shift recording over 40 incidents.

23. A key function of MHST is to avoid the use of s136. In total, MHST responded to 635 incidents that were potential incarcerations under section 136 from 1st of July 2022 to 30 June 2023. As a result, an estimated 65.4% of s136 detentions were avoided.

24. The proportion of s136s prevented by the service has varied but remained largely consistent over time:

    - Feb 22 - Sep 22: 77.9%
    - Oct 22 - Jul 23: 67.3%

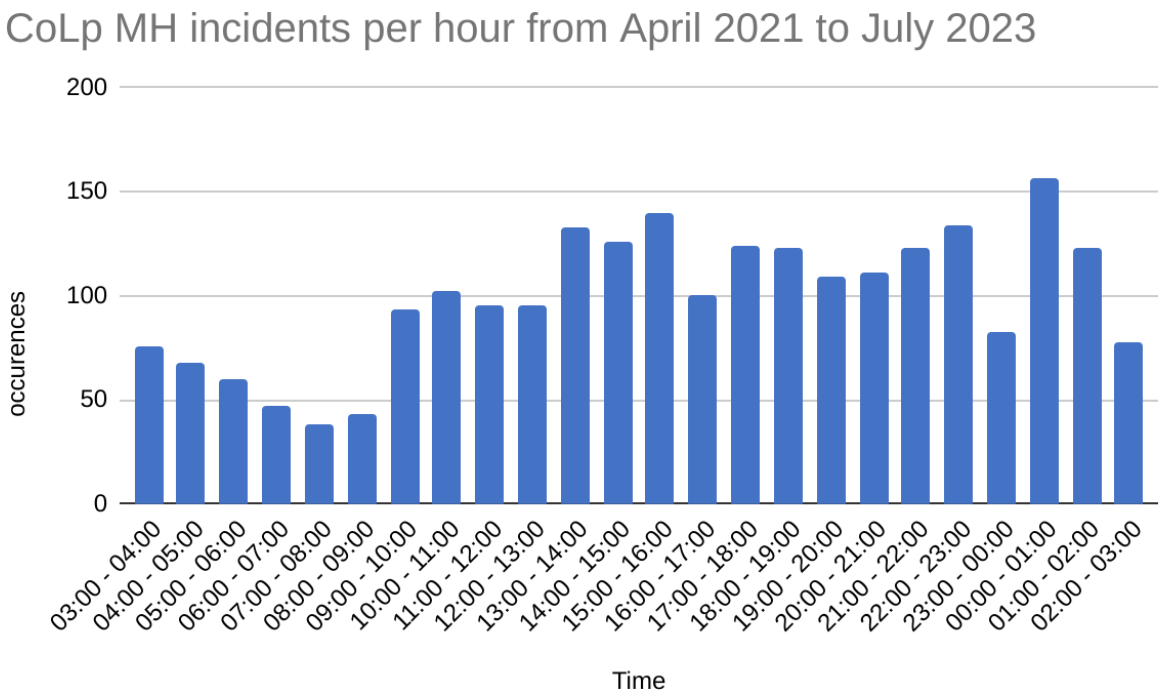
    Prior to this, since 2017 the service had varied between 65% and 76%.

25. Discussions with the MHST team are ongoing to assess the effectiveness of the new 12-hour model in place since October 2022. Issues emerging include:

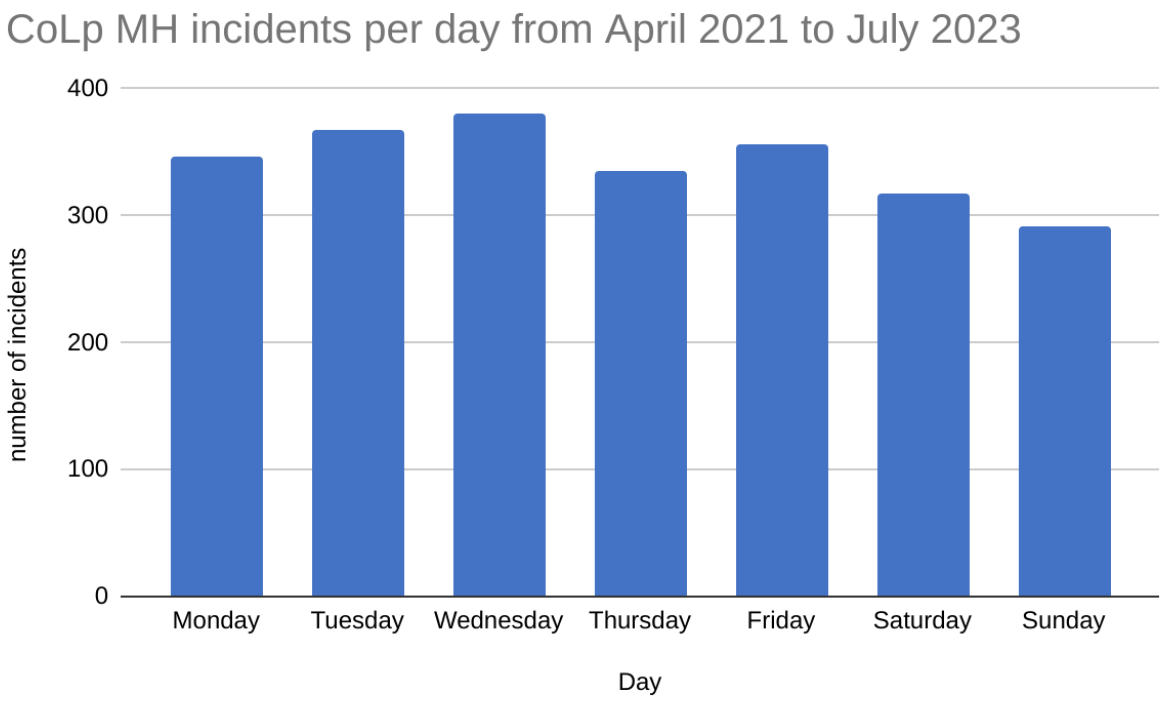
    - Possible need for additional cover past 3am
    - Challenges for staff scheduling due to incidents occurring at the end of the shift being more difficult to handover promptly

26. We have sought further data from City of London Police to determine whether any changes to the existing model would be appropriate, and we will liaise with NHS commissioners of the service if so.

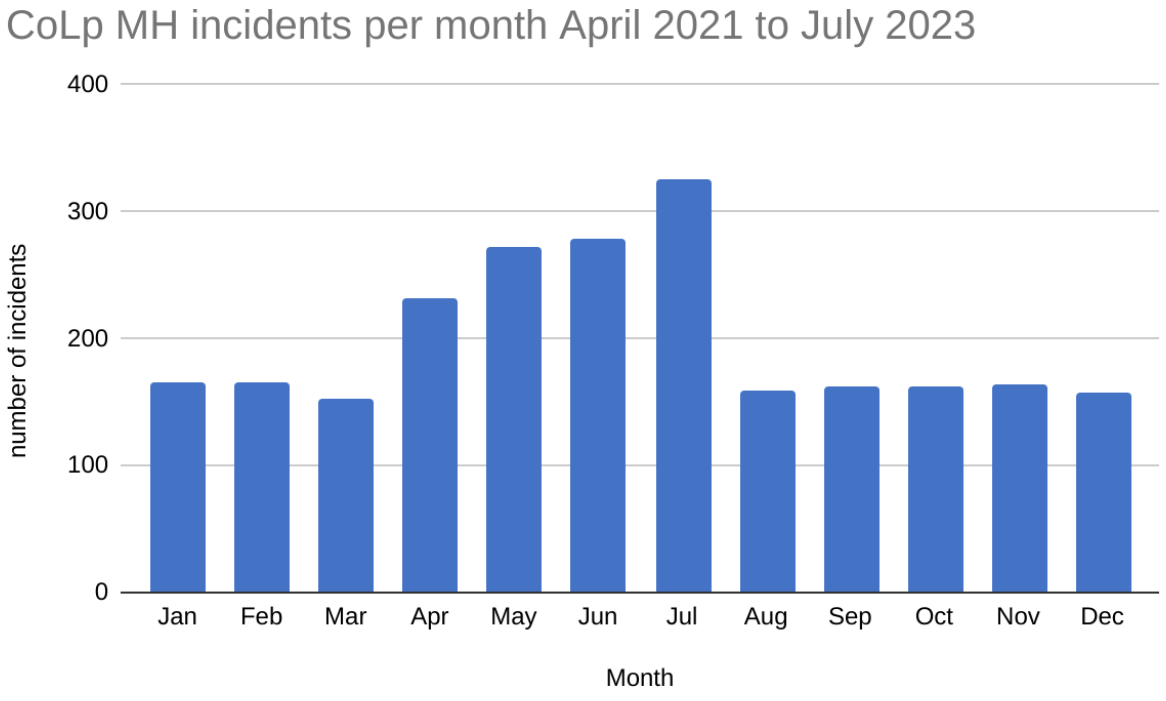
27. CoLp MH data April 2021 - July 2023



The above graph shows that activity levels peak from midnight to 1am and are at their lowest from 6am to 9am.



The above graph shows that activity is fairly similar more days of the week with a slight decrease on Thursday and a more notable decrease on sunday.



The above graph shows increased activity from April to July, activity levels are similar from August through to March.

Action Plan Progress Summary

28. Overall, 65 actions have commenced since the launch of the action plan, of which 10 are completed, 55 are in progress.

29. 4 new actions have commenced since the last annual report to the Health and Wellbeing Board.

30. Some of the new actions added to the plan since the last annual update include:
    - The events guidance note on risk associated to events on the subject of suicide.
    - Adapting the upcoming national highways software on location risk assessment for tall buildings and urban structures.
    - the production of an enhanced suicide prevention report.

31. Significant milestones include:
    - Training in Suicide Awareness and Prevention of City workers through the Business Healthy network still sees high uptake, with 192 people trained in the last 4 years, an additional 2 sessions are planned for 2022-23 to empower even more City workers to be the eye and ears of the emergency services. Ad hoc training is also delivered to businesses who have had incidents.

    - The Bridge Watch programme (volunteer patrols on the bridges) was finally successful in recruiting a programme lead, we are expecting mobilisation by the end of 2023.

    - The Secure City Programme's Vulnerable People workstream, which looks at technological solutions to improve situational awareness for emergency and support services on the City Bridges, continues to progress field trials within a wider, innovative IT programme. A key finding early in the workstream is that while there is a wide interest in this type of solution set, CoL is ahead of many other areas in conducting field trials.

RAG Status Key and Summary

Status of Actions	
Major Problems	0
Minor Problems	7
In Progress/ongoing	47
Completed	10

32. The majority of actions are green, either underway or on track to deliver. One action that has progressed but with delay (thus is amber) is the secure city programme.

33. No actions have failed to progress as originally envisaged (aka Red rating)

Conclusion and Recommendations

34. The past year has seen significant progress in the area of suicide prevention across the Corporation and its partners. Mental health street triage has implemented their recommended change in hours and we are currently assessing how well they are working.

35. The action plan has moved forward since its review, new actions have been added and many of the older actions are either complete or in progress.

Appendices

Appendix 1 – Suicide Prevention Action Plan for 2022–25

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2022-25 Suicide Prevention ACTION PLAN: DASHBOARD AND TABLE

Priority 1: **Reduce the risk of suicide in key high risk groups**		Priority 2: **Tailor approaches to improve mental health in specific groups**		Priority 3: **Reduce access to the means of suicide**		Priority 4: **Those who are bereaved or affected by suicide to feel informed and supported throughout their experience**		Priority 5 : **Support the media in delivering sensitive approaches to suicide and suicidal behavior**		Priority 6: **Support research, data collection and monitoring**	
12 Actions completed or ongoing	1 Amber	8 Actions completed or ongoing	0 Amber	12 Actions completed or ongoing	2 Amber	10 Actions completed or ongoing	1 Amber	7 Actions completed or ongoing	0 Amber	10 Actions completed or ongoing	1 Amber
AMBER: Approach taxi companies to train the drivers in spotting the signs of suicidal behaviour in their passengers and notifying the police				**AMBER**: install and maintain cameras on City of London Bridges to allow fast identification of which Bridge a person is on if they call, with monitoring at high risk times.		**AMBER**: contact funeral parlors in the city/used by city residents to ensure they are aware of bereavement services for those affected by suicide				**AMBER**: Resolve issues with receiving feedback from hospitals regarding the outcome of the mental health assessments after S136. The City Police Suicide	

		commission a feasibility study of physical measures on the bridges and make a decision based on findings			Profile of 2020 recommends that “an Information Sharing Agreement with the NHS should be established so that requests can be submitted to hospitals which request the outcome of assessment for any individual taken to hospital. This should be completed for every individual that attempts suicide; to ensure that all risk information is shared and appropriate safeguarding measures completed.”

PRIORITY 1 Reduce the risk of suicide in key high groups

Objective: To reduce the risk of suicide for young and middle aged men and women

Action:	Measure/outcome:	Lead partner	Comments:	RAG status
1.1.1 Promote the training of frontline staff in organisations including the City of London Police, the Metropolitan Police and staff who work near at risk locations in mental health first aid, suicide awareness, suicide intervention to help them engage men and women in conversations about - Wellbeing and mental health - Accessing appropriate information/self-help support - suicide	· Number of frontline staff trained · Training material · Promotion of training ·Examples where training has been used to good effect	Public Health	training is promoted as soon as it is available to CoLp, Frontline staff (education, social care, etc), park guards etc	Ongoing
1.1.2 Promote and provide information, training and supporting resources to City employees through Business Healthy member organisations including	· Information relevant to suicide on the Business Healthy resource pages · Number of Business Healthy members	Public Health Business Healthy	Business healthy runs quarterly training sessions that are always well attended and well received	Ongoing

Small to Medium Enterprises. for SMEs				
1.1.3 Train barbers in the City of London to talk to men about emotional health/the Release the Pressure campaign/five to thrive.	· Number of barbers who undertake training · Feedback from barbers on how this is perceived and used · Exposure of campaign	Public Health	Half of the city barbers were trained in May 2019 and PH is recommissioned some training via the lion barbers collective to train more barbers in march 2023	Green
1.1.4 Provide suicide prevention training to primary care professionals	· Number of practice nurses who have had mental health training	North East London Clinical Commissioning Group	Tower Hamlet CEPN regularly offers training to primary care professionals and the NEL ICB provides an SP webinar to GPs, practice staff, healthcare assistants etc.	Ongoing
1.1.5 Approach security firms to train security guards in spotting suicidal behavior and having the confidence to intervene	number of security guards trained in suicide awareness	Public Health and Business healthy	Security professionals have been trained through the BH sessions + since February 2022 the worshipful company of security professionals has approached the SPSG members to see where joint working could be done	
1.1.6 Approach taxi companies to train the drivers in spotting the signs of suicidal behaviour in their passengers and notifying the police	number of drivers trained in suicide awareness	Public Health and TFL	working towards: - promoting the Zero Suicide Alliance 25 min free online training on the taxi drivers newsletter which goes out to 125,000 license holders - incorporating suicide prevention training into the	Amber

			compulsory training for applicants to get a taxi license	
1.2 City of London Corporation commissioned services to promote suicide awareness campaign where appropriate	· Add 'Suicide awareness / prevention' component to Stress and the workplace section of drug and alcohol talks delivered to City businesses and refer TP service users to MH services as appropriate	Turning Point, prospects, young hackney	Partner organization staff have been trained in suicide awareness and are promoting suicide awareness campaigns	Ongoing
1.2.1 Promote 24/7 crisis hotlines with a marketing campaign targeting primarily resident and City worker males (using Kent's Release the Pressure campaign).	· Number of businesses which have achieved the London Healthy Workplace Charter	Public Health Business Healthy	Public Health and business healthy regularly promote hotlines and campaigns via various mediums	Ongoing
1.3 Support City of London businesses to achieve the London Healthy Workplace Charter award and also to comply with HSE Stress Management Standards and NICE Guidance		CoL Port health and public protection Business Healthy	We continue to promote the GLA's Good Work Standard, which is the main accreditation now. While it incorporates element of the Healthy Workplace Award and has a good focus on mental health but no specific reference to suicide prevention: https://www.london.gov.uk/sites/default/files/mayors_go	Ongoing

			od_work_standard_employer_guidance_00.pdf	
1.4 continue implementing the Mental Health Street Triage service: Mental Health clinicians to accompany the City of London Police on callouts	· reduced incarceration rates under s136, reduced suicide incidents, systemic savings as per 2022 evaluation	East London Foundation Trust/North East London Clinical Commissioning Group City of London Police	After trialling an 18 hour a day model, the service now has new operating hours of 3pm to 3am, this facilitates recruitment of mental health clinicians and ensures that the period of high activities are covered	Ongoing
1.5 CoL, LBH and ELFT joint suicide audit	audit completed and shared with members of the steering group and stakeholders	East London Foundation Trust/ Public Health	The City and Hackney suicide audit is due by autumn 2023, other work has delayed this audit	Ongoing
1.6 Explore the possibility of a network of safe places in the City to take people in MH crisis	network with security staff present in 5+ locations nearby frequently used location	Public Health and City of London Police	Conversations around training and safeguarding are taking place, scoping for location has also started	Ongoing
1.7 Street Pastors to be positioned at high risk locations in the City at high risk times.	· Street Pastors regularly patrolling the City.	City of London Police	The street pastors patrol the City when they have capacity, we are hoping they will make themselves available to the bridgewatch patrols once they are	Ongoing

			mobilised	

PRIORITY 2 Tailor approaches to improve mental health in specific groups

Objective: Tailor approaches to improve the mental health of Children and young people and men in the City of London

Action:	Measure/outcome:	Lead partner	Comments:	RAG status
2.1 Provide training to increase knowledge of children and young people's emotional health, self-harm and suicide risk awareness amongst practitioners across a range of settings, in particular · school nurses · teachers · clinicians · Social Workers · police · probation staff · school staff · community workers.	Number of practitioners to have been offered mental health first aid training · Number of practitioner to have taken up mental health first aid training	Public Health	Free training is regularly offered to education professionals and frontline staff through the North East London Sustainability and transformation partnership	Ongoing

2.2 Improve mental health among specific groups through the implementation of the Mental Health Strategy	· Annual progress of the mental health action plan.	Public Health, North East London Clinical Commissioning Group	BAME, LGBTQIA+, SEND, single men in their 40s, people with PD have been some of the cohorts we have focused on	ongoing
2.3 Identify and support children/young people/vulnerable families where children are at risk of emotional and behavioural problems	· Every Looked After Child who needs it has a suicide prevention plan.	City of London Children's Social Care	the City Mental Health alliance has produced this guidance which we are promoting https://citymha.org.uk/Resources/Parents-Toolkit	Ongoing
2.4 Help parents to feel competent in protecting their children from harmful suicide-related content online by raising awareness of e-safety education on good practice in creating a safer online environment for children and young people (as compiled by UK Council for Child Internet Safety (UKCCIS)	· E-training module for parents to be disseminated to schools.	City and Hackney Safeguarding Children Partnership	City MH alliance has created this guidance https://citymha.org.uk/Resources/Parents-Toolkit which is being promoted the release of the City Safer Schools App is available for parents and continues to be promoted.	Ongoing
2.5 Migrant mental health – Ensure there are services to support migrants and undocumented individuals to	· Enhanced mental health service commissioned for Looked After Children and Care	City of London Children's Social Care	City social care have a Trainee Family Therapy Clinic with Kings College London which is open to any	Ongoing

access mental health services, particularly Care Leavers.	Leavers		child or family known to early help or children's social care, for early intervention. This is well used. City social care also run an Early Intervention Mental Health for UASCs jointly with Coram. This is working to improve gut health and sleep. CHSCP published key messages for practices Work is also being done with afghan and ukrainian refugees	
2.6 Student mental health - ensure HEIs staff are trained and can signpost students	· at least one staff in City HEI campus trained in suicide awareness	Public Health	The city's suicide prevention lead promotes resources, free trainings to HEIs and education settings. The samaritans attend fresher weeks	Ongoing
2.7 Social Prescribing – encourage adopting of the Five to Thrive principles to enhance wellbeing, reduce social isolation, provide peer support , reduce depression and build resilience	· Promotion of CCG lead five to thrive campaign - dissemination of video	North East London Clinical Commissioning Group	FTT website is now redesigned to reach even more people. FTT team promotes Suicide awareness and Mental health literacy trainings regularly as well other wider MH campaigns	Ongoing

2.8 Adapt the Public Health England document ' Identifying and responding to Suicide Clusters and Contagion' so shapes a local response.	Document produced	CHSBC	the first document was completed and circulated to the members of the group but there is now a new one Revised guidance if not already circulated - here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/839621/PHE_Suicide_Cluster_Guide.pdf Operationally, there is confidence that contagion / cluster is being considered as part of Joint Agency response meetings under new child death review arrangements - guidance is being used in this context	Completed

PRIORITY 3 Reduce access to the means of suicide

Objective: Reduce the opportunities people have to complete suicide in the City of London

Action:	Measure/outcome:	Lead partner	Comments:	RAG status
3.1 Include suicide risk in health and safety considerations by local authority planning departments and Environmental Health Officers and developers	· Suicide considerations in standard risk assessment/health and safety tick box template. · Suicide considered in Health Impact Assessments	CoL Planning and Port Health and public protection	Suicide prevention and application of the Planning Advice Note is a standing item for pre-application discussions on development schemes and is also included in all committee and delegated reports as necessary. The planning guidance on how to mitigate suicide risk in high places has been approved and published, PH and EHOs have delivered training to planning officers, PH offers advice on a regular basis to developers and architects, PH is sharing learnings at various national and pan london suicide	Ongoing

			prevention groups/webinars/ conference because other areas are seeking to implement something similar	
3.2 Engage with Transport For London, the British Transport Police and network rail to identify opportunities for further prevention of suicide at their locations	· Relationship to be built between City of London public health and TFL/BTP/network rail	Public Health, North East London Clinical Commissioning Group	BME, LGBTQIA+, single men in their 40s, people with PD have been some of the cohorts we have focused on	ongoing
3.2.1 Evaluate 'The London Bridge Pilot' to reduce suicide and attempted suicide at this location	Evaluation produced	Public health	Evaluation finalised in 2019	Completed
3.3 Work with the Samaritans, East London Foundation Trust (ELFT) and City and Hackney Mind to develop a sustainable model of suicide prevention developed as part of the Bridge Pilot to City of London Workers	· Number of people trained · Examples where training has been used to good effect.	CoL P Public Health	The mental health street triage service, operated by ELFT MH clinicians, is still operating in the square mile (its hours of operations were expanded in july 2021 for 12 months and an evaluation of the service has found that it saves a lot of money at the system level by reducing s136), the bridge watch program should be mobilised by winter 2023	Ongoing

			and CoL has commissioned a feasibility study of the bridges that is still going through governance. Samaritans are still delivering Business Health suicide awareness training to workers near the river + there is new training being developed by thames reach academy supported by the tidal thames water safety forum	
3.4 install and maintain cameras on City of London Bridges to allow fast identification of which Bridge a person is on if they call, with monitoring at high risk times.	· Cameras on bridges that are monitored by the CoLp control room, coast guards should have access for search and rescue	One Safe City/ Secure City CoLp	May 2023 - the project to install new high definition cameras on the City of London Bridges is well underway. London and Millennium Bridge cameras are implemented and footage is available on the test video management system on a limited basis, with the full new system being implemented this summer with full deployment expected by the autumn, dependent on the innovative IT environment. Camera and enabling telecommunications installation is in progress for upgrading the CoLP cameras	Amber

			on Tower Bridge and will start shortly on Southwark and Blackfriars Bridges.	
3.5 mobilise bridge watch programme patrols	volunteers patrolling the 5 BHE owned bridges 24/7	Ascension Trust, CoL Police, RNLI, PLA, PH	Bridge Watch has finally managed to recruit a programme lead, recruitment of the volunteers is starting and we are hoping to mobilise before the end of 2023	Ongoing
3.6 Put RNLI signs on embankments to contain the message 'dial 999 and ask for the Coastguard'.	Signs on embankment	RNLI and PH	Signs are up	Complete
3.6.1 maintain the signage on the lifebuoys on the City of London Bridges to contain the message 'dial 999 and ask for the Coastguard'	Signs are maintained	RNLI , PLA City of London Built environment		Ongoing
3.7 Work with the London Borough of Tower Hamlets and the London Borough of Southwark to get permission to place Samaritans signs on Tower and Southwark Bridges	· Signs on Tower and Southwark bridges.	Public health	Signs are up	Complete

3.8 Implement the vulnerable People And Bridges Security Project within the Secure City Programme.	bridges are monitored 24/7 and intervention is faster and easier	CoL Police and CoL	trials of several solutions took place in the RNLI pool in january and in situ in march, once evaluated commissioning of solutions will start	Ongoing
3.9 Share suicide awareness and prevention guidance with the relevant stakeholders	· guidance is shared as widely as possible and general confidence in engaging someone in crisis grows	All	Public health is sharing guidance with developers, construction companies, licensed premises, city licensing annually visits the ten premises along the waterfront and shares PLA's updated guidance on safety equipment, suicide prevention leaflets; CoLp is engaging with the business crime prevention partnership (50 premises)	Ongoing

3.10 Continue to engage with the Tidal Thames water safety forum and input into the action plan of the Tidal Thames: drowning prevention strategy	Partners share knowledge and learning about safety on the Thames as well as data of incidents along the river	RNLI , PLA, community safety, port health, public health City of London Built environment	PH attends all meetings of the TTWSF, currently Thames reach academy is developing a training for people working along and on the river with the listening place, PH has given feedback and CoLp will attend the pilot training on june 8th to give their view of it	Ongoing

3.11 commission a feasibility study of physical measures on the bridges	final answer on what physical measures can be implemented on the 5 city bridges	PH, BHE, Town clerk, Paul Monaghan (chief engineer), Ian Hughes (SCP), Peter Shadbolt (planning)	The public protection study was finished in december 2022. It went through governance early 2023 then The committee chairs decided on may 10th to pause the governance on the public protection study until we have a strategic plan after a multi agency suicide prevention summit takes place in the fall of 2023	Amber
3.12 Adapting the upcoming national highways software on location risk assessment for tall buildings and urban structures.	software or risk assessment framework for urban structure	PH, planning, national highway	the PH suicide prevention officer has met with national highways about their upcoming software, it is not completed yet thus cannot yet be adapted to urban structure just yet	Amber

PRIORITY 4 Those who are bereaved or affected by suicide to feel informed and supported throughout their experience

Objective: Those who are bereaved or affected by suicide to feel informed and supported throughout their experience

Action:	Measure/outcome:	Lead partner	Comments:	RAG status
4.1.1 Provide training and resources for primary care staff to raise awareness of the vulnerability and support needs of family members when someone takes their own life	· Number of primary care staff who have received training	CCG City of London Coroner	Primary care staff is regularly trained (training with MIND planned for 21/11/23) + Thrive LDN is commissioning some training for GPs	Ongoing
4.1.2 Engage city businesses to identify best practice regarding the mental health of its employees and promote it – particularly to those that have already experienced a suicide in their workforce.	· Follow up with businesses who have undergone training · Promote the suicide prevention agenda within City business groupings such as the City Mental Health Alliance and "This Is Me – In the City" (Lord Mayor's Appeal)	CoL Health and Safety Business Healthy	May 2023 lord mayor appeal update : This is Me Spring event held on 19 April attended by over 70 individuals. Amplifying conversations around workplace wellbeing during MHAW. Contributions from our corporate partners and other businesses our network on socials. Supported MHAW events by sourcing speakers from our charity partners and This is	ongoing

			Me networks. Over 26,000 green ribbons distributed since the start of 2023. News stories on wellbeing activities through This is Me are also available on our website: News And Events | Latest News | The Lord Mayor's Appeal 2022/2023 (thelordmayorsappeal.org) This is Me hub updated with new resources Next in person event in planning stages to be held in October to coincide with World Mental Health Day.	
4.1.3 Risks to be assessed by the City Corporations Environment health officers following on from any suicides in public/the workplace and any preventative /remedial measures are identified for action	Number of risk assessments being undertaken by the CoL Health and Safety team following suicides in City of London businesses (should be systematic/coincide with completion data)	CoL planning, PH, CoLp	PH and Planning have developed a planning guidance that can be used before or after the design stage, this guidance can be helpful to rooftop bars/terraces which have had incidents before. CoL p also has a designing out crime officers who can give advice on suicide risk mitigation in businesses. As per the newly approved suicide completion response protocol, CoLp notices EHOs of any completion in a business and EHOs (supported by PH) offer	Ongoing

			advice on risk mitigation and training in suicide awareness.	
4.2 Provide accessible, concise information on the processes and standards in a Coroner's inquiry to family members	Number of bereaved families given information (should be systematic/coincide with completion data)	The Coroner	This is standard procedure by coroner's office. This is ongoing on a separate action log. the "new" standard of proof for suicide, has led to less open verdicts because it is more clear cut, it gives families more clarity and make dealing with families more straightforward and it will be good for the next suicide audit.	Ongoing
4.3 Provide bereaved families with an explanation of policies on investigation of patient suicides, opportunity to be involved and information on any actions taken as a result. Refer families to City of London bereavement services web pages	· Proportion of families who are referred to bereavement services (should be systematic/coincide with completion data)	CoLp	CoLp Family Liaison Officer should advise them to what is available to them, the FLO's would do their own research and find specific contacts for them to use.	Ongoing
4.4 Offer those bereaved as a result of suicide	· Number of people offered bereavement	CoLP and coroner	Information on bereavement services is offered by CoLp	Ongoing

signposting to bereavement services	support (should be systematic/coincide with completion data)		systematically, it is also available on various websites (CoL, North East London Integrated Care Board)	
4.5 contact funeral parlours in the city/used by city residents to ensure they are aware of bereavement services for those affected by suicide	number of funeral parlours aware of the bereavement services .	Public health	The suicide prevention lead has compiled a list of the funeral parlours (fenix funeral) but still needs get in touch with them, delayed by covid and the work on the bridges	amber
4.6 promote training around bereavement	number of people the training is being promoted to	PH	promotion of NEL training as well as cruse offer takes place regularly	ongoing
4.7 Bereavement support for children who have lost a parent or carer	Number of people utilising CYP bereavement services	NEL ICB	The children and young people's bereavement service at St Joseph's hospice is now accepting referrals for young people who have lost a parent, carer or significant person in their life due to a bereavement of any kind (this was previously covid-related bereavements only).	ongoing

4.8 Create and send the bereavement support pack to stakeholders, residents and partners	bereavement pack sent to city VCS and partners	PH	The pack is finalised, it contains a bereavement video from LBH, bereavement leaflets (60 copies have already been sent to LBH VCS)	complete
4.9 Promote Public Health England 'Help Is At Hand' document to key partners and make available in City libraries	· Help is at hand document readily available in libraries.	PH and libraries	Help is at hand has been distributed to libraries	complete

PRIORITY 5 Support the media in delivering sensitive approaches to suicide and suicidal behaviour

Objective: The media to report on suicide and suicide behaviour sensitively, taking into account guidance and support from other stakeholders

Action:	Measure/outcome:	Lead partner	Comments:	RAG status
5.1 Ensure that local/regional newspapers and other media outlets: · provide information about sources of support and helplines when reporting suicide · avoid insensitive and inappropriate graphic illustrations with media reports of suicide · avoid use of photographs taken from social networking sites without relative consent · avoid the re-publication of photographs of people who have died by suicide · report appropriately where there is evidence of a cluster	· All suicides reported on in a sensitive and appropriate way	City of London Corporation and CoLP media Teams Samaritans media team	The media guidelines have been shared. Media outlets don't always follow them but the CoLP and COLC media teams follow up with them when they don't. In feb 2022 we developed a briefing for media enquiry around the feasibility study of physical measures on the bridges in case any media outlet notices the tender and asks questions + are preparing proactive comms ahead of the usual spring increase in incidents	Ongoing

5.2 Challenge, where possible, the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide	· Evidence of challenge of harmful or inappropriate material	CoL	We have offered our support to the samaritans and NSPA in their campaign to have some sections of the online harm bill to be modified. CoL Suicide prevention lead officer has met with Hull university to help in their research project of unhelpful online content when it comes to suicide prevention PH SP officers keeps engaging with organizations who challenge harmful content	ongoing
5.3 Promote the samaritans communication toolkit to encourage the use of positive appropriate language in all communications and during purdah	change in language, successfully, commit, are no longer widely used	All	use of appropriate language and terminology is important when discussing suicide. All partners should avoid using outdated terms, but are also asked to demonstrate kindness if colleagues misspeak - we are all working to become better people and professionals.	Ongoing
5.4 notify the samaritans and NSPA about harmful media content for them to follow up on	number of reports to NSPA and samaritans	PH and All	this is ongoing, every time there is inappropriate comms, the suicide prevention lead officer notifies the samaritans media team and the NSPA	Ongoing

5.5 Share the 'Samaritans' Media Guidelines for Reporting Suicide with City Corporation, City Police and NHS media teams and ensure that they are aware of the sensitive nature of suicides	· Number of organisations aware of the Samaritans media guidelines	The samaritans	The guidelines have been shared and continue to be shared regularly	Complete
5.6 Promote Business in the Community's "suicide post-vention toolkit for employers" to the Business Healthy network	· Posts on the Business Healthy website/ newsletter/ social media (World Suicide Prevention day - 10 September) · Include as a resource in training packs	CoLP and coroner	shared and continue to be shared regularly	complete
5.7 develop a guidance for the events team to consider the risks of putting on events on the subject of suicides	guidance produced and adopted by the relevant committee	PH, CoL events teams	the PH suicide prevention officer has gone to an events team quarterly meeting to propose the idea of a suicide guidance on events and this was received enthusiastically	Green

PRIORITY 6 Support Research, data collection and monitoring

Objective: TA comprehensive database of suicide in the city of london and the whole of london to be built

Action:	Measure/outcome:	Lead partner	Comments:	RAG status
6.1 Share local, national and international data and research on suicide prevention and effective interventions, and identify gaps in current knowledge	· Shared with relevant partners	All	The suicide prevention lead officer regularly shares data with partners; regularly presents at conferences, webinars, forum to share learnings. We are also always thriving to improve our data collection and that of partners.	ongoing

6.2 Work with the local Coroner in order to aid accurate data collection and aid the development of targeted suicide prevention strategies	· Joined up working and information sharing between the coroner and public health	Coroner, port health, public protection	the coroner has shared data with PH to be included in the suicide audit of 2017-2022, the coroner and PH SP lead met in June 2023 and are sharing information	ongoing
6.3 work with NHS England on the Child Protection Information System CP-IS	health alert system includes details of children in care or subject to cp plans.	CHSCP	Awaiting update on timeline from NHSE	Ongoing
6.4 Join and contribute to the Thrive London Real Time Surveillance System (pan london suicide data base)	input into the database and use it to inform intervention	Thrive LDN, CoLp and PH	The City of London has joined the Thrive LDN real time surveillance database, this innovative suicide surveillance system is designed for use by multi-agency group, allowing councils, police, mental health services, suicide prevention groups to share real time surveillance data and coordinate responses. The system is innovative as it uses a report from the police force of a potential suicide as the basis for reporting, as oposed to coroner decision of confirmed suicide. This allows a timeframe of days following the incident for information to be added and	Ongoing

			action to be taken as opposed to months after. access is tailored by both residence of deceased and location of death. Thrive is now working on a self harm database as well as recording suicide attempts and contemplation, this involves a lot of work in terms of agreeing on definitions across all organizations involved	
6.5 CoLp to share real time surveillance data with UCL in order for them to analyze the patterns of movement and why people come to the square mile to attempt suicide	study with recommendation produced	CoLp	We have received a draft of the report from UCL end of july 2023	Ongoing
6.6 Resolve issues with receiving feedback from hospitals regarding the outcome of the mental health assessments after S136. The City Police Suicide Profile of 2020 recommends that “an Information Sharing Agreement with the NHS should be established so	information sharing agreement with NHS in place	CoLP and NHS	information management team in Force is checking if CoLp can have that information under the DPA	amber

that requests can be submitted to hospitals which request the outcome of assessment for any individual taken to hospital. This should be completed for every individual that attempts suicide; to ensure that all risk information is shared and appropriate safeguarding measures completed."				
6.7 Routinely collect data on attempted suicide in the City from Section 136 booklets	· S136 data to be collected by the City of London Police and shared with public health		colp has given access to NICHE to theMHST clinicians and are working on improving data discrepancy between the CoLp data and the MHST data	green
6.8 Develop an overarching data sharing agreement to allow the sharing of personal level suicide data between partners including the London Ambulance Service, British Transport Police, City of London Police and the City Corporation.	· Data sharing agreement in place and signed by all partners	CoL	After consulting legal, it has been established that the safer city data sharing agreement is applicable to suicide prevention because it mentions the care act. there is thus no need to create a new data sharing agreement.	complete
6.9 Develop the mechanisms	· Evaluation of 'the	PH	See action 3.3 the Mental	complete

for evaluating local suicide prevention work	Bridge Pilot'		health street triage was evaluated in early 2022 and was found to avert costs at the system level by reducing incarceration under s136 of the MH act, the service has paid for itself and potentially prevented 21 suicides	
6.10 Produce an enhance suicide prevention report	enhanced suicide report produced and shared	senior corporate affairs officer and all	work on the report has started, a first draft is expect by august 18th	green
6.11 Organize a city suicide prevention conference to showcase our work and share good practice and learnings with partners and stakeholders	conference organised and learning shared	senior corporate affairs officer, town clerk and PH	the conference is set to occur on october 26th at the guildhall, the programme for the morning is finalised, we are still finalising the afternoon workshops	Green

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Committee: Health and Wellbeing Board	**Dated:** 22/09/2023
Subject: Mental Health Services for People with Severe Mental Illness	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	1,2,3,4
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**N/A**
What is the source of Funding?	**N/A**
Has this Funding Source been agreed with the Chamberlain's Department?	**N/A**
Report of: Sandra Husbands, Director of Public Health	**For Information**
Report author: Jennifer Millmore, Public Health Andrew Trathen, Public Health and Ellie Ward, Community and Children's Services	

Summary

The report sets out how mental health services in the City of London are governed, delivered and integrated with other services, specifically those services for people with severe mental illness.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. Mental health problems affect around one in four people in any given year. They range from common problems such as depression and anxiety to conditions such as schizophrenia and bi-polar disorder.

2. When it was last surveyed, it was estimated that 13.4% of City of London residents have a common mental illness, this is significantly lower than the London or England average rates.

3. Severe mental illness can be very well managed and stable but in other cases, less so and often there are interactions with other conditions or situations which

can create complexity and the need for more support from health and social care agencies.

4. Mental ill health can be more prevalent and cause inequalities within certain communities.

5. The City of London has a high rough sleeping population, many of whom experience significant mental ill health and also sees a number of suicide attempts from its tall buildings and bridges each year.

6. The Coronavirus pandemic and cost of living crisis are having an impact on people's mental health. This is a particular issue both nationally and locally for young people where demand for services increased significantly following the pandemic, resulting in long waiting times and difficulties accessing services needed.

7. In the current climate, mental health services are reporting that patients are increasingly presenting with additional complexities which intersect with and worsen mental ill health and make them more complicated to treat. There has also been a marked increase in the number of people presenting in mental health crisis.

Current Position

8. There are a range of services provided across the NHS, Social Care and the Voluntary and Community Sector which support residents across the spectrum of mental health and wellbeing.

Clinical Services

9. Clinical services in relation to mental ill health will be provided by both primary care and by specialist mental health services. In the case of the City of London, specialist mental health services are provided by the East London Foundation Trust (ELFT). ELFT work across the North East London (NEL) footprint which provides continuity for City of London residents who are registered with Tower Hamlets GPs. ELFT provide services for both adults and children.

10. In terms of clinical services and associated support for people with complex mental health conditions, services are structured as follows:

Level of need	Support offered to all	Team / Service	Function / Support offered
Low / Moderate SMI	● Groups ● Activities ● Advice & Information ● Digital Offer ● Personal Health Budgets ● Step up Support if needed	Primary Care	On going support mainly through yearly medication reviews and physical health checks. Care planning and access to social prescribing etc. There is also the opportunity to have mental health practitioners which will sit across primary care and neighbourhoods.
Moderate / Complex		Neighbourhood Mental Health Team	Wellbeing Support Support with the wider determinants of health such as employment and benefits Social connections Advocacy Navigation Some outpatient clinics
Complex Long Term Support		Neighbourhoods Recovery Service	Outpatient clinics and care coordination
Brief intense support needed (not yet in crisis)		Assessment Service	Assessments and brief intervention.

11. Bed based care and crisis lines are also provided by ELFT.

12. ELFT also provide a specifically commissioned Street Triage Service working with police to respond to incidents where there is an immediate threat to life flagged by the 999 control room.

13. The NHS also provide a range of talking therapies for people with common mental health problems, such as stress, anxiety and depression, delivered by fully trained and accredited NHS Practitioners.

14. Safe Connections is being provided by a range of partners working collaboratively across North East London, to provide support to anyone who is feeling at risk of suicide and needs to access support. This is in addition to existing crisis helplines.

15. ELFT are commissioned by the City of London Corporation to provide their Approved Mental Health Practitioner (AMHP) service which delivers any Mental Health Act (MHA) assessments that need to be undertaken. They also provide care coordination for mental health patients where appropriate and deliver social circumstances reports in relation to Mental Health Tribunals (where patients may seek to be released from a section).

Adult Social Care

16. Adult Social Care (ASC) are responsible for providing social care services to people with mental health conditions where appropriate under the Care Act 2014. They will work closely with health and voluntary and community sector providers to support people to maintain their independence, live safely in the community and achieve their outcomes.

17. Some people who have been in hospital under the Mental Health Act can get free help and support after they leave hospital. This is often referred to as section 117 aftercare.

18. Aftercare can include healthcare, social care and supported accommodation as appropriate. The Mental Health Act says that aftercare services are services which are designed to:

    - meet needs that arise from or relate to a person's mental health problem, and
    - reduce the risk of a mental condition deteriorating, and a return to hospital.

The City and Hackney Wellbeing Network

19. The newly recommissioned City and Hackney Wellbeing Network is funded by CIty and Hackney Public Health and provided by a partnership of voluntary and community organisations, led by Mind CHWF. The service provides holistic, person centred support to residents with complex mental health needs.

20. In 2022, approximately 1% of Wellbeing Network clients were from the City of London, while it represents about 3% of the total City and Hackney population. As a result, increased promotional efforts through City stakeholders and at relevant City events is taking place and, once the new service is more established, outreach work is planned.

Voluntary and Community Sector Services

21. In addition to the commissioned Wellbeing Network and some IAPT provision, the Voluntary and Community Sector also provides independent community based mental health support.

22. The Dragon Café in the City provides a welcoming place, in one of the City libraries, for a fortnightly programme of events designed for anyone who is feeling the pressures of work or life in and around the City of London.

23. The City Wellbeing Centre is an innovative model which provides counselling and psychotherapy services to City residents and workers (and those in neighbouring boroughs) based on a differential payment scale to enable a wider range of people to access therapy services.

24. In terms of businesses, there is the City Mental Health Alliance, an alliance of businesses, working together with mental health experts and partner organisations, to support mental health in the workplace. In addition, Business Healthy is a community and online resource for business leaders in the City of London, committed to improving the health and wellbeing of their workforce.

Integration

25. As noted above, there are a number of ways in which services collaborate and work together to support people with mental health conditions. There are also specific programmes to better integrate mental health services with other services.

26. The recommissioned City and Hackney Wellbeing Network has been designed to increase integration both internally and with external partners. Clients supported by the network can attend interventions provided by a range of community sector partners all working together. The service will also be working with external partners to develop shared plans where more than one service is working with the same client. Clients are also supported to access interventions from external partners that will contribute to their recovery.

27. Across City and Hackney, the neighbourhood model provides the basis to deliver more integrated local community services which are closer to home. Community Mental Health Services were transformed to develop a neighbourhood approach across all 8 neighbourhoods in City and Hackney. These neighbourhood mental health teams include a range of roles including Senior Neighbourhood practitioners, Community Connectors and Assessment workers. These Neighbourhood Teams work with a range or wider roles across City and Hackney such as Occupational Therapists, Clinical Psychologists and Community Mental Health Pharmacists. Overall, the new model is designed to provide a hive of support not just for residents, carers and their families but also for staff, partners and primary care colleagues.

Governance, planning and prioritisation

28. At the NEL level, there is the North East London Mental Health, Learning Disability and Autism (MHLDA) Collaborative which is a collaborative between health commissioners (the Integrated Care Board) and providers of MHDLA across the footprint. These are namely ELFT and the North East London NHS Foundation Trust (NELFT).

29. This sub-committee is responsible for, amongst other things, leading annual planning for MHLDA services in North East London across the Integrated Care System (ICS).

30. At the City and Hackney Partnership level, there is a Mental Health Integration Committee which brings together partners in healthcare, social care and the voluntary sector with the aim of reviewing and analysing local need, provision and performance and use this information for strategic decision making, planning and prioritisation of decisions locally.

31. There are also a number of Alliances in City and Hackney around Child and Adolescent mental health, dementia and Psychological Therapies and Wellbeing. These are provider lead boards that support integration and collaboration between mental providers in City and Hackney.

32. City and Hackney Public health are currently undertaking an adult's mental health Joint Strategic Needs Assessment (JSNA) for City and Hackney which will inform strategic mental health priorities across all partners and a City and Hackney Mental Health Action Plan. A key part of this work will focus on improving the integration of the local mental health system and the patient experience.

Corporate & Strategic Implications

Strategic implications – The provision of mental health services across health, social care and the voluntary and community sector contributes to and aligns with corporate priorities

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

Furthermore, the work is also aligned with a wide range of other strategies including the City and Hackney Mental Health Strategy, the City and Hackney Place Based Partnership Strategy, the NEL Integrated Care System Priorities and wider government strategies on mental health.

Financial implications - none

Resource implications - none

Legal implications -none

Risk implications - none

Equalities implications – mental ill health and its impacts is experienced differentially by different communities. When services are commissioned, they are subject to an Equalities Impact Assessment to assess the impact of the proposals on different groups and to amend proposals where necessary. The commissioning and delivery of these services can contribute to the reduction of health inequalities by targeting groups with the highest levels of need and tailoring the offer to ensure services are accessible to all groups.

Climate implications - none

Security implications - none

Conclusion

33. This report outlines some of the services available across City and Hackney to support people with mental health conditions. It also sets out how these are governed and where mental health services are integrated.

Appendices

None

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