Public Document Pack

Health and Wellbeing Board

Date: **FRIDAY, 13 SEPTEMBER 2024**

Time: 11.00 am

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

Members:

Mary Durcan, Court of Common Council (Chairman)
Helen Fentimen OBE JP, Community & Children's Services Committee (Deputy Chairman)
Gail Beer, Healthwatch
Nina Griffith, City and Hackney Place Based Partnership and North East London Integrated Care Board
Deputy Marianne Fredericks, Port Health and Environmental Services Committee
Dr Sandra Husbands, Director of Public Health
Gavin Stedman, Port Health and Public Protection Director
Deputy Randall Anderson, Court of Common Council
Simon Cribbens, Safer City Partnership
Tony de Wilde, City of London Police
Matthew Bell, Policy and Resources Committee
Judith Finlay, Executive Director, Community and Children's Services
Ceri Wilkins, Court of Common Council
David Curran, Barts Health NHS Trust

Enquiries: **emmanuel.ross@hackney.gov.uk - Agenda Planning**
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Whilst we endeavour to livestream all of our public meetings, this is not always possible due to technical difficulties. In these instances, if possible, a recording will be uploaded following the end of the meeting.

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 of the previous meeting held on 5 July 2024.

For Decision
(Pages 5 - 10)

4. **BETTER CARE FUND 2024-25**

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

For Decision
(Pages 11 - 82)

5. **POPULATION HEALTH HUB UPDATE & HEALTH INEQUALITIES FUNDING**

Report of the North East London Integrated Care Board (NEL ICB).

For Information
(Pages 83 - 116)

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

Report of Healthwatch, City of London.

For Information
(Pages 117 - 126)

7. **SUICIDE PREVENTION ANNUAL UPDATE**

Report of the Director of Public Health.

For Information
(Pages 127 - 164)

8. **TOBACCO CONTROL JSNA**

Report of the Director of Public Health.

For Decision
(Pages 165 - 192)

9. **ANNUAL REVIEW OF THE TERMS OF REFERENCE OF THE HEALTH AND WELLBEING BOARD**

Report of the Town Clerk.

For Decision
(Pages 193 - 196)

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

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

12. **EXCLUSION OF PUBLIC**
13.

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. **NON-PUBLIC MINUTES**

To agree the non-public minutes of the previous meeting held on 5 July 2024.

For Decision
(Pages 197 - 198)

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**

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HEALTH AND WELLBEING BOARD

Friday, 5 July 2024

Minutes of the meeting of the Health and Wellbeing Board held at Committee Rooms - 2nd Floor West Wing, Guildhall on Friday, 5 July 2024 at 11.00 am

Present

Members:
Mary Durcan, Court of Common Council (Chairman)
Gail Beer, Healthwatch
Deputy Marianne Fredericks, Port Health and Environmental Services Committee
Gavin Stedman, Port Health and Public Protection Director
Simon Cribbens, representing Executive Director, Community and Children's Services
Matthew Bell, Policy & Resources Committee
Deputy Ceri Wilkins, Court of Common Council
Jonathan McShane, City and Hackney Place Based Partnership and North East London Integrated Care Board (ICB)

In Attendance
Thomas Clark (ICB)
Amy Wilkinson (ICB)
Sadie King (ICB)
Dr Matt Liveras

Officers:

Ellie Ward	-	Community and Children's Services
Emmanuel Ross	-	City and Hackney Public Health Service
Chris Lovitt	-	City and Hackney Public Health Service
Gudrun Andrews	-	Environment
Paul Bentley	-	Environment
Chris Pelham	-	Community and Children's Services
Rachel Pye	-	Environment
Rachel Cleve	-	Healthwatch
Claire Giraud	-	City and Hackney Public Health Service
Rhys Campbell	-	Town Clerk's
Kate Doidge	-	Town Clerk's

1. **APOLOGIES FOR ABSENCE**

Apologies received from the Helen Fentimen (Deputy Chair), Deputy Randall Anderson and Judith Finlay (Executive Director, Children's and Community Services) in advance of this meeting.

Simon Cribbens attended as substitute member for Judith Finlay.

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

There were no declarations.

3. **MINUTES**

RESOLVED – That the public minutes and non-public summary of the previous meeting held on 3 May 2024 be approved as a correct record.

4. **PRESENTATION FROM DR MATT LIVERAS**

The Health and Wellbeing Board received a presentation from Dr Matt Liveras, Consultant Psychiatrist and Medical Lead at Klearwell.

After this presentation Members raised questions regarding the process of Ketamine Induced Psychotherapy to cure depression and access to this form of treatment in future. Dr Liveras confirmed that whilst the symptom of depression was likely to return, it was expected that the therapeutic side of this treatment would help to promote longer term positive changes in the patients. Whilst the cost of such therapy was expensive, and remained a service exclusive to the private sector, there was a mechanism to offer Ketamine Induced Psychotherapy within the NHS.

RESOLVED – That the presentation be received, and its contents noted.

5. **BETTER CARE FUND Q4 RETURN**

The Board received a report of the Executive Director of Community and Children's Services, concerning the approval of the Better Care Fund Quarter 4 return. Following an introduction to the report, officers advised Members that going forward this report should be brought to the Board for approval instead of being signed off under urgency procedures which had been considered.

RESOLVED - that Members approve the Better Care Fund Quarter 4 return.

6. **AIR QUALITY ANNUAL STATUS REPORT FOR 2023**

The Board received a report of the Interim Executive Director for Environment. A introduction to the report confirmed that the Air Quality Status report was an annual report, under local authority statutory obligations, which was expected to be submitted to the General London Assembly at the end of the year. It was confirmed that the City Corporation had made great progress decreasing levels of pollution in last 5 years, adhering to the national standards of pollutants in the process.

In response to the Chair's question regarding ozone level, it was confirmed that ozone level were not prescribed as an air pollutant and the City Corporation had no statutory obligation to report on ozone levels, however since the data was available officers felt obligated to provide it to the Board for information. A Member asked if there were any plans to include

Carbon Dioxide and Methane in air pollutant monitoring. The response was that these greenhouse gas emissions were only monitored in a climate sense rather than an air pollutant which was not covered by the framework.

Following a point raised, it was confirmed that a short-term study of air quality at Smithfield Market was conducted. This study was requested by a Market constable and for a period of two months and was not expected to be extended but could if required.

RESOLVED – That the report be received and its contents noted.

7. HEALTHWATCH CITY OF LONDON PROGRESS REPORT

The Board received a report from Healthwatch, City of London, to consider a progress update.

The Board heard from the Healthwatch representative who provided a summary of the progress update. This included updates regarding the concerns of the effectiveness of the Neighbourhoods Programme, their Public Board meetings, Patient Panels, and Digital Apps project. The Board was informed that there was an excellent turnout for the Health in the City event and Healthwatch were working with the Neaman Practice to produce a similar event in 2025. Officers asked if the same could be done on the east-side of the City with the representative confirming that a smaller more bespoke event had been planned for Aldersgate.

RESOLVED – That the report be received and its contents noted.

8. UPDATE ON STRATEGIES FOR GP, PCN, AND NEIGHBOURHOOD SERVICE PROVISION IN THE CITY

The Board received a report from the ICB in relation to updates on the North East London Integrated Care Board's (NEL ICB) strategy relating to primary care provision in the City including options for expanding or relocating the Neaman Practice; the status and performance of Goodman's Fields (GF) Health Centre and the Hoxton Surgery; how the GF's boundary could be expanded to include the Tower ward; and the impact of Neighbourhoods on service provision.

Members highlighted discrepancies featured in the report, most notably the number of patients registered at the Neaman Practice, and asked the ICB representative to provide clarification on the matter since there was a clear statistical issue. Approximately 50% of the patients mentioned in the report were not registered with the Neaman Practice despite residing in the City. The ICB representative confirmed that this percentage was for those who possessed a City of London address, however it was difficult to determine which of these were "Ghost Patients". Members asked if there was any action taken to conduct a list cleaning exercise since the definitive figures were needed in order to allocate the appropriate funding for the expansion or relocation of the Neaman Practice.

Members expressed that this was not the report that they had commissioned and

asked to receive a more detailed report which listed more healthcare facilities options for local residents, such as the potential expansion of Goodmans field.

Following a point raised regarding the status of the Neaman Practice, Members were keen to know whether the practice was expected to relocate or had it been granted the opportunity to expand on the current premises. Members were then informed that whilst the City Corporation held a lease for one of the floors to the building, the lease for the remaining floor remained with the landlord. The City Corporation would first need to surrender their lease to vacate to the two floors which would expect to be a costly process. The Chair asked if a business case had been presented on behalf of the Neaman Practice but at the time of this meeting no business case had been put forward. ICB offered to help with some aspects of their business case and it was advised that they would work with representatives of the Neaman Practice to develop a business case before the next Board meeting. However, they also clarified that the responsibility for developing and submitting the business rests with the practice.

RESOLVED – That the report be received and its contents noted.

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

There were no public questions.

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

Officers informed the Board of an event held in relation to the HIV Confident Charter where the Deputy Chair, Lord Mayor and Chair of Fast Track Cities were in attendance and all were keen to take forward proposals that would ensure that the City Corporation would become a HIV Confident Charter.

An officer updated Members about the work undertaken by the Local Government Association (LGA) and the Hackney Health and Wellbeing Board, to gauge how the Board works in a partnership with other local authorities. Shortly after this meeting the LGA were expected to contact Members of the Board with a view of establishing further discussion at a workshop.

11. **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 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.

12. **ENHANCED SUICIDE PREVENTION INITIATIVE**

The Board received a report of the Interim Executive Director of Environment to consider the Enhanced Suicide Prevention Initiative.

RESOLVED – That, the report be received and its contents noted.

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

There were no non-public questions.

14. **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.

The meeting ended at 13:05pm.

Chairman

Contact Officer: emmanuel.ross@hackney.gov.uk - Agenda Planning
rhys.campbell@cityoflondon.gov.uk - Governance Officer/Clerk to the Board

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Committee: Health and Wellbeing Board	**Dated:** 13 September 2024
Subject: Better Care Fund 2024-25	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	Providing Excellent Services
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 must 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 financial year. Last year, local systems had to submit plans spanning the period 2023 – 25. The 2024-25 plans included were outlines.

The latest requirements are for revised plans 2024–2025 and these were submitted on 12 June 2024. These plans are now submitted to the Health and Wellbeing Board for approval.

Recommendation(s)

Members are asked to:

- Approve the revised City of London Better Care Fund Plans 2024–25.

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 North East London 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 focuses on supporting hospital discharge and out of hospital care.

4. Last year, plans were required for the two-year period 2023 – 25 with 2024-25 being outline plans.

5. The DHSC policy and guidance documents for plans are produced each year but are often published after the start of the financial year.

6. Guidance for refreshed plans for 2024-25 was published in April 2024 and the City Corporation plans were submitted on 11June 2024. All plans must be approved by the local Health and Wellbeing Board (HWB).

7. 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

8. For 2024/25, the pooled budget is £1,392,275 consisting of an NHS contribution of £943,650 and a City of London Corporation (City Corporation) contribution of £439,743 as required. The City Corporation does not put in any additional funds but this year, a DFG underspend and carry forward has been recorded as an additional contribution in the summary table in Appendix 2.

9. A range of schemes are funded through the BCF, as set out in Appendix 2. Of the pooled budget for 2024/25, £357,283 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 £172,763 required.

10. The City of London schemes in the 2024-25 plan remain broadly the same as the previous year.

11. Proposed plans are attached as Appendices 1 and 2 and include a narrative plan, which was produced to cover the period 2023 – 25 and is a joint local system plan for the City Corporation and the London Borough of Hackney. The narrative plan was agreed last year but is included here for context and information. A City Corporation template for 2024 – 25 is also included with details of income, expenditure and schemes.

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

13. The Health and Wellbeing Board is asked to approve the revised plans for 2024-25 schemes and spend.

Corporate & Strategic Implications

Strategic implications

The BCF aligns with our corporate priorities of:

- Providing excellent services

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

14. The Health and Wellbeing Board is asked to approve revised BCF plans for 2024-25.

15. 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.

16. The funding from the pooled budget for City Corporation services is above the minimum required and supports a range of work.

Appendices

- Appendix 1 – BCF Narrative Plan for City and Hackney.
- Appendix 2 – City Corporation template for 2024 - 25

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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.

1. **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 e ntirely 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)

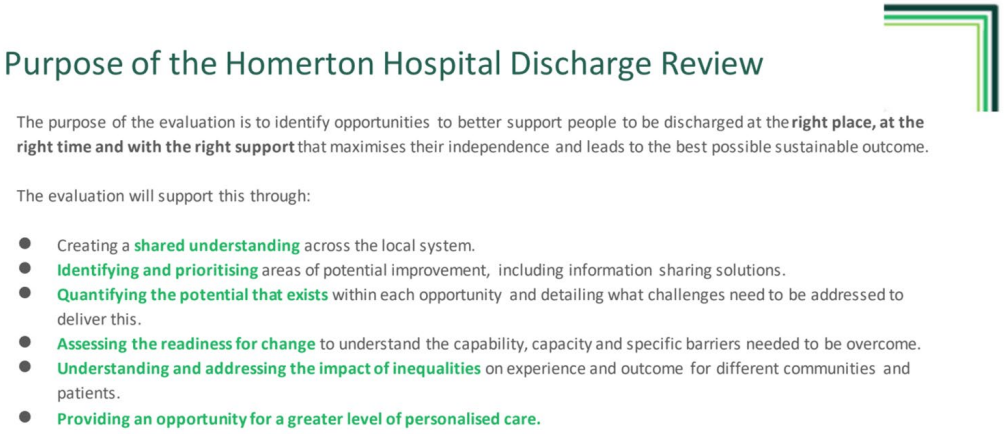
Those that contribute partially to this objective include:

- 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.



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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 po ts 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 rev iew 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

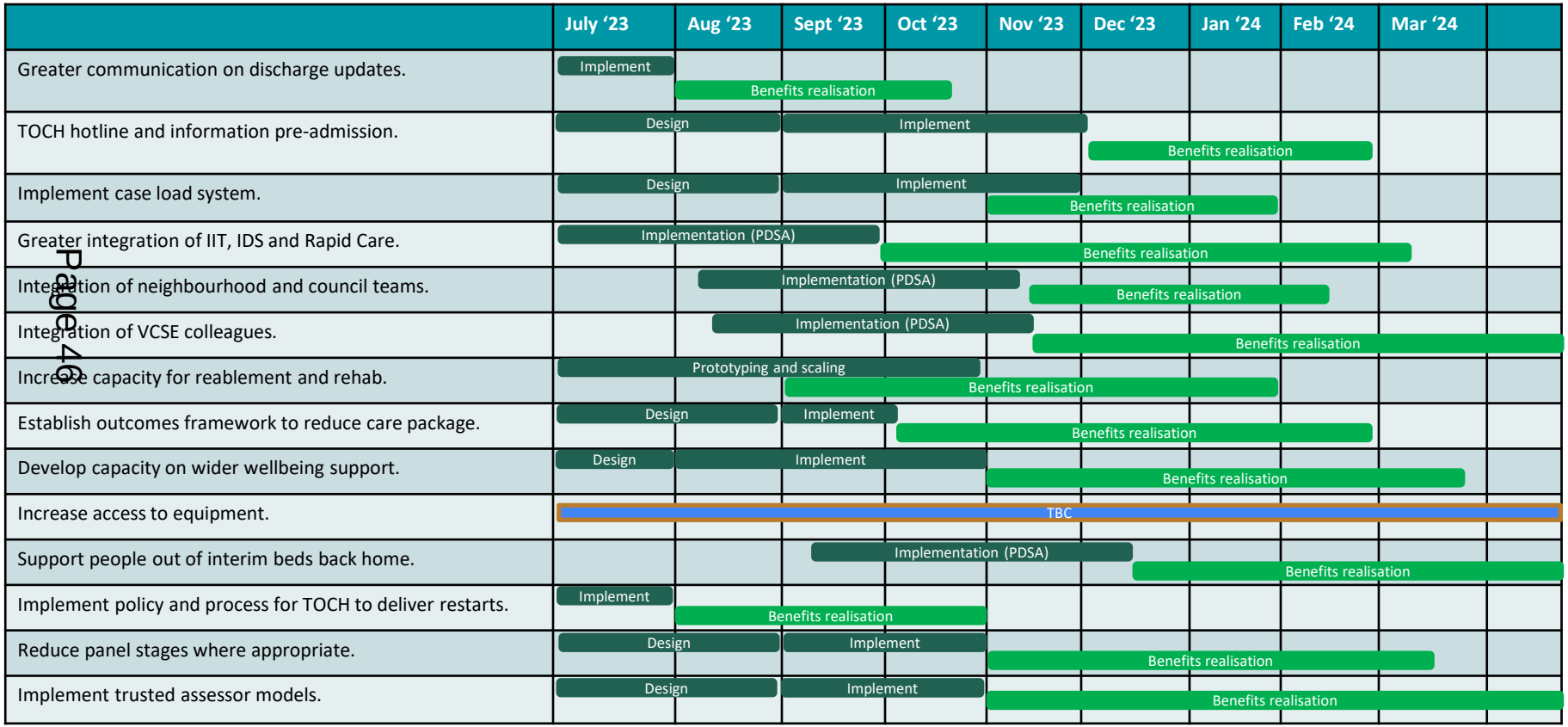
The funding will help deliver the changes we wish to see which are covered in the previous slide (Slide 26)

	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

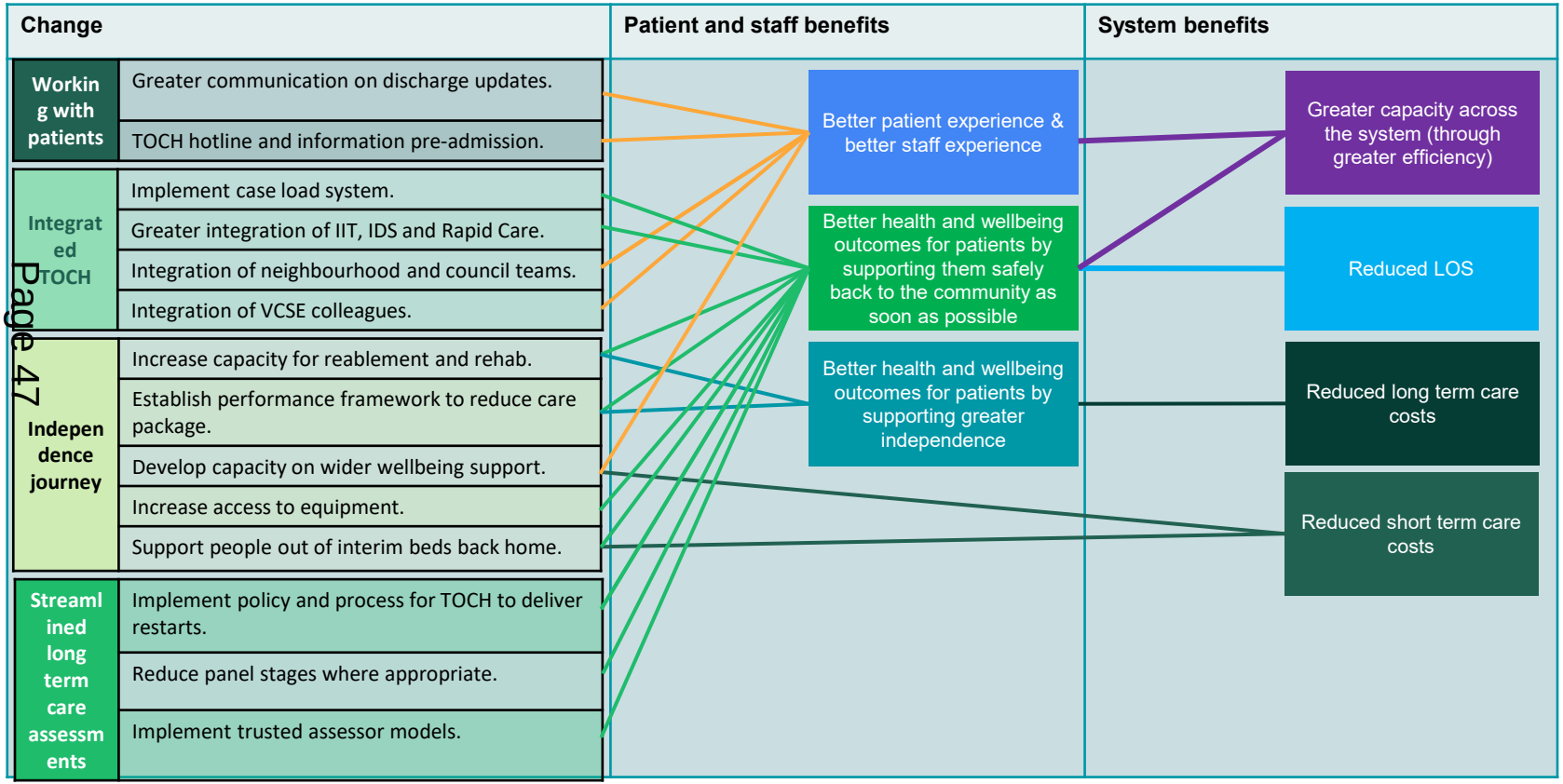
Change		Details of change	Benefits
Independence journey	Increase capacity for reablement and rehab.	• Developing increase capacity for complex cases to go through reablement and rehab; including outcome based contracts and explicit incentives regarding care package reduction. • Thresholds and process 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 MADMs 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

Strategic and delivery infrastructure

North East London Health and Care Partnership: Population Health and Health Inequalities Steering Group

City and Hackney Population Health Hub

City of London HWB Board

Hackney HWB Board

City and Hackney Health Inequalities Steering Group

City and Hackney Place-Based Partnership

Eight Neighbourhoods
- PCN Inequalities DES
- Neighbourhood Partnerships

The **direct** harms of COVID-19 disease and the **indirect** effects of lockdowns and other restrictions have affected some groups much more than others, including:

- Black, diverse, ethnic communities
- Older people
- Children / young people (educational and employment impacts)
- Residents of care homes / settings
- People with pre-existing health conditions
- Men (diagnoses and deaths)
- Women (social and economic impacts)
- People at risk or poor mental health
- People living in poverty or on low incomes
- People in 'key worker' roles and / or insecure employment
- People living alone or socially isolated
- Marginalised groups such as homeless people, asylum seekers, prisoners, street-based sex workers

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.

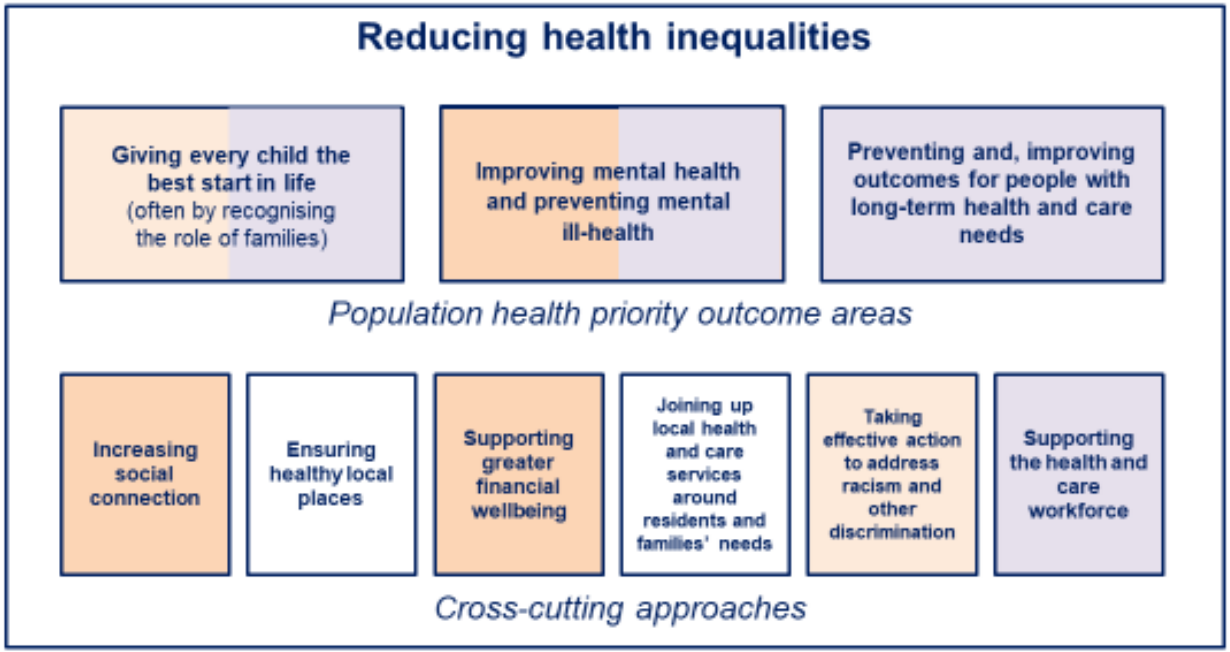
The City and Hackney Place-Based Partnership and both Health and Wellbeing Boards have adopted a population health approach that aims to improve physical and mental health outcomes, promote wellbeing, and reduce inequalities.

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

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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Better Care Fund 2024-25 Update Template

2. Cover

HM Government

NHS England

Version 1.0.0

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:	020 7332 1535		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 13/09/2024	<< 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	Cllr	Mary	Durcan	mary.durcan@cityoflondon.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Charlotte	Pomery	charlotte.pomery@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Amy	Wilkenson	amy.wilkinson@hackney.gov.uk	Yes
	Local Authority Chief Executive		Ian	Thomas	Ian.Thomas@cityoflondon.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Judith	Finlay	judith.finlay@cityoflondon.gov.uk	Yes
	Better Care Fund Lead Official		Ellie	Ward	ellie.ward@cityoflondon.gov.uk	Yes
	LA Section 151 Officer		Mark	Jarvis	mark.jarvis@cityoflondon.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 -->						

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.

Template Completed

	Complete:
2. Cover	Yes
4.2 C&D Hospital Discharge	Yes
4.3 C&D Community	Yes
5. Income	Yes
6. Expenditure	Yes
7. Narrative updates	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2024-25 Update Template

3. Summary

Selected Health and Wellbeing Board: City of London

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£40,457	£40,457	£0
Minimum NHS Contribution	£943,650	£943,651	-£1
iBCF	£323,659	£323,659	£0
Additional LA Contribution	£0	£43,563	-£43,563
Additional ICB Contribution	£0	£0	£0
Local Authority Discharge Funding	£75,627	£75,627	£0
ICB Discharge Funding	£8,881	£8,881	£0
Total	**£1,392,275**	**£1,435,838**	**-£43,563**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	2024-25
Minimum required spend	£247,339
Planned spend	£927,873

Adult Social Care services spend from the minimum ICB allocations

	2024-25
Minimum required spend	£172,763
Planned spend	£357,283

Metrics >>

Avoidable admissions

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	52.3	49.7	47.2	44.8

Falls

		2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	748.4	733.6
	Count	80	82
	Population	531	541

Discharge to normal place of residence

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 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)	93.8%	96.6%	94.5%	93.6%

Residential Admissions

		2022-23 Actual	2024-25 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	403	575

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	
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 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: City of London

Hospital Discharge

Capacity - Demand (positive is Surplus)	Capacity surplus. Not including spot purchasing												Capacity surplus (including spot puchasing)											
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-4	-1	0	0	-1	0	0	0	-2	-2	-1	0	0	0	0	0	0	0	0	0	-1	-1	-1	0
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	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 (pathway 3)	-3	-3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
25	Contact Hours per package
0	Contact Hours per package
126	Average LoS (days)
0	Average LoS (days)
138	Average LoS (days)

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes

Please briefly describe the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation – e.g. social support from the voluntary sector, blitz cleans. You should also include an estimate of the number of people who will receive this type of service during the year.

Support from the Care Navigator - direction to vol sector services such as City Connections or Carers Support. Blitz cleans are available, strengths based practioner support, occupational therapy screening. For associated carers. Please note above, figure for all of Pathway one combined is 25 hours

Yes

Capacity - Hospital Discharge		Refreshed planned capacity (not including spot purchased capacity												Capacity that you expect to secure through spot purchasing											
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	5	10	7	5	4	4	6	4	5	6	7	5	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	1	1	1	1	1	1	1	1	1	1	1	1												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	4	1	0	0	1	0	0	0	1	1	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	4	4	4	4	4	4	4	4	4												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	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 (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	3	3	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 (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	4	4	4	4	4	4	4	4	4												

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Demand - Hospital Discharge		Please enter refreshed expected no. of referrals:											
Pathway	Trust Referral Source	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Expected Discharges:	Total Discharges	**90**	**92**	**92**	**87**	**85**	**84**	**84**	**84**	**86**	**83**	**84**	**95**
Reablement & Rehabilitation at home (pathway 1)	Total	**5**	**10**	**7**	**5**	**4**	**4**	**5**	**4**	**5**	**6**	**7**	**5**
	BARTS HEALTH NHS TRUST	2	6	4	2	2	2	3	2	3	3	3	2
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	2	1	1	2	0	1	1	1	1	1	2	1
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	0	1	0	0	0	0	0	0	0	0	0	0
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1	1	2	1	2	1	1	1	1	2	2	2
	OTHER	0	1	0	0	0	0	0	0	0	0	0	0
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Short term domiciliary care (pathway 1)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
	BARTS HEALTH NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0	Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**4**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**2**	**2**	**1**	**0**	Yes
	BARTS HEALTH NHS TRUST	0	0	0	0	1	0	0	0	2	1	0	0	Yes
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	3	0	0	0	0	0	0	0	0	1	0	0	Yes
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	1	1	0	0	0	0	0	0	0	0	0	0	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	1	0	Yes
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0	Yes
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Other short term bedded care (pathway 2)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
	BARTS HEALTH NHS TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0	Yes
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**3**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
	BARTS HEALTH NHS TRUST	0	1	0	0	0	0	0	0	0	0	0	0	Yes
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	3	0	0	0	0	0	0	0	0	0	0	0	Yes
	HOMERTON HEALTHCARE NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	0	2	0	0	0	0	0	0	0	0	0	0	Yes
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0	Yes
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Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: City of London

Community — **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	1	1	1	1	1	1	1	1	1	1	1	2
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours	
Full Year	Units
0	Contact Hours
1	Contact Hours
0	Contact Hours
0	Average LoS
0	Contact Hours

Checklist

Complete:

Checklist
Yes
Yes
Yes
Yes
Yes

Capacity - Community

Please enter refreshed expected capacity:

Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	Monthly capacity. Number of new clients.	8	9	8	9	9	8	9	8	9	9	8	9
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	1	0	1	0
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Checklist
Yes
Yes
Yes
Yes
Yes

Demand - Community

Please enter refreshed expected no. of referrals:

Service Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	7	8	7	8	8	7	8	7	8	8	7	7
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	1	0	1	0
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Checklist
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2024-25 Update Template

5. Income

Selected Health and Wellbeing Board: City of London

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
City of London	£40,457
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£40,457**

Complete:

Yes

Local Authority Discharge Funding	Contribution
City of London	£75,627

Yes

ICB Discharge Funding	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
NHS North East London ICB	£8,881	£8,881	

Yes

Total ICB Discharge Fund Contribution	£8,881	£8,881

iBCF Contribution	Contribution
City of London	£323,659
Total iBCF Contribution	**£323,659**

Yes

Local Authority Additional Contribution	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
		£43,563	Carried forward DFG from 23/24
Total Additional Local Authority Contribution	**£0**	**£43,563**	

Yes

NHS Minimum Contribution	Contribution
NHS North East London ICB	£943,650
Total NHS Minimum Contribution	**£943,650**

Additional ICB Contribution	Previously entered	Updated	Comments - Please use this box clarify any specific uses or sources of funding

Yes

Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£943,650**	**£943,650**	

	2024-25
Total BCF Pooled Budget	**£1,435,838**

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 2024-25 Update Template

6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: City of London

<< Link to summary sheet

	2024-25		
Running Balances	Income	Expenditure	Balance
DFG	£40,457	£40,457	£0
Minimum NHS Contribution	£943,650	£943,651	-£1
iBCF	£323,659	£323,659	£0
Additional LA Contribution	£43,563	£43,563	£0
Additional NHS Contribution	£0	£0	£0
Local Authority Discharge Funding	£75,627	£75,627	£0
ICB Discharge Funding	£8,881	£8,881	£0
Total	**£1,435,838**	**£1,435,838**	**£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).

	2024-25		
	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£247,339	£927,873	£0
Adult Social Care services spend from the minimum ICB allocations	£172,763	£357,283	£0

Checklist

Column complete:

Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes

One or more Funding Sources have an underspend/overpend (see first table at top of this sheet)

									Planned Expenditure												
Scheme ID	**Scheme Name**	**Brief Description of Scheme**	**Scheme Type**	**Sub Types**	**Please specify if 'Scheme Type' is 'Other'**	**Previously entered Outputs for 2024-25**	**Updated Outputs for 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	Previously entered Expenditure for 2024-25 (£)	Updated Expenditure for 2024-25 (£)	% of Overall Spend (Average)	Do you wish to update?	Comments if updated e.g. reason for the changes made
1	CoL-Care Navigator Service	To ensure safe hospital disharge for City of London residents	Integrated Care Planning and Navigation	Care navigation and planning			0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution		£63,396	£60,000	97%	Yes	Change in cost of commissioned contract
2	CoL-Carers' support	To provide specialist indpendent support, information and advice for	Carers Services	Other	Provides specialist independent	55	80	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution		£15,175	£60,000	100%	Yes	Continuation and mainstreaming of wider support service which was previously a pilot
3	Brokerage pilot (one-year)	To provide a more efficient and effective commissioning of	Residential Placements	Other	Commissioning	12	12	Number of beds	Social Care		LA			Local Authority	Minimum NHS Contribution		£52,830	£65,000	100%	Yes	Increased costs of the work
4	CoL-Discharge Scheme	To prevent hospital admissions and provide an intensive discharge to	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs			0		Social Care		LA			Private Sector	Minimum NHS Contribution		£235,881	£163,000	66%	Yes	Revision based on predicted capacity and demand
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	5	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG		£37,091	£40,457	48%	Yes	DFG allocation now confirmed
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		£323,659		100%	No	
7	Adult Cardiorespiritory Enhanced and	ACERS Respiratory Service is a 7 day service, that provides care and support	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution		£23,446	£23,033	12%	Yes	NHS Contract uplift revised
8	Bryning Day Unit/Falls Prevention	The Bryning Unit is a multidisciplinary team running a weekly	Prevention / Early Intervention	Other	Physical health and wellbeing		0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution		£14,613	£14,356	100%	Yes	NHS Contract uplift revised
9	Asthma	This service will offer asthma expertise in the community in order to train	Community Based Schemes	Other	Education and training of HCP and patients.		0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution		£1,447	£1,422	1%	Yes	NHS Contract uplift revised
10	St Joseph's Hospice	Community-based and inpatient palliative care services	Personalised Care at Home	Physical health/wellbeing			0		Other	Charity	NHS			Charity / Voluntary Sector	Minimum NHS Contribution		£88,472	£86,111	27%	Yes	NHS Contract uplift revised
11	Paradoc	The service provides an urgent GP and paramedic response service to patients	Urgent Community Response				0		Primary Care		NHS			NHS Acute Provider	Minimum NHS Contribution		£21,592	£21,213	100%	Yes	NHS Contract uplift revised
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			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution		£167,915	£163,823	83%	Yes	NHS Contract uplift revised

13	Adult Community Nursing	To provide an integrated, case management service to patients living within the	Personalised Care at Home	Physical health/wellbeing			0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution		£224,222	£218,759	67%	Yes	NHS Contract uplift revised
14	Pathway Homelessness Hospital	Multidisciplinary hospital discharge team for homeless individuals. Also	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		£0		0%	No	
15	Pathway Charity Franchise Fee	Direct Support from Pathway's Support Service	Enablers for Integration	Other	Data, evaluation, workforce				Other	Works across acute and mental health	NHS			Charity / Voluntary Sector	Minimum NHS Contribution		£0		0%	No	
16	DES Supplementary Care Homes	GP enhanced services within older adults care homes.	Personalised Care at Home	Physical health/wellbeing			0		Primary Care		NHS			NHS	Minimum NHS Contribution		£5,595	£5,475	2%	Yes	There was no uplift applied to the contract.
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			0		Primary Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution		£10,914	£10,744	3%	Yes	NHS Contract uplift revised
18	Neighbourhood - Community Pharmacy	Community pharmacy	Integrated Care Planning and Navigation	Other	Community pharmacy		0		Community Health		NHS			NHS	Minimum NHS Contribution		£2,152	£0	3%	Yes	Scheme not funded through BCF going forward
19	Local authority discharge funding	Support hospital discharge	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			0		Social Care		LA			Local Authority	Local Authority Discharge		£74,700	£75,627	25%	Yes	Updated allocation
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			0		Social Care		LA			Local Authority	ICB Discharge Funding		£8,881		3%	No	
21	System pressures	Respond to system pressures	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity			0		Social Care		LA			Local Authority	Minimum NHS Contribution		£12,010	£9,283	3%	Yes	Revision based on predicted capacity and demand
22	Out of hours rapid response end of life care	Rapid response overnight support, information and crisis internvention to	Personalised Care at Home	Physical health/wellbeing			0		Other	Charity	NHS			Charity / Voluntary Sector	Minimum NHS Contribution		£3,990	£3,998	1%	Yes	NHS Contract uplift revised

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 or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2024-25 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: City of London

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

The City of London has small totals for hospital discharge numbers and therefore we are able to accurately monitor and forecast demand. The 2024/25 demand figures are based on 2023/24 actuals + average percentage growth. In terms of predicting capacity, we do not have block contracts but rather contracts we call on for reablement, homecare and a rapid response / Discharge to Assess Scheme. Neither of these have a limit and can manage with demand in a timely way. Residential care is spot purchased.

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?

No issues identified. Over the last few years we have commissioned additional resources for our Intermediate Care team via Ageing Well, Physical Capacity or Discharge Funding. This additional capacity supports managing seasonal variation and response targets.

What impacts do you anticipate as a result of these changes for:

i. Preventing admissions to hospital or long term residential care?

We have a strong preventative approach and good quality services which mean that we are able to keep people independent at home for longer with small numbers of residents tending to enter long term residential later, and for shorter periods.
The prevention offer includes Occupational Therapy, Strength Based Practitioners, and a rapid response service which can put intensive social care support in place for a period of up to 72 hours to prevent hospital admission. The BCF scheme funds the rapid response service as part of the wider discharge scheme.

ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

The BCF funds a care navigator to support safe hospital discharge and make the links with adult social care and primary care to prevent any delays in hospital discharge. It also funds a discharge and prevention scheme which includes a rapid response service (as a discharge to assess scheme) to facilitate hospital discharge. The BCF plan also includes money for further development of the Care Transfer Hub. One of the things that causes delays for City of London patients leaving hospital is family input and views. In the NEL sub-region, the Accelerating Care Reform is being used to fund a Carers Support Worker who will also support family carers in terms of facilitating hospital discharge.

Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.

We have a strong partnership approach across the ICS. Assumptions for intermediate care have been made based on Trust and local authority service level year-end performance.

Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?	**Yes**

Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.

Checklist Complete:	Linked KLOEs (For information)
Yes	Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?
Yes	Does the plan describe any changes to commissioned intermediate care to address gaps and issues? 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 capacity needed for additional services?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?
Yes	Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?
Yes	

The borough demand volumes across all sub pathways have been derived after a review of MSIF data, 2023-24 service level year-end performance and NHSE Discharge Sitreps for all North East London acute trusts. As City residents use a mix of non-NEL hospitals and NEL hospitals, and the volume of activity per pathway is low, we predominantly used adult social care data for demand per acute site. To be in line with the North East London 2024/25 NHSE operating plan, a 1.6% growth has been applied to the previous years reporting.	Yes — Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care?

Approach to using Additional Discharge Funding to improve

Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people. Discharge monies enhances the capacity of the BCF funded Discharge and Prevention Scheme. Discharge and prevention supports the rapid response requirements to discharge from hospital at earlier stages than pre pandemic; supporting interim equipment needs at pace, assessment at home to stabilisation, wrap around services to support and facilitate the discharge. The scheme includes activities to prevent hospital admission utilising rapid response and additional support to reduce likelihood of admission, supported by strong social work and occupational therapy services. Practitioners engage from hospital admission to discharge and onward pathways, utilising reablement and strength based solutions where appropriate.	Yes — Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Is the plan for spending the additional discharge grant in line with grant conditions?
Please describe any changes to your Additional discharge fund plans, as a result from o **Local learning from 23-24** o **the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)** We have seen successful delivery of schemes during 2023-24 however, are utilising some of the funding to further develop the City and Hackney Care Transfer Hub which will work closely with the Care Navigator and Discharge scheme to reduce delays and improve patient experience and outcomes. Within our planning work we specifically reviewed and took account of the national evaluation in relation to the monitoring of discharge funding, and in particular the additional discharge funding. As can be seen in the BCF, based on monitoring and demand and capacity modelling, we reduced the overall amount allocated to our discharge scheme but ensured that the additional discharge funding remained allocated to this.	Yes — Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"

Ensuring that BCF funding achieves impact

What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics? Officers in the City of London and the ICB work closely together to oversee all funding streams within the BCF, review performance against metrics and jointly agrees to plans which support transformation and achievement of BCF objectives. Representatives from this group makes recommendations and raises items for consideration with other committees within our Place governance structure.	Yes — Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?

Better Care Fund 2024-25 Update Template

7. Metrics for 2024-25

Selected Health and Wellbeing Board: City of London

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	116.2	51.7	38.0	77.0	Population figure for Q2 actual is incorrect. Setting target for the City can be tricky due to the swings we see with the small population. We have taken the average of the 4 quarters, which is 58.10, then applied a 10% reduction for Q1 followed by a 5% reduction per quarter as per below.	We would like analyse the data to see if there is condition specific information available. If we can better understand the activity, we can work with community services or primary care in particular pathways to improve performance. 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	Yes
	Number of Admissions	9	4	-	-			
	Population	8,618	5,745	-	-			
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan			
	Indicator value	52.3	49.68	47.2	44.84			Yes

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

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	847.7	748.4	733.6	Based on the falls dataset provided by NHSE, a 2% improvement has been applied to both the count and indicator of falls, which should fulfil ambition in a conservative manner.	We have a acute falls response service (Paradoc & IIT Rapid Response) operating 7 days per week which works closely with our telecare service (now called technology enabled care) and our local care homes. In addition we have a range of falls prevention services delivered by the voluntary sector and a proactive care programme (some services funded outside of the BCF) which identifies patients at risk and refers into relevant services. Other schemes funded by the BCF which support this target,	Yes
	Count	14	80	82			Yes
	Population	1,464	531	541			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

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.	
	Quarter (%)	93.5%	96.3%	94.2%	93.3%	We have taken into account our performance across 2023-24 and the schemes funded by the BCF or the Discharge Fund. To show an improvement, 0.3% has been applied for the plans for	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	Yes
	Numerator	129	105	98	98			

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)	Denominator	138	109	104	105	show an improvement, 0.3% has been applied for the plans for each quarter.	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.		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan				
	Quarter (%)	93.8%	96.6%	94.5%	93.6%				
	Numerator	127	105	105	112			Yes	
	Denominator	136	109	111	120			Yes	

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.		
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	403.2	293.0	644.7	575.3	The number ofadmissions to residential homes are fairly low; however, given our small population size any variation can significantly impact on our annual rate. We have taken into account our performance across 2023-24.	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 appropriate. 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	5	5	11	10			Yes	
	Denominator	1,240	1,706	1,706	1,738				

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

Better Care Fund 2024-25 Update Template

8. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: City of London

	Code	2023-25 Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) to be confirmed for 2024-25 plan updates	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	Complete:
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 (in line with the Health and Wellbeing Board's formal governance arrangements) approval? **Paragraph 11 as stated in BCF Planning Requirements 2023-25* 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* Have all elements of the Planning template been completed? *Paragraph 11*	Cover sheet Cover sheet Cover sheet Cover sheet	Yes				Yes
	Not covered in plan update - please do not use	**A clear narrative for the integration of health, social care and housing**	Not covered in plan update						
	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? 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?	Cover sheet Planning Requirements	Yes	Yes but DFG works differently in the City of London			Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4 & PR6**	**A demonstration of how the services the area commissions will support the BCF policy objectives to:** **- Support people to remain independent for longer, and where possible support them to remain in their own home** **- Deliver the right care in the right place at the right time?**	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service? Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care? Have gaps and issues in current provision been identified? Does the plan describe any changes to commissioned intermediate care to address these gaps and issues? Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC demand, capacity and flow estimates in NHS activity operational plans and BCF capacity and demand plans? Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?		Yes				Yes

Additional discharge funding	**PR5**	**A strategic, joined up plan for use of the Additional Discharge Fund**	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? Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?		Yes				Yes
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**	PR 4 and PR6 are dealt with together (see above)						
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 and NHS commissioned out of hospital 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? Does the total spend from the NHS minimum contribution on NHS commissioned out of hospital services match or exceed the minimum required contribution?		Yes				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? Where there have been significant changes to planned expenditure, does the plan continue to support the BCF objectives? Has the area included estimated amounts of activity that will be delivered/funded through BCF funded schemes? (where applicable) Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? Is there confirmation that the use of grant funding is in line with the relevant grant conditions? Has the Integrated Care Board confirmed distribution of its allocation of Additional Discharge Fund to individual HWBs in its area? 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		Yes				Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric setting out: - supporting rationales that describes how these ambitions are stretching in the context of current performance? - plans for achieving these ambitions, and - how BCF funded services will support this?		Yes				Yes

Committee(s): City of London Health & Wellbeing Board	**Dated:** 13 September 2024
Subject: Population Health Hub & Health Inequalities Funding	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	**N/A**
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: Anna Garner, Head of Performance and Population Health, NHS NEL ICB	**For Information**
Report authors: Anna Garner, Joia De Sa and Maisha Siddique	

Summary

City and Hackney were allocated £875K of funding in 2022/23, and several projects were funded:

- MATCH (embedding health equity into our health and care services)
- Foot health (toe nail cutting for housebound patients)
- Resident engagement to support development of Super Youth Hubs
- Community CHEST (funding small voluntary sector organisations who receive social prescribing referrals)
- Resident led solutions to improve immunisation coverage
- Projects to improve outcomes for homeless population: service psychologist
- Projects to improve outcomes for homeless population: Routes 2 Roots (housing support)
- Projects to improve outcomes for residents with mental illness: Individual employment placement support
- Projects to improve outcomes for residents with mental illness: Talking Therapy for people with long term conditions

City and Hackney were then allocated £821K from 2023/24 money (information has been bought to this board on this previously).

This report summarises the learning from the projects which we have received information from so far (not complete but we are working on this). We will continue asking projects to complete the monitoring template every 6 months, and report to Health and Wellbeing Boards annually with learnings.

Recommendation(s)

Members are asked to note the report.

Monitoring Overview

Health Inequalities & Prevention

Project Name	Funding allocated in 22/23	Funding Allocated in 23/24	Report received?
MATCH - Embedding Health Equity	£475,000	£220,000	Yes
Social prescribing community chest	£25,000		Yes
CAMHS Youth Health Hubs	£100,000		Awaiting Report
Community engagement to improve childhood immunisations	£71,000		Yes
Interventions to support C&H Homeless Population	£184,000		Awaiting Report
Foot care for Housebound	£65,000		Awaiting Report
IPS Employment Roles for SMI Patients	£60,000		Awaiting Report
IAPT for long term conditions	£60,000		Awaiting Report
Outreach Physical Health Check Work	£60,000		Yes
LBH Money Hub		£170,000	Yes
Fit4Health Stroke Rehab		£65,000	Yes
Care Leavers Free Prescriptions		£6,000	Awaiting Report
Piloting Interventions with PCNs/Neighbourhoods		£180,000	Not yet started

MATCH
(eMbedding heAlth equiTy in City & Hackney)

Project summary

Project description (including provider, objectives, target population, how to enlist target population):

eMbedding heAlth equiTy (MATCH) is a programme of work being tested by the City and Hackney Population Health Hub that aims to support teams, services, organisations and communities to improve equity in outcomes, with focus and resources for different groups proportionate to their level of need.

A five-step process is being trialled which involves:

1. Bringing people together,
2. Collating data and insights to identify needs,
3. Using different 'lenses' to review what we know to generate change ideas,
4. Going through a prioritisation process to identify key change ideas, and
5. Implementing change ideas, testing and learning.\

In Year 1, 5 programme areas are being taken forward with a focus on: women's health, maternity, CVD, food poverty and anti-racist commissioning. For more information see these slides.

Funding allocation and how this is being used:

MATCH is a four year programme. £475,000 has been allocated for the first year of the programme and £220,000 for the subsequent three years.

£63,000 is allocated per programme area. Additional funding is being used to support resident involvement in MATCH and programme evaluation.

Planned start and end date (and any changes from this)

MATCH is a four year programme running from 2023/24 until 2026/27.

Is the project complete?

No - Ongoing

Highlight Report

Period:

Description of what has taken place over this period:

- 2 programme areas (maternity and food poverty) have completed the 5 step process.
- Stakeholder workshops have been delivered to generate change ideas and a grants process has been developed to fund these.
- The remaining 3 programme areas are aiming to complete this process within the next 2-3 months.
- Evaluation of the programme is in progress (pre-questionnaires completed, stakeholder interviews planned for July)

Key dates/milestones coming up

- Completion of year 1 programme areas (Q3 2024)
- Review of the first year of the programme is in progress and plans are being implemented for year 2 of the programme, including the identification of 3 new programme areas, which will be initiated in July.

Risk Rating : [please indicate]

On Schedule | Concerns | High Risk

What risks are there to delivery? How do you plan to mitigate these?

- Capacity limitation for the delivery of the women's health programme. This is mitigated by reducing the number of workshops delivered.
- Budget concerns for the anti-racist commissioning programme. This is currently being explored.

Key Reflections/ Learning from this period?

- Importance of communications strategy to support process
- Delivery timescales should be shorter in year 2
- Need to explore how stakeholders can continue to be involved after the change ideas have been developed
- Value of resident involvement in decision making (assessing grant applications)
- Importance of having time to plan and developing playbook to support year 2 programme areas
- Opportunity to test MATCH with limited support and funding for one of the year 2 programme areas

Evaluation

What are you collecting to allow assessment of the success and learning from your project? When are you collecting this data? Do you have any so far - what is this telling you so far?	**Successes** What have you/are you learning? What are the implications for the system?	**Challenges:** What have these been? What is the learning from these and what would you do differently next time?

• Pre-questionnaires for the 5 programme areas have been completed.
• Two Internal reflection sessions (one general and one on resident involvement in MATCH) have been held and the learning from these is being collated in order to inform recommendations for year 2 of the programme.
• Highlight reports are completed by each programme area every other month.
• Individual programme narrative reports will be completed by 19th June 2024.
• Stakeholder interviews are planned for July 2024.
We are evaluating how participants found the process and the impact of both individual change ideas and the wider impact on the work of teams.
	• Relatively strong engagement from partners across the system
	• Outlining a clear process to follow and developing tools and resources has been beneficial
	• Successful examples and learning R.E. resident involvement
	  ○ Starting to share power
	  ○ Open approach to MATCH fund has been beneficial
	  ○ Tiered resident roles
		• More support needed for programme teams - need to develop a standard framework to support people with implementing and evaluating
		• Lack of stakeholder understanding of process and reduced engagement - importance of communications strategy to support effective communications throughout programme
		• Difficult to convey all relevant information to stakeholders during workshops - alternative to workshop model to be explored

Reflections

Is there anything that you have identified that we could be doing as a system that would improve the lives of our residents? Is there anything you want to raise to the 'system' that we need to change?	**Sustainability** How do you plan to embed the impact and learning from this project going forward? What would help you to do this?
	• Through MATCH we aim to develop a process to embed health equity which can be replicated by other teams and organisations. • We are developing a range of tools and resources to support this. • We will be carrying out an external evaluation of the programme and will share the results of this among stakeholders across the system. • We will also deliver 'lunch and learn' sessions on MATCH, sharing learning on what has worked and what we have changed. • We also aim to identify opportunities to share our work beyond City and Hackney.

Fit 4 Health
Exercise after a stroke

Project summary

Project description (including provider, objectives, target population, how to enlist target population):

Delivery of an exercise after stroke scheme by the Hackney Leisure, Parks and Green Spaces Team. The programme is open to adults who have suffered a stroke or a Transient Ischaemic Attack (TIA) and who reside in Hackney or are registered to a City and Hackney based GP.

Aims:

Aim 1: To encourage, engage and increase physical activity levels amongst people who have had a Transient Ischaemic Attack or stroke.

Change: People using the service to achieve greater levels of physical activity.

Aim 2: To offset the post-stroke decline in activity tolerance and subsequent risk of cardiovascular disease.

Change: Improved 6-minute walk test results.

Aim 3: To reduce social isolation via empowering the at-risk population to use local parks, sports, leisure and community facilities.

Change: People using the service to report greater community integration and confidence in accessing community services.

Aim 4: To promote recovery and increase quality of life and wellbeing.

Change: People using the service to report improved quality of life and perceived health**.** Fit 4 Health will help in the prevention of premature death.

Funding allocation and how this is being used:

.We started delivery of the scheme on 19 September 2023. Funding of the programme is up to August 2026. Due to collection of data and analysis, the results may not be known until October 2026**.**

Planned start and end date (and any changes from this)

The programme started on 15 August 2023 in line with funding agreement.

Is the project complete?

Ongoing

Highlight Report

Period:

Description of what has taken place over this period:

We have delivered two programmes; Programme 47 (Sept-Nov 2023) and Programme 48 (Jan - March 2024). We are currently delivering Programe 49 (April - June 2024).

The Slow Paced Walk commenced 17 April 2024 in Clissold Park and is due to pause on 6 November 2024 and re-commence in April 2025.

Also we delivered our Enablement Day event on 23 February 2024.

We attended two stroke board meetings and two programme reports were produced and circulated to Clinical Commissioning Group (CCG), Public Health and referring Health Professionals.

Key dates/milestones coming up

Final assessments for Programme 49 will ta

ke place on 11 and 13 June 2024. Programme 50 will then commence from 18 June 2024.Client feedback day and celebration of the clients' achievements, planned for 2 August 2024.

What risks are there to delivery? How do you plan to mitigate these?

A small pool of qualified and experienced exercise professionals. This is a nationwide problem. This can impact delivery as absence cover is difficult. This is coupled with an ageing workforce. We are searching for additional staffing and are looking to upskill current contactors.

Recently we have experienced issues with the Clissold Leisure Centre due to layout and condition of machines. We are relaying our concerns to the centre manager. We have currently seen a drop in TIA referrals. We have flagged this with the CCG to establish why this occurred and hope via the TIA pathway the matter can be resolved soon.

Key Reflections/ Learning from this period?

Clients completing the programme often report improvements in stamina and energy. This makes it more likely that they will be able to continue with exercise and meet national guidelines for physical activity.

The staff client ratio has been of great help to clients especially those with high needs and stroke related impairments. This has also resulted in excellent attendance rates and average completion rates of between 78% across both programmes.

It has been evidenced across the Hackney & City Stroke Pathway that there has been an increase in clients presenting with significant disabilities which can require more one-to-one support from staff. Transport issues due to changes to the delivery model of community transport (Dial-a-Ride) has impacted the ability of clients to attend sessions.

Generally there is a shortage of appropriate exit routes for clients who have been severely affected by stroke once they have left the programme.

Evaluation

What are you collecting to allow assessment of the success and learning from your project? When are you collecting this data? Do you have any so far - what is this telling you so far?	**Successes** What have you/are you learning? What are the implications for the system?	**Challenges:** What have these been? What is the learning from these and what would you do differently next time?
We are collecting demographics, referrer details, employment status, 6-minute walk test results, height and weight, blood pressure, heart rate, fruit and vegetable intake, smoking status, physical activity levels, self-reported stroke-related GP/hospital visits, carers' feedback, wellbeing questionnaire responses, self-reported stroke recovery rates, and programme evaluation feedback. This information is gathered at referral, initial and final assessments, and feedback day (annually). In summary: • **Attendance:** Programme 47 had 23 clients, Programme 48 had 27. • **Energy Levels:** 88% reported improvements. • **Walk Test:** 63% increased walk ability and stamina. • **Psychosocial:** 67% reported better socialisation. • **Confidence:** 60% felt more confident accessing community spaces, reducing social isolation.	Based on our observations as exercise professionals we have learnt that it is not easy for the average person to maintain regular physical activity within their daily lives. The preservation of this habit is much harder for stroke sufferers, but once a client commits to Fit 4 Health they recognise the wider benefits of exercise and are keen to continue the programme for longer. • We have gained much insight into client levels of satisfaction through the invitation of written comments at the end of each programme.	Transport has been one of the main challenges. There are two main reasons for this: - The TFL post-covid policy of allowing only one journey per week was not reversed. - The introduction of a TFL app to book Dial a Ride journeys. The above caused great difficulty with our clients who had communication difficulties and were not familiar with technology. Owing to this many clients experienced difficulty accessing sessions. This situation has eased slightly with TFL relaxing their policies on booking but still remains an issue. Also, based on client feedback and endorsed by referring health professionals, clients found it difficult to identify mainstream exercise provision that addressed their needs. Therefore provision of an advanced programme was made available where such a situation arose.

Reflections

Is there anything that you have identified that we could be doing as a system that would improve the lives of our residents? Is there anything you want to raise to the 'system' that we need to change?	**Sustainability** How do you plan to embed the impact and learning from this project going forward? What would help you to do this?
We support the vision of a unified approach and the emphasis on 'prevention' with enhanced resources available to community programmes to help offset the strain on the NHS and Social Care services.	To further highlight good practice to help overcome a lack of disability exercise provision within the community. We hope that our learnings will help guide providers/decision makers to establish better exit routes for those who have had a stroke or living with a disability. To help the situation we would suggest a fund to upskill exercise professionals in the ability to deliver exercise for those with a disability and therefore increase the availability of exercise provision within our community. Accompanied with this should be instructor incentives to encourage the take up of work which specifically caters for high need clients

Community engagement and the piloting of Grassroots initiatives to improve childhood immunisations coverage

Project summary

Project description (including provider, objectives, target population, how to enlist target population):

Provider: Springfield Park PCN
Objectives: Increase childhood immunisations coverage
Target population: Charedi Community

Aims

Immunisation uptake in the NE of Hackney where there is a high Charedi population, is significantly lower than the rest of the borough. We want to increase immunisation to reduce this inequality

We aim to change this population based health inequality through:

- Increased community engagement
- Increased diseases / vaccination awareness messaging via community channels
- Increased call/recall for those overdue

Funding allocation and how this is being used:

.We started delivery of the scheme on 19 September 2023. Funding of the programme is up to August 2026. Due to collection of data and analysis, the results may not be known until October 2026.

Planned start and end date (and any changes from this)

Project timeframe: 6 months July 2023 - December 2023

Is the project complete?

Complete

Highlight Report

Period:

Description of what has taken place over this period:

- Running of sunday clinics and health events
- Advertisements in Jewish Press
- Feedback on Advertisements from community members, co-production on campaign messaging
- Evaluation of activities from community members

Key dates/milestones coming up

- Charedi Imms Health Event July 2023
- Get Ahead before Yomim Tovim Campaign September 2023
- October Health Event

What risks are there to delivery? How do you plan to mitigate these?

Project completed

Key Reflections/ Learning from this period?

- Enhancing promotion prior to Jewish holidays is a good way to increase uptake of vaccinations
- Co-production leads to better resonating messages
- Offering immunisations at events alone does not incentivise community members to attend and get vaccinated in as much as when offered with other aspect of health, health checks, oral health, healthy weight advice ect

Evaluation

What are you collecting to allow assessment of the success and learning from your project? When are you collecting this data? Do you have any so far - what is this telling you so far?	**Successes** What have you/are you learning? What are the implications for the system?	**Challenges:** What have these been? What is the learning from these and what would you do differently next time?
Immunisation data - Tracking week by week numbers is supporting us to understand which messages resonate most with community members. It also helps indicate what times of the year can lead to lower engagement. Data and engagement insights show winter months saw a drop which has led to the intervention of domiciliary visits being increased around this time. This data showed that events had much higher vaccinations delivered than normal clinics. One weekend saw 100 immunisations at a health event, compared to the regular average of around 40 immunisation at regular additional weekend • In total between July 23 - Dec 23 - 928 Vaccinations were delivered • September Get ahead Campaign evaluation (attached) - This short two week burst campaign saw 200 vaccinations alone	• Enhancing promotion prior to holidays is a good way to increase uptake, key messaging specifically mentioning 'get ahead before..' led to highest clinic numbers • Co-production leads to better resonating messages • Imms alone does not draw community members in as much as when offered with other aspect of health, health checks, oral health, healthy weight advice ect	Events takes lots of resource and someone to project manage. Can be difficult if that manager is on leave, so requires multiple team members to be across engagement events Focus more effort / promotion at specific timepoints such as prior to Jewish holidays Expand range of people engage with as small group may not be represented of a single community

Reflections

Is there anything that you have identified that we could be doing as a system that would improve the lives of our residents? Is there anything you want to raise to the 'system' that we need to change?	**Sustainability** How do you plan to embed the impact and learning from this project going forward? What would help you to do this?
Target amplified messaging at specific timepoints over the year, based on community, data and qualitative driven insights gathered from this project. Also health events timed to specific timepoints in the year where engagement is likely to be highest. Strive for co-production with every communication - a panel who were incentivised would help, as it can time consuming for them to comment	Imms alone does not draw community members in as much as when offered with other aspect of health, health checks, oral health, healthy weight advice ect. As a system we should be looking to offer more of these health events as the wider benefits outside of immunisations are very apparent The insight of increasing around specific holidays is likely applicable to other communities across London. Although well known, co-producing assets with community members was clear in having an impact in this project. We should continue to push the co-production agenda across the system.

Hackney Money Hub

Project summary

Project description (including provider, objectives, target population, how to enlist target population):

Hackney Money Hub is an easily accessible, multi-disciplinary service that brings together some benefits assessment support with assessment for a range of discretionary grants managed by LBH, in a delivery model with active outreach at its heart.

Money Hub takes a data led approach to targeting vulnerable populations. We use a range of LBH-held data to target outbound campaigns raising awareness of specific benefits. The outreach team also targets community venues serving those priority populations as set out in the Hackney Poverty Reduction Framework.

Funding allocation and how this is being used:

£170,000 per year 23/24; 24/25; 25/26 (please note funding was received in 22/23 financial year) - Funding used for four community outreach officers

Planned start and end date (and any changes from this)

April 2023 - March 2026

Is the project complete?

Ongoing

Highlight Report

Period:

Description of what has taken place over this period:

The team has bedded in post the restructure and is focussed on delivery. This includes:

- 11,935 applications received via the easy to use online application form
- £2.61m paid out in grants
- £2.27m in increased incomes
- Over £530,000 gained in increased disability benefits, including at Tribunal
- Campaign to increase outreach, with ~40 outreach sessions delivered March - May.
- Outreach was reviewed to ensure new venues align with Hackney Poverty Reduction Framework. Eg) Carib-Eats; North London Action for the Homeless; Refugee Welcome Hub; Environmental Services Staff briefing

Two outbound awareness raising campaigns - one focussed on council tax reduction and the other on pension credit. Campaign planned for July likely focussing on families migrating to UC, currently protected from the two child benefit cap.

Key dates/milestones coming up

- Recruitment of additional Temporary Accommodation Officer
- Throughput review in progress to determine most effective tools to manage information/ case management and reporting

What risks are there to delivery? How do you plan to mitigate these?

Major risk is inflow volume. MH receives between 130-200 applications per week on average, plus spikes in winter and March (financial year end). Inflow also affected by inappropriate referrals from LBH customer service wrongly directing residents to MH. Risk is staff capacity struggles to process in time and backlog builds

Mitigation: actively working to provide clearer eligibility guidance on websites. Working with customer service and social landlords to educate about Money Hub's role and scope and where to redirect.

Key Reflections/ Learning from this period?

Outreach is effective at reaching residents who would not otherwise seek help from the borough

Specialist disability support provides good cost-benefit value, achieving substantial settlements for vulnerable residents where other advice services are overwhelmed

Money Hub is often the tip of the system failure iceberg. More needs to be done upstream with residents, DWP, benefits and revenues officers to get ahead of avoidable problems

Evaluation

What are you collecting to allow assessment of the success and learning from your project? When are you collecting this data? Do you have any so far - what is this telling you so far?	Successes What have you/are you learning? What are the implications for the system?	Challenges: What have these been? What is the learning from these and what would you do differently next time?
Data Collection: • Daily collection of data on applications, benefits claimed, and awards made through case work and assessments. **Current Status**: • No formal evaluation framework with associated outcomes in place. **Observations from 18 Months of Operation**: 1. **Whole Person Ethos**: Integrated into practice, fostering holistic support, though not uniformly applied. 2. **Demand for Support**: Simplified application process reveals high demand, leading to staff capacity challenges. 3. **Multiple Support Needs**: Residents typically require various types of support. 4. **Maladministration Issues**: Many help requests involve errors by public bodies and residents. 5. **Immediate vs Long-term Support**: Effective immediate support, but limited in ensuring long-term financial wellbeing due to insufficient resident income. 6. **Housing Affordability**: High rents outpace average incomes, making social rents unaffordable for many benefit-dependent residents.	• multi-disciplinary team, sitting alongside each other, offers benefits for the resident as it makes it easier to deliver whole person support • Outreach - both in community and via outbound SMS/ email campaigns - have reached residents who would not usually approach for help • Moneyhub is the end point for many people. Applications to MH reveal a lot of failure demand due to error further 'upstream' in the system. For example, failure by social landlords, DWP, CAB, other stakeholders to address the residents' issues	• More support needed for programme teams - need to develop a standard framework to support people with implementing and evaluating • Lack of stakeholder understanding of process and reduced engagement - importance of communications strategy to support effective communications throughout programme • Difficult to convey all relevant information to stakeholders during workshops - alternative to workshop model to be explored

Reflections

Is there anything that you have identified that we could be doing as a system that would improve the lives of our residents? Is there anything you want to raise to the 'system' that we need to change?	**Sustainability** How do you plan to embed the impact and learning from this project going forward? What would help you to do this?
Having a single overarching resident-facing financial assessment service with clear service performance indicators and highly skilled staff would allow a more fulsome financial profile of each resident to be created. In turn this would increase the resolution of residents' multiple issues, maximise their income, allow appropriate repayment plans to be arranged and reduce error and failure demand. This could cover all payment-related functions, including benefits, council tax, Adult Social Care charging, family and children's advice, parking etc. Build more housing. The root cause of applications to Money Hub is insufficient incomes relative to living costs. The main cause of high living costs is rent. Even social rents are beyond what a substantial minority of residents can afford who have only benefits income. By building more decent, truly affordable housing, residents will be able to afford food, heating and lower financial stress, as well as avoid housing-related ill health caused by damp, mould etc.	We are gathering a range of information to inform future plans within the local authority on how best to scope and deliver advice services. This includes source of application, number of issues/ needs per person and a log of failure demand. These will be built into direct communications with colleagues and, in due course, further developments of advice provided by or commissioned by LBH

SMI Outreach Physical Health Check Work

Project summary

Project description (including provider, objectives, target population, how to enlist target population):

The main aim of this pilot: to improve the uptake of physical health checks for at least 50% of SMI patients identified as not attending at their GP practices or responding to calls for their annual physical health checks

Three main objectives:

- improving physical health checks uptake for underserved SMI population
- understanding the barriers faced by this subgroup in accessing services to inform future planning.
- ensuring that all sections of the SMI patient population are supported to access annual physical health checks.

Funding allocation and how this is being used:

£60,000

The funding given to the City and Hackney Office of the PCN for this pilot was for the recruitment of a full time Health Care Assistant to work across the two PCNs comprising 11 GP practices. HCA recruited and started in post on the 12th of June 2023

Planned start and end date (and any changes from this)

12th June 2023 - 11th of June 2024

Is the project complete?

Complete

Highlight Report

Period:

Description of what has taken place over this period:

A full time HCA recruited, in post on the 12th June 2023 working across 11 GP practices within two PCNs. Started engaging patient group from August 2023. Summary activities up to the end of March 2024:

- 254 patients identified as not engaging with practices
- 235 (93%) were contactable and offered an appointment
- 158 received a full health check (67%)
- Of the total **254** in the cohort:
- 177 identified as not having had health checks in 2+ years
- 96 (61%) received full health checks

Having a dedicated resource who spends time engaging with patients, listening to them and explaining to them the importance of having a health check has been beneficial.

Key dates/milestones coming up

- Pilot ends on 12th of June 2024. Evaluation report expected by end of June 2024

What risks are there to delivery? How do you plan to mitigate these?

- Risks-Delays in funding arrangement which could have derailed the delivery of the pilot
- Mitigation-honest conversation with the office of the PCN regarding the challenges and a reassurance of the funds being available except for due processes that needed concluding.
- Challenges accessing practices list/EMIS system to identify patient group
- PCN development managers have been very instrumental in engaging with practices and explaining the project and benefits to them

Key Reflections/ Learning from this period?

- Important for all funding arrangements between the local authority and ICB to have been sorted and agreed before awarding any grants.
- The new procurement processes to be clearly outlined and shared with project leads from the outset so they know how to manage communications and any delays with prospective providers
- Do comms to practices in advance of any pilot starting to gain their commitment and avoid any delays

Evaluation

What are you collecting to allow assessment of the success and learning from your project? When are you collecting this data? Do you have any so far - what is this telling you so far?	Successes What have you/are you learning? What are the implications for the system?	Challenges: What have these been? What is the learning from these and what would you do differently next time?
The following data are being collected and a full evaluation report will be completed by June ending when the project ends; • Number of SMI patients identified as not attending GP or responding to calls for health checks despite multiple invitation • Number of SMI patients identified as having not had physical health checks in 2+years • Number of SMI patients in cohort contacted and offered an appointment for health checks • Number of patients receiving full physical health checks • Number of home visits • Qualitative information on barriers preventing patients from attending their GP or accessing health checks • Qualitative information on support provided to patient to access other community resources	• A dedicated HCA resource to engage with patients who do not attend their GP for health checks is beneficial. • Offering of home visits is paramount to meet the needs of patients who are housebound. • Identifying other community assets and developing pathways for referrals with these assets is important in providing ongoing support and interventions for SMI patients such as social prescribers • Consideration for out of hours SMI Physical health checks clinics including Saturdays? • Some patients indicated they did not have SMI and feel healthy hence why they have not attended the GP for health checks • Others contacted reported no longer live in the borough • Primary care list cleansing to address the last two points above	• For some patients, practices do not have up-to-date contact telephone details or home addresses-planned home visit to verify details. In some cases, RiO data used to update GP records. • Lots of DNAs- more focused recalls and home visits offered leading to better engagement. • Home visits not always possible as a second person needed. Will be necessary to have a part time resource (HCA or person with lived experience to support this pathway by pairing with the full time HCA).

Reflections

Is there anything that you have identified that we could be doing as a system that would improve the lives of our residents? Is there anything you want to raise to the 'system' that we need to change?	**Sustainability** How do you plan to embed the impact and learning from this project going forward? What would help you to do this?
A couple suggestions, more to follow once project has been evaluated and final report written end of June • Primary care and secondary working collaboratively to engage and support more patients • As a system thinking about an outreach model to engage with the underserved SMI patients' group ensuring access for all. Thinking about how do we fund this model	• Plans to apply the same approach but to extend the full time HCA resource to cover 4 PCNs. The success of this will inform the need for at least two dedicated HCAs to cover all 8 PCNs. • Home visits to be incorporated in all SMI physical health checks offer both in secondary and primary care. Consideration for the possibility of primary care outreach HCA to work alongside secondary care HCAs to facilitate joint home visits. Alternatively, is for a part time person with lived experience to be recruited to support home visits. • Develop an SMI physical health- social prescribers' pathway to promote ongoing support and community interventions • Further discussions on possibility of using current extended clinics to also offer health checks • Develop a strategy at system level on list cleansing both in primary and secondary SMI physical health improvement network to take the lead on this

Social Prescribing Community Chest

Project summary

Project description (including provider, objectives, target population, how to enlist target population):

Hackney Giving and City and Hackney NHS and local authorities are working together to pilot a small grants programme for voluntary and community sector organisations working in Hackney and/or the City of London. The NHS recognises that not-for-profit organisations have access to, and are trusted by, communities in a way that the statutory sector often is not. This programme will test an approach of funding voluntary and community sector organisations to work with communities to help them to access support services. It will be evaluated in summer 2023 and may lead to further, similar, programmes in future.

Aims of the Project:

- To increase access to health services and financial support for people living in Hackney and the City who experience barriers to provision.
- Specifically, the grants aimed to help not-for-profit organisations assist local residents in overcoming these barriers, facilitating easier and more effective access to necessary services.

Funding allocation and how this is being used:

£25,000 was available for distribution to not-for-profit organisations in Hackney and/or the City of London. £3,750 was allocated to Hackney CVS to cover the administration of the programme.

Planned start and end date (and any changes from this)

The programme opened for applications on 2 June 2023, with a deadline of 6 July 2023. The earliest that projects could begin was 7 August 2023, for completion by 31 January 2024.

Is the project complete?

Complete

Highlight Report

Period:

Description of what has taken place over this period:

23 applications were received. Two were from organisations that did not meet the programme eligibility criteria.

The application and assessment process used was as follows:

1. Applications for funding were submitted via a written application form.
2. Hackney Giving assessed the eligibility of applicant organisations.
3. Eligible applications were assessed against a written score framework by two scorers, working independently. They then met to discuss each application and agree on a final score.
4. Final scores were analysed by Hackney Giving to provide a recommended package of projects. Recommendations were categorised into “approve”, “for consideration” and “decline”.
5. A grants panel meeting to decide the final package of projects to be approved was held. The panel consisted of representatives from NHS North East London, Hackney CVS and the wider voluntary and community sector.
6. All applicants were notified of the outcome. Successful applicants received a formal offer letter and details of how to submit an invoice for payment. Unsuccessful applicants were invited to request feedback on why their application was declined.

This process has been used on other Hackney Giving rounds and is considered to be fair and robust.

Key dates/milestones coming up

Project completed

What risks are there to delivery? How do you plan to mitigate these?

Timing and Delays: The program faced significant delays due to tight timelines and procedural requirements, which pushed back the launch and affected the delivery schedule.

Funding Limitations: The funding levels were low, which limited the scope and effectiveness of the projects, making it challenging to significantly impact the target barriers.

Operational Challenges: Administrative costs exceeded the provided fees, putting a strain on program management due to insufficient financial support.

Key Reflections/ Learning from this period?

Effective Outreach: Active and varied outreach efforts proved crucial for engaging the community and ensuring broad participation in the program.

Adequate Funding for Administration: The program underlined the necessity of securing sufficient operational funding to cover administrative costs without compromising service delivery.

Community Feedback: Positive feedback from grant recipients validated the impact of the program and provided insights into effective community support strategies

Evaluation

What are you collecting to allow assessment of the success and learning from your project? When are you collecting this data? Do you have any so far - what is this telling you so far?	Successes What have you/are you learning? What are the implications for the system?	Challenges: What have these been? What is the learning from these and what would you do differently next time?
1. To assess the success and gather learnings from our project, we collected a range of data, including feedback from grant recipients, the number of people benefited, and specific outcomes related to each funded initiative. 2. This data was collected throughout the project lifecycle, with final monitoring forms processed at the conclusion of each initiative. We also conducted visits to various projects in delivery, allowing us to gather direct observations and feedback. 3. The data collected provided us with valuable insights into the effectiveness of the interventions. For instance, grant recipients reported significant improvements in access to health and financial services for their beneficiaries. The feedback was overwhelmingly positive, highlighting enhanced well-being and increased empowerment among participants.	• Each reported how they are able to help people access health and financial services • Projects reported how participants' engagement had wider benefits • Grant-holders appeared grateful for Hackney Giving's approach	**Timing:** A challenge for Hackney Giving was the programme time scale presented at the start, which we worked to meet, and the subsequent delay, detailed above. As a consequence of the delay, Hackney Giving's small team interleaved two grants assessment processes for different funders at the same time. **Level of funding:** The level of funding provided was low. This was raised as a challenge by several organisations. In addition, an administration fee of £3,750 has not covered Hackney Giving's costs. Without grant funding from other sources, meaning staff are already in place and operational, we would not have been able to run this programme. **Expectations:** As detailed above, the language around programme outcomes is important. With the level of funding available, it was unrealistic to expect grant-holders to reduce barriers to access, which have been entrenched. It was appropriate to alter the wording to "increasing access".

Reflections

Is there anything that you have identified that we could be doing as a system that would improve the lives of our residents? Is there anything you want to raise to the 'system' that we need to change?	**Sustainability** How do you plan to embed the impact and learning from this project going forward? What would help you to do this?
• Throughout the project, we identified several areas where systemic changes could significantly improve the lives of our residents. A key observation was the need for increased and more flexible funding to support grassroots initiatives effectively. This would enable not-for-profit organisations to better address the specific barriers their communities face. • Additionally, we found that more streamlined and less bureaucratic funding processes could greatly enhance the efficiency of grant distribution and project implementation. Simplifying these processes would allow organisations to focus more on delivery and less on administrative compliance. • We also highlighted the importance of enhancing collaboration between local authorities, health services, and community organisations. A more integrated approach would ensure that services are more accessible and tailored to the unique needs of different community groups. • Lastly, we advocated for the establishment of a more continuous feedback mechanism between project implementers and funding bodies. Such a system would allow for real-time adjustments and improvements, ensuring that projects remain relevant and impactful throughout their duration.	• We recognise the necessity of ongoing support and resources to embed the impact and learning from our project. Continuous funding and support are crucial for maintaining and expanding the initiatives launched through the grants. • To ensure the sustainability of our efforts, we plan to strengthen our partnerships with local authorities and health services. This will enable us to secure a stable foundation for the successful initiatives we have developed.

Committee: Health and Wellbeing Board - For information	**Dated:** 13 September 2024
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 the end of Q1 2024/25, and July and early August 2024.

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

1.1 Healthwatch City of London

The HWCoL team continue to operate from the Portsoken Community Centre and through hybrid working – both at the office and home working.

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

1.2 Contract with the City of London Corporation

The current Healthwatch contract is due to end mid-September. In line with City of London procurement rules, and procurement options appraisal has been discussed by category board and the preference is to direct award the contract to City of London Healthwatch. A notice to this effect has been published and subject to this process completing without response, the contract will be awarded on 28th August 2024. Health and Wellbeing Board will receive a verbal update at the next meeting

2 Public Board Meetings

There have been no public Board Meetings during the period of this report.

3 Business Plan and Local Objectives

HWCoL have produced the business plan for 2024/25. The plan was out for public consultation from 24th July until 7th August, no comments were received. The HWCoL Board have approved the final plan which has been shared with Commissioners. The plan has now been published on the website, Annual Business Plan 2024/25 | Healthwatch Cityoflondon a summary is below.

The business objectives remain the same as last year and comply with both Healthwatch statutory role, and the contract with the City of London Corporation:

1: HWCoL's voice is recognised: representing the City of London's residents, workers, and students, ensuring that their voice is heard in every forum where change to the delivery of health and social care is discussed.
2: HWCoL recruits and retains a team of committed volunteers: to deliver our vision through a range of bespoke opportunities.
3: HWCoL is a trusted partner:

- trusted by City residents, students, and workers to raise the issues important to them, with those taking decisions affecting their health and social care needs.
- trusted by the bodies taking decisions, ensuring that they seek HWCoL's views as an organisation they need, due to HWCoL's reputation as a reliable source of patient feedback.

4: HWCoL delivers informative research: that impacts positively on City of London residents, workers, and students experience of health and social care services and outcomes.
5: HWCoL is financially stable: holding sufficient cash in the bank to manage any unexpected cashflow issues over the length of the contract.

Whilst the plan identifies what needs to be done to meet both the contractual obligations and those required under the Healthwatch licence, it is important that these translate into real actions that are important to those we serve. The points below specifically identify those actions HWCoL intend to take that will resonate with local people and reflect how they experience local services.

1)Deliver ten patient panels to inform you about Health and Social care topics that are important to service users

2) Hold a summer information event in June and an AGM in October, both events will give residents essential information on local Health and Social Care services and on the work of Healthwatch City of London.
3) Undertake two research projects
4) Conduct two Enter and Views – St Bartholomew's Hospital Cardiology Department and the Neaman Practice recommendations for improvement.
5) Maintain, train, and use a dedicated team of volunteers.
6) Scrutinise how the City of London Corporation awards and monitors its contracts for Social Care provision.

N.B. The plan will be subject to change should the contract renewal from the City of London Corporation require it.

4 Healthwatch City of London Annual Report: Your Voice Counts
In July HWCoL published the Annual Report for 2023/24. The report gives an overview of the impact made over the past year, highlights successes and an overview of projects and events.

Highlights include:

- Holding six Patient Panels, which brought experts and community members together to discuss areas of concerns regarding Health and Social Care in the City. Topics included Cancer Screening Programmes, the new Cancer Wait Times Standards, Hard of hearing and Deaf Awareness, CPR training, Safeguarding and Medicine Management.

- Successfully campaigning for accessible services in Foot Health. Through campaigning we were able to secure the funding for a grant extension from the City of London Corporation to the provider, Hoxton Health who provide the essential nail cutting services at the Neaman Practice, for those who are unable to cut their toenails.

- Continuing to work and collaborate with the Neaman Practice to ensure that residents' concerns and feedback were heard and responded to.

- Championing residents' views and brought insights directly to health and social care providers in the City as well as North East London NHS and the planners of services

A copy of the report was distributed to members of the Health and Wellbeing Board however, it can be accessed via the website Healthwatch City of London Annual Report 2023-24 | Healthwatch Cityoflondon

5 Communications and Engagement

5.1 Patient Panels
Patient panels are designed as information sessions on topics of concern or interest to residents They also enable residents to give feedback on those services and share ideas for improvements.

5.1.1 Patient Panel July – City of London Health and Wellbeing Strategy

In July, HWCoL were joined by Ellie Ward, Head of Strategy and Performance, Department of Community and Children's Services, City of London Corporation. Those present received a presentation informing them about what a Health and Wellbeing Strategy is designed to do and how it addresses health inequalities including how the key priorities were decided on. The main priorities of the strategy were shared, Building Financial Resilience, Tackling Social Isolation and Building Social Connection, and Improving Mental Health. A discussion followed to explore to enable residents to share their views on the strategy and the outcomes they would like to see. Many raised points concerning being able to access Health services via traditional routes and not digitally. tackling homelessness and where to report it and accessing affordable healthy foods were also discussed.

5.1.2 Patient Panel August

Special Educational Needs and Disabilities and Alternative Provision Strategy Consultation.

In early August, HWCoL were joined by Hannah Dobbin, Strategy and Projects Officer, Department of Community and Children's Services and Ellie Ward, Head of Strategy and Performance, Department of Community and Children's Services, City of London Corporation, who presented the draft Special Educational Needs and Disabilities and Alternative Provision Strategy. Hannah discussed how the strategy was co-produced with the Parent Carer Forum, Homerton Healthcare NHS Foundation Trust, NHS North East London, and NHS East London NHS Foundation Trust.

The vision for the strategy is taken from the City of London's Children and Young People's Plan 2022-25:

> The City of London is a place where all children and young people feel safe, have good mental health and wellbeing, fulfil their potential and are ready for adulthood whilst growing up with a sense of belonging.

In attendance was one resident who has a background in education and in SEND, who welcomed the strategy and asked the City to ensure that it was adhered to. Other questions to the panel included the number of people where the impact of the strategy would be felt(around 30) and how the City will ensure funding continues to support implementation. The City stated that the funding will be available and that it is looking at the possibility of funding additional groups to address the issues faced by SEND young people.

The consultation has now been extended to 2nd September, with the timeline of December for it to be approved and implementation begin.

5.1.3 Panels scheduled for Autumn 2024/25 include:

- 6th September: Cardio-pulmonary resuscitation (CPR) training with the London Ambulance Service (LAS)
- October (Date TBC): Menopause Advice and Information (October is menopause awareness month with 18th being Menopause day)
- November (Date TBC): Diabetes Advice and Information (World diabetes day 14th Nov)

- December (Date TBC): Mental Health support over the festive season

5.2 Annual Survey
Between 26th June and 24th July HWCoL carried out its annual survey. The survey seeks feedback from stakeholders and residents regarding HWCoL performance and effectiveness in its role.

The stakeholder survey had twelve responses with the resident survey, disappointingly, only receiving six. The stakeholder survey increased response rate from nine last year.

Points to note: Residents

- HWCoL currently appears to target an older population with the majority of respondents over the age of sixty-five.
- Thirty-three percent of resident respondents believe that HWCoL are, 'very effective in their role,' one respondent highlighted how HWCoL 'have successfully lobbied for changes and broadened areas of concern,'
- Thirty-three percent of respondents find that the information provided by HWCoL is, 'extremely useful' and 66 percent of respondents believe that is it, 'useful'. One respondent, stated that, 'you cannot go into depth on every issue, but you always provide a very good place from which to start.'
- 100 percent or respondents felt that our information is trustworthy, one respondent highlighted that it is, 'because you provide information independent of the providers and I believe it to be factual and unbiased'.
- One respondent did highlight the issues they are facing with the Neaman Practice and the lack of face-to-face appointments, which they do not believe have been addressed.

Points to note: Stakeholders

- Eighty-three percent of stakeholders believe HWCoL are 'very effective in our role,' one respondent highlighted how, 'they are dynamic and a constant positive presence in the COL.'
- Eighty-one percent of stakeholders feel that HWCoL holds Health and Social Care providers to account

Conclusion
Despite the low response rates, it was a positive response from respondents and stakeholders. Points to address, is how to increase the number of respondents for future surveys and how to increase the diversity in respondents, as 50 percent of respondents in the community survey live in the Barbican, HWCoL will need to target and succeed in engaging community members living in the eastern part of the city.
The full report will be available on the HWCoL website late August on our reports page https://www.healthwatchcityoflondon.org.uk/news-and-reports

5.3 Health in the City Event
At the end of June, HWCoL held the first Health in the City Day in collaboration with the Neaman Practice. A hugely successful event which saw nearly one hundred local residents turn up to meet a variety of teams from the NHS and the voluntary sectors.

Dr Chor and Dr Hillier from the Neaman Practice supported the event, as well as representatives from health services and community services, including, NHS Cancer Alliance, Diabetes UK, City Advice, Representatives from the City of London Adult Services and the Children's team, Mental Health Voice, City Carers Community, Older People's Reference Group and the Forget Me Not Café, the Together Better Programme and Social Prescribing team from the Shoreditch Park and City PCN.

HWCoL are grateful to be joined Health and Wellbeing Board Chair and Court of Common Councillor Mary Durcan, Ellie Ward, Head of Strategy and Performance Department of Community and Children's Services and Ian Tweedie, Head of Service, Adult Social Care, on the day.

The team have received valuable feedback from both stallholders and the attendees and in the process of planning a similar event in the Portsoken Area of the City.

Some of the feedback received:
'I thought it was excellent. Well attended and enabled us to engage with clients and partners in particular the Neaman practice'
'*Thoroughly enjoyable day'*
'***What a great event it was last Saturday! Not only was there a rich supply of information and provider contact, but the atmosphere was so pleasant and welcoming'***
'*To achieve that excellent result first time was amazing, and reflected a huge amount of preparation, and concerted, conscientious effort on the day'*

Conclusion
Looking at the feedback from the day, it's clear that there is an appetite for this kind of information event. The stallholders found it useful and were able engage with residents they had not previously engaged with.

Dr Chor and Dr Hillier's presence proved an incentive for many to come.

5.4 Neighbourhoods Programme engagement
Following the last Health and Wellbeing Board meeting, HWCoL has arranged a meeting with Sadie King, Neighbourhoods programme lead, City and Hackney, to better understand the programme, its aims and how it works for the local community and what benefits it brings to City residents.

HWCoL have also met with Amy Wilkinson, Director of Partnerships, Impact and Delivery NHS North East London Integrated Care Board & City and Hackney Place Based Partnership to discuss observations regarding the impact of the Neighbourhoods Programme in the City . It was a very encouraging meeting where the team learned about a new working group with officers from the CoL exploring

how to achieve a greater City focus. Amy agreed to take forward HWCoL concerns, and it was agreed to develop a more collaborative approach going forward for the benefit of the residents of the City of London.

6 Projects

6.1 Digital Apps in Healthcare

This project focuses on the plethora of apps used by both Primary and Secondary Care services. The team are exploring accessibility, integration, and usefulness.

Substantial progress has been made on this project. The desktop research has been completed and is being written up and a survey has been conducted to better understand patients use of the apps. The survey was shared across the Shoreditch Park and City Primary Care Network and with City residents. Hard copies were placed in all City libraries and community centres, with envelopes for responses. The survey has now closed with fifty-six responses. Two focus groups have been held so far, one in person with eight attendees and one on-line with two attendees, this may sound a low figure, but it enabled a good in-depth discussion.

When the project is completed, the report will be shared with users, those managing the Apps, to City and Hackney Place based Partnership, NEL ICB, the City Health and Wellbeing Board as well as HWE to support their work in this area.

6.2 Access to sexual health services for non-City Residents

HWCoL have supported the City of London Corporation in this project by undertaking telephone surveys that try to determine the amount of City workers who are using non-residential postcodes to access sexual health services, which may be resulting in sexual health providers incorrectly recording City workers as residents.

Over the space of a week, the team contacted different sexual health clinics within the City to establish whether clinics would accept a non-residential postcode when trying to book an appointment. There were a range of scenarios used on different days/times to get a wider understanding of the response the clinics would give. The team called on different days/times to ensure a variety of responses.

The report was submitted to the CoL in June. The main findings confirmed that for over half of the calls that were made, the clinics accepted a non-residential postcode when booking an appointment with no issues, even when HWCoL staff directly asked if a non-residential address could be used.

6.3 Campaign for Men's Health Strategy

HWCoL are currently scoping out a project to campaign for the development of Men's Health Strategy for North East London; we know that men are less likely to seek help in regard to their physical and mental health and we are seeking to further understand what resources and services in the City are needed to enable men to seek help. There is at present no Men's Health strategy and we will be collaborating with partners to campaign for the development of a comprehensive strategy, The team plan to launch the campaign later in the Autumn.

7 Enter and View programme

Healthwatch have a statutory function to conduct Enter & View visits to health and care services to review services at the point of delivery. Following a halt in Enter and View due to Covid HWCoL have now recommenced this important activity.

7.1 Barts Health NHS Trust Cardiology Department

On Thursday 13th June, the HWCoL team and volunteers conducted and Enter and View visit to the Barts Health NHS Trust Cardiology Department which is based at St Bartholomew's Hospital.

Based on feedback from residents the Enter and View focused on communication, the current administrative services, and the impact on care.

The visit, arranged with Matthew Young, the General Manager for Electro Physiology, Intervention and Networked Cardiology, saw interviews take place with managers, team leaders, administration staff, receptionists, and patients.

The interviews with the administration team and managers were very insightful, immediately it has highlighted that the many different processes used by the various teams, and the many different applications used to book and process appointments, and how they are used inconsistently can cause issues.

Disappointingly, the team were not able to interview many patients due the nature of the department visited. HWCoL requested another, shorter, visit to interview patients in other cardiology departments rather than just the Electrophysiology Department and Intervention, Department, this took place on 25th July.

The report must be written within four weeks of the final visit and will then be sent to St Bartholomew's hospital team for comment before publication.

We would like to extend our thanks to the team at St Bartholomew's Hospital who were extremely helpful and open about their work, and to thank our volunteers.

7.2 Neaman Practice

HWCoL plan to conduct an Enter and View visit to the Neaman Practice in Q4 this year. The team have raised access to Shingles and Pneumonia vaccinations for those who eligible and how this is communicated.

8 Q1 Performance Framework (Contractual Obligations)

There has been no notable change in performance as measured by the Key Performance Indicators. Twenty green indicators and four amber indicators. The main concern is attendance of the public at HWCoL events; however, the Patient Panel series have proved popular with new people attending each time.

9 Planned activities in Quarter 2 2024/25

In support of the delivery of the business plan during Q2 the team at HWCoL will:

- Continue with Digital Apps project with additional focus groups and write up.
- Produce the Enter and View reports from the Barts Cardiology Department visit
- Continue with the Patient Panel Series, developing a full autumn programme.

10 Conclusion

In conclusion it has been a busy few months at HWCoL, producing the annual report and conducting our annual survey to ensure we listen to the concerns of those we serve.

Gail Beer
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Committee	Dated:
Health and Wellbeing Board	13/09/2024
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. Suicide is the biggest killer of people under the age of 35 and the biggest killer of men under the age of 50. It is the leading cause of death in the UK for 10-19 year olds, with 5,642 reported people dying in this way in 2022. 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. The Office for Health Improvement and Disparities (OHID - previously Public Health England) 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 July 2023 and 30th of June 2024, there have been less than 5 suicides, with a total of 103 attempted suicides.

5. Between 1st of July 2023 and 30th of June 2024, there had been a total of 110 incidents whereby the subject had contemplated suicide or had suicidal

thoughts.

Emerging Trends throughout 2023

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 68% of the attempted suicides occurred during the night and the peak days were Wednesday and Thursday.

8. Bridges remain the most common location type for suicide attempts within the City, with 74% attempted suicides occurring on bridges. The second most common location was on the street with 16%.

9. The qualitative analysis shows that 51% 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.

Demographics at the end of 2023

10. 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 2023. The data covers both completed and attempted suicides. Please note that the most recent data from the coroner was not available for this report.

11. ***Age range:*** Similar to the year 2022, there was a mixed aged range for attempts: 26 individuals aged under 18 (17%), 65 were aged 18 to 29 years of age (43%), 32 in their 30s (21%), 19 in their 40s (12%), and 9 in their 50s (6%). There was one count of an individual aged 60 and another who was aged 70.

    Completions were also mixed in 2023 (between ages 26 and 62).

12. ***Gender***: Males represented 53% of attempted suicides, females represented 44% and those of unknown gender represented 1%.

13. ***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 2022- 30 June 2024

Year	Attempts	Contemplations	Completions
2021	**127**	**119**	**<10**
2022	**129**	**132**	**< 5**
2023	**144**	**145**	**< 10**

2024 to date (30/6/24)	**42**	**41**	**< 5**

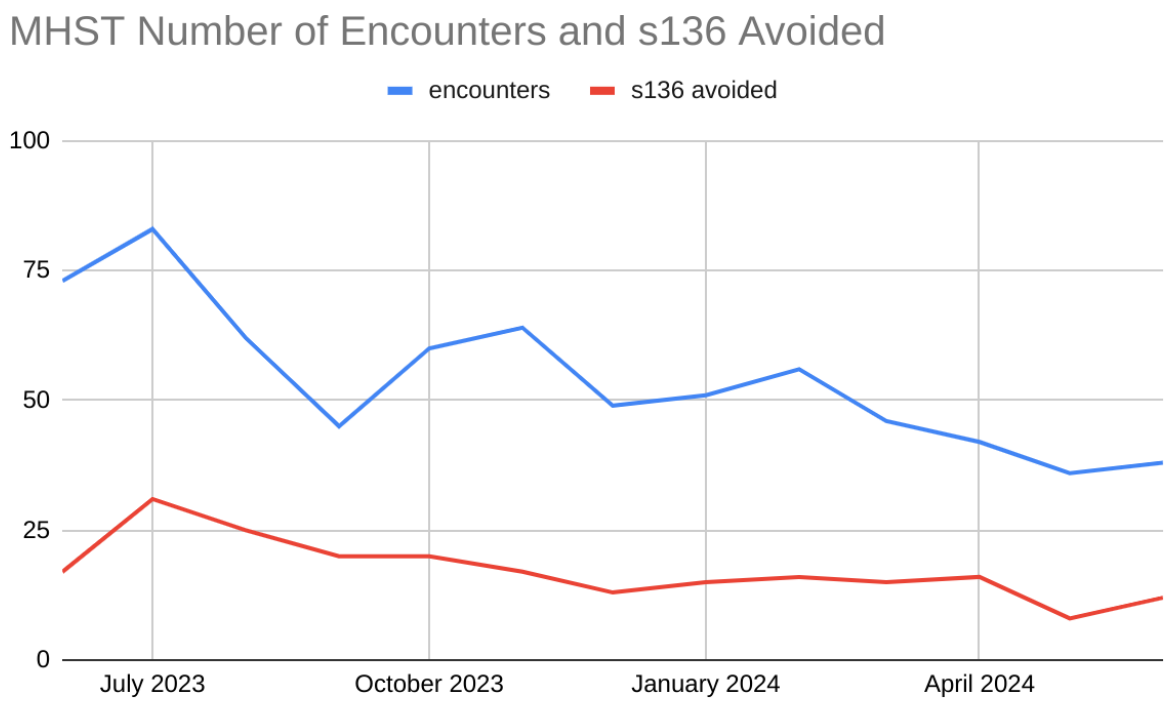
*data up to XXXX 2024

Mental Health Street Triage

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

15. New core hours for the service became 3pm to 3am. This new model started on October 4th 2022 and is operating well.

16. MHST Activity levels July 2023 - June 2024:



17. A key function of MHST is to avoid the use of s136[1]. In total, MHST responded to 310 incidents that were potential incarcerations under section 136 from 1st of July 2023 to 30 June 2024. As a result, an estimated 71.6% of potential s136 detentions were avoided.

18. Since starting in 2017, this proportion has varied between 65% and 76%.

19. The MHST team received a police commendation in July 2024 for their professionalism, commitment and outstanding work supporting members of the

[1] Section 136 of the Mental Health Act 1983 allows a constable to remove or keep a person who appears to be suffering from mental disorder and in need of care or control.

public and the City of London Police through crisis incidents, interventions and a great support mechanism.

Bridge Watch

20. The bridge watch volunteer patrol programme is now stood up. It is operating as part of the Ascension Trust, a charitable project funded by grants.

21. The seed funding for the first two years was granted by City Bridge Foundation in early 2023. The programme lead was recruited in July 2023. Volunteer onboarding started soon after, volunteers undergo at least 35 hours of training (safeguarding, throw bag, suicide awareness and intervention, etc).

22. Patrols started in December 2023 on Tower and London Bridge and then expanded to all five bridges by March 2024.

23. Partners include members of the Tidal Thames Water Safety forum (Royal National Lifeboat Institute, London ambulance service, London Fire Brigade, HRM Coast guards, City of London Police, City and Hackney Public Health), City Bridge Foundation, Beachy Heads Chaplaincy, park guards, Thrive LDN.

24. Thrive LDN has generously filmed a promotional video for Bridge watch: https://www.youtube.com/watch?v=rnN5lVE8AGw&t=2s

25. The bridge watch website is now live: https://bridgewatch.uk/

26. Some key data:
    - 559 hours of patrol from December 4th 2023 to 30 June 2024.
    - 33 interventions
    - 4 clearly expressed threats of jumping
    - 12 suicidal people
    - 12 MHST intervention, 8 section 136
    - The volunteers have helped find a missing vulnerable person and a missing child
    - 38 volunteers trained and patrolling in July 2024, 17 to be trained over the summer of 2024
    - Volunteers were trained in naloxone in July 2024

27. The development group (composed of most of the above partners) is exploring alternative funding sources for additional funding to provide administrative support for the programme lead and to offer volunteers incentives (daily rate/travel costs to increase coverage at night).

28. Bridge Watch has successfully bid for a Public Health Intervention Responsive Studies Teams (PHIRST) evaluation, provided by the National Institute for Health and Care Research (NIHR). This will provide an academically rigorous piece of research to better understand Bridge Watch as a public health intervention. These evaluations are only offered to a small number of programs, and it is a significant achievement to secure this opportunity. The outputs will help develop the service and allow better informed decisions for the future of the program. Work on the evaluation started in February 2024 and will conclude at the end of 2025.

Action Plan Progress Summary

29. Overall, 65 actions have commenced since the launch of the action plan, of which 10 are completed, 55 are in progress.

30. No new actions have commenced since the last annual report to the Health and Wellbeing Board but enhanced actions have been scoped out and will start soon (please see paragraph 34).

31. Significant milestones include:
    - Training in Suicide Awareness and Prevention of City workers through the Business Healthy network still sees high uptake. Since 2016, 31 sessions have been delivered (up until April 2024) and 470 people have been trained, representing over 135 organisations. An additional 2 sessions are planned for 2024-25 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) is now operating.
    - The Safe Havens network ("A place of temporary refuge for a person to facilitate their onward journey'') is now in place, with 60 locations (shops, cafes, pubs, libraries), and growing.

RAG Status Key and Summary

Status of Actions	
Major Problems	0
Minor Problems	7
In Progress/ongoing	45
Completed	12

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)

Enhanced Suicide Prevention Action Plan

34. A report *Suicide Prevention Measures in the City of London* was published on 26 October 2023. (**Full report can be accessed at this link as Appendix 2**).

35. The report summarised suicide prevention measures in the Square Mile, with a view of celebrating good practice, improving partnership working and identifying gaps and opportunities across local suicide prevention networks.

36. At the request of Members, a one-day conference on suicide prevention was also organised, the *City Hope Conference* and held on 26 October 2023.

37. This event gathered 156 senior professionals from more than 100 organisations in suicide prevention and mental health to review progress, learn from past actions, and discuss future initiatives.

38. Out of this conference came four widely agreed suggestions which were approved by the Policy and Resources committee in July 2024. They are:

- The appointment of a suicide prevention planning officer in the City Corporation to work alongside public health, police and City Bridge Foundation colleagues.
- The development of a Suicide Prevention Charter setting out the duties and responsibilities of all departments and institutions in the City Corporation to prevent suicide.
- More focused engagement with Financial and Professional Services in the Square Mile, targeting males as they represent 85.4% of suicide completions in the Square Mile.[2] Through the formation **of a City-led private sector suicide prevention network.** The network will bring together private sector partners to promote best practice, share effective strategies and lever in additional resources. The network will promote collaborative efforts to address mental health challenges, particularly in high-pressure work environments.
- **Continue to work with City Bridge Foundation to assess and review suicide-prevention measures on CBF bridges.** This aligns with the City Bridge Foundation's commitment to study a report from the Bridge Owners Forum's work on suicide prevention measures and their commitment to return to this discussion in future looking at data from CBF-funded initiatives such as Bridge Watch and the charity's £10m Suicide Prevention Funding Programme.

[2] City of London Suicide Audit 2023 (2017 – 2022)

Conclusion and Recommendations

39. The past year has seen significant progress in the area of suicide prevention across the Corporation and its partners. Bridge Watch has started operating and enhanced initiatives have come out of the *Suicide Prevention Measures in the City of London* report and the October 2023 conference.

40. 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
Appendix 2 - Suicide Prevention Measures in the City of London, October 2023

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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	10 Actions completed or ongoing	4 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	

		Implement the vulnerable People And Bridges Security Project within the Secure City Programme. commission a feasibility study of physical measures on the bridges and make a decision based on findings Adapting the upcoming national highways software on location risk assessment for tall buildings and urban structures.			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 Small to Medium Enterprises. for SMEs	· 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
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 recommissioned some training via the lion barbers collective to train more barbers in march	Green

			2023	
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 - two sessions specifically for security professionals were organised in late feb and late march 2024	
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 compulsory training for applicants to get a taxi license - TFL has a new suicide prevention lead who is working towards progressing this, we have also asked the Department for transport for their help with this - texts on suicide prevention and spotting the signs is potentially being added to the TFL taxi	Amber

			drivers handbook	
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_good_work_standard_employer_guidance_00.pdf	Ongoing

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. We constantly review the service to ensure it has the best operating model possible, this is done in conjunction of the impact of the Bridge watch patrols	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 was finalised and presented to the City Health and Wellbeing board in the autumn of 2023	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	The safe havens network has been created by safe business organisation, they have 60 locations and are always finding new ones, the list of locations has been shared with relevant partners such as Bridge Watch and the CoLP	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, this compliments park guards and bridgewatch patrols	Ongoing

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 - since the new national strategy noted problem gamblers as an at risk cohort, work is being done on gambling harm (training frontline staff, needs assessment, etc)	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 access mental health services, particularly Care Leavers.	· Enhanced mental health service commissioned for Looked After Children and Care Leavers	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 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	Ongoing

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; the City Suicide prevention lead is part of a national advisory group which is currently writing a guidance for HEIs on suicide prevention.	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	Completed

			being used in this context	

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 3 trainings 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 prevention groups/webinars/ conference because other areas are seeking to implement something similar	Ongoing

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 ; BTP and TFL are both on our steering group and we do joint work with them (Eg: training taxi drivers in suicide prevention) TFL is also now leading a working group on incidents on the river.	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 mobilised in december 2023 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	Ongoing

			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	Mar24 – The project to implement new high definition cameras on the City of London Bridges is nearing completion. London Bridge cameras have been implemented as part of the recent (Feb24) go-live of the CCTV/VMS system, Millennium and Tower Bridge cameras are implemented on the test system pending troubleshooting. Southwark and Blackfriars Bridge civil works are well advanced and will initially be commissioned on the test system. The cameras are now fully live	ongoing
3.5 mobilise bridge watch programme patrols	volunteers patrolling the 5 BHE owned bridges 24/7	Ascension Trust, CoL Police, RNLI, PLA, PH	- 559 hours of patrol from December 4th 2023 to 30 June 2024 - 33 interventions - 4 clearly expressed threats of jumping - 12 suicidal people	Ongoing

			- 12 MHST intervention, 8 section 136 - 38 volunteers trained, 17 to be trained - Volunteers are getting trained in naloxone in July - Need to reapply for CBF funding in february 2025 - Exploring alternative funding sources for additional funding: administrative support for the programme lead + to offer volunteers incentives (per diem/travel costs coverage to help at night - National institute for health research will evaluate Bridge watch for impact	
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	Signs are up and maintained	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	Solutions with high expected usefulness are being trialled, however the project has experienced delays behind IT delays impacting the core components of the programme	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	Ongoing

			(50 premises)	
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 develiring a training for people working along and on the river with the listening place, PH has given feedback as well as CoLp. the 3 year report on the drowning strategy is now available	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 2023 to pause the governance on the public protection study and it is being restarted in the April 2024	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 on 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	March 2024 : Over 100 people attended in person This is me events in 2023 with a further 67 attending first event of 2024 (focussed on the links between physical and mental health. The events engaged with seven speakers from organisations across the City as well as expert insight provided by our partner charity MQ Mental Health. We plan once again this year to support mental health awareness week through a variety of means to encourage organisations to get involved and capture and highlight their activities. This will include a planning webinar to inspire businesses to get involved, the collation of good news stories and the provision of speakers for events. Over 30,000 green ribbons were distributed in 2023 and the number of individuals that have completed wellbeing in the workplace training sits at over 51,000 with 12 new organisations using the training in 2023.	ongoing

			The remainder of the year will see the delivery of 5 webinars and a further in person event in addition to the planned mental health awareness week activity. As always, the latest news and activities can be found on our website whilst the This is Me resource hub, remains free to access and contains a range of materials designed to support workplaces on the wellbeing journey.	
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 signposting to bereavement services	· Number of people offered bereavement support (should be systematic/coincide with completion data)	CoLP and coroner	Information on bereavement services is offered by CoLp systematically, it is also available on various	Ongoing

			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 pack sent to city	PH	The pack is finalised, it	complete

bereavement support pack to stakeholders, residents and partners	VCS and partners		contains a bereavement video from LBH, bereavement leaflets (60 copies have already been sent to LBH VCS)	
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	· 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.	Ongoing

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			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	
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	change in language, successfully, commit, are no longer widely used	All	use of appropriate language and terminology is important when discussing suicide. All	Ongoing

positive appropriate language in all communications and during purdah			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.	
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. She has also consulted several galleries and museums to find out the best format for the upcoming events guidance.	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 action to be taken as opposed to months after. access is tailored by both residence of	Ongoing

			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 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.”	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 - July 2024 no data sharing agreements in place apart from between COLP and Homerton, royal London and Newham hospitals.	amber

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 for evaluating local suicide prevention work	· Evaluation of 'the Bridge Pilot'	PH	See action 3.3 the Mental 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	complete
6.10 Produce an enhance suicide prevention report	enhanced suicide report produced and shared	senior corporate affairs officer and all	A report *Suicide Prevention Measures in the City of London* was published on 26 October 2023. The report summarised suicide prevention measures in the	complete

			Square Mile, with a view of celebrating good practice, improving partnership working and identifying gaps and opportunities across local suicide prevention networks.	
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	At the request of Members, a one-day conference on suicide prevention was also organised, the *City Hope Conference* and held on 26 October 2023. This event gathered 156 senior professionals from more than 100 organisations in suicide prevention and mental health to review progress, learn from past actions, and discuss future initiatives.	Complete

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Committee(s): City of London Health & Wellbeing Board	**Dated:** 13 09 2024
Subject: City & Hackney Tobacco Needs Assessment 2024	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	Providing excellent services Diverse engaged communities
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: Dr Sandra Husbands, Director of Public Health	**For Decision**
Report author: Connor Melia, Senior Public Health Specialist	

Summary

This report summarises a more detailed presentation (Appendix I) which sets out:

- a summary of the recently published Tobacco Needs Assessment for City and Hackney
- the local response to the evidence and intelligence
- an overview of the newly re-commissioned City & Hackney stop smoking service, including new funding streams
- a set of recommendations for Board Members to consider.

Recommendation(s)

Members are asked to:

- Note the content of the 2024 City and Hackney Tobacco Needs Assessment
- Consider and respond to the following questions.
    1. Does the Board endorse the recommendation for a joint City & Hackney partnership commitment to reduce the harms from tobacco?
    2. How can the Health and Wellbeing Board - as a collective body and as leaders within your organisations - use its influence to implement the recommendations of the tobacco needs assessment?
    3. How can we better align our local tobacco control plans with the implementation of the City Health & Wellbeing Strategy priorities (improving mental health, increasing social connection, supporting greater financial security)?

Main Report

1. Background

1.1 Tobacco smoking remains the biggest cause of preventable illness and premature death (accounting for almost 75,000 deaths a year in England) and the leading cause of health inequalities (accounting for half the difference in life expectancy between the richest and poorest in society).

1.2 Locally, work to combat tobacco-related harms is led by the City & Hackney Tobacco Control Alliance (TCA).

1.3 It is essential that the work of the TCA is guided by the latest evidence to maximise our potential for reducing smoking-related harms. The publication of the 2024 City and Hackney Tobacco Needs Assessment (TNA) provides updated context in relation to tobacco control; providing insights on the local picture of smoking behaviours, examining the latest evidence and best practice as well as the local response, and making recommendations for local partnership action.

2. Current Position

2.1. The TNA focuses on key areas such as prevention, identification, treatment, and support. It addresses inequalities in access across demographics, geography, socioeconomic factors, and vulnerable groups; while also exploring the role of e-cigarettes and workplace interventions in combating smoking. The report emphasises the need for strong, sustained collaboration to address smoking-related inequalities, and concludes with eight broad recommendations, which are summarised below.

1. Prioritise preventing smoking (and vaping) initiation and support young smokers to quit, with focus on whole-school approaches and peer-led initiatives.
2. ‘Denormalise’ smoking through a robust tobacco control plan, advocating for smoke-free public spaces and reaffirming partnership commitments.
3. Tailor support for high-prevalence communities to quit, collaborating with relevant partner organisations to ensure a targeted approach.
4. Continue funding evidence-based community stop-smoking services, offering flexible support, harm reduction and transparent information on vaping.
5. Improve reporting of smoking status in GP records to facilitate targeted very brief advice and referrals to stop smoking services.
6. Sustain investment in enforcement to curb illicit tobacco and e-cigarette supply, preventing underage sales and associated harms.
7. Launch a coordinated campaign to address vaping misconceptions, raise

awareness about illicit products and strongly discourage non-smokers and youth from taking up.

8. Implement a comprehensive local comms strategy to increase quit attempts, emphasise tobacco harms and promote all available offers of support to quit.

2.2 The TNA recommendations will continue to inform and guide the broad tobacco control programme of work, led by the City & Hackney Tobacco Control Alliance (TCA). This includes the recent re-commissioning of a new stop smoking service (launched in July 2024), ongoing partnership with Trading Standards, plus wider activity detailed in the accompanying presentation (Appendix 1).

2.3 The City & Hackney TCA (chaired by Hackney Council's Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture) brings together key partners to provide strategic leadership at a systems level on local tobacco control work. Our partnership priorities directly link with many of the recommendations outlined in the TNA (Box. 1 below)

Box. 1, City & Hackney Tobacco Control Alliance partnership priorities 2023-2026 (2024 priorities in green).

1	Re-set our **strategic approach** through senior level re-engagement, and ensure alignment of tobacco control priorities with the Health & Wellbeing Strategy implementation plan and City & Hackney Place Based Partnership delivery plan
2	Develop and implement a proactive, coordinated approach to local **communications** about smoking - consistent messaging, maximise use of all available channels, focused on high prevalence communities/groups, measure impact
3	Co-design a new **stop smoking service** that is explicitly focused on reducing stubborn **inequalities** in smoking prevalence and addresses the needs of disadvantaged communities
4	Ensure careful coordination (and effective communication) of NHS and local authority funded **tobacco dependency and stop smoking treatment pathways**
5	Review/refresh our approach to **smokefree environments** - including promotion of smokefree homes (including training and comms) and social housing public spaces, and refresh of NHS and local authority smokefree policies
6	Better enable **young people** to live smoke free by 'denormalising' smoking - targeted comms for parents who smoke, continue work to reduce supply of illegal tobacco (and vapes), education outreach, youth engagement (e.g. system influencers, youth leaders, young black men inspirational leaders)
7	Review and strengthen system-wide action to address **illegal and niche tobacco** use

8	Improve local understanding of how to maximise the benefits and balance the risk of using **e-cigarettes** and agree a partnership position to inform our local communications and service delivery

3. Options

N/A

4. Proposals

The key proposal is for partner organisations represented on this Board to (re)commit to comprehensive action in tackling local smoking-related harms. This would involve:

4.1 City of London Corporation signing up to the Local Government Declaration on Tobacco Control

This would formalise the Corporation's commitment to reducing tobacco-related harms and reinforce its leadership role in promoting public health and reducing health inequalities.

4.2 NHS partners renewing their commitments under the NHS Smokefree Pledge

This renewal would reaffirm the NHS's commitment to supporting smoke-free environments, integrating smoking cessation support, and addressing smoking-related health disparities across City and Hackney.

5. Key Data

5.1 In 2023, GP data on smoking prevalence (City residents registered with a GP in North East London ICB) was unchanged from 2016, at 10.5% of the total adult population - an estimated number of 772 smokers.

5.2 Based on the combined City and Hackney analysis, the TNA identified significant and stubborn inequalities in smoking prevalence. For example, social renters are around 50% more likely to smoke compared to the general population and 8 times more likely to smoke compared to those who own their property.

5.3 Certain ethnic subgroups, such as the Bangladeshi community, are also more likely to smoke, as are those with severe mental illness and homeless populations.

Corporate & Strategic Implications – [*Please state 'none' if not applicable instead of deleting any of the sub-headings below]*

Strategic implications

As the biggest driver of poor health and inequalities, comprehensive action on tobacco control (as described in the appended paper) plays a key role in delivery of the Health and Wellbeing Strategy. Through it's focus on ensuring equitable access to evidence-based support to quit, and commitment to community collaboration, our plans also contribute to two key outcomes of the Corporate Plan - providing excellent services and diverse engaged communities.

Financial implications

None

Resource implications

None

Legal implications

None

Risk implications

None

Equalities implications

The presentation in Appendix I highlights the fact that the impacts of smoking-related harm are not experienced equally, with already disadvantaged and vulnerable communities (including those with protected characteristics) bearing the greatest impact, thus further exacerbating inequalities due to increased smoking prevalence.

In developing and implementing key priorities via the TCA, the broad programme of work outlined in Appendix I seeks to minimise smoking prevalence and reduce the burden of ill-health from tobacco smoking in our most vulnerable populations.

Climate implications

Every stage of the tobacco supply chain poses serious environmental consequences, including deforestation, the use of fossil fuels and the dumping or leaking of waste products into the natural environment. Action to reduce use of tobacco products will, consequently, have positive environmental impacts.

The increasing use of disposable vapes (commonly used as a smoking cessation tool, but soon to be banned) presents a growing environmental challenge due to improper disposal. These devices often contain lithium batteries and plastic components, which contribute to electronic waste and environmental pollution. Ensuring the safe disposal and recycling of vapes is critical to mitigate their environmental impact and reduce harm to the climate.

Security implications

None

6. Conclusion

6.1 Addressing tobacco-related harms is essential for reducing preventable illness and health inequalities in City and Hackney. By strengthening partnerships and recommitting to comprehensive tobacco control efforts, we can ensure targeted interventions reach the most vulnerable communities and drive progress toward the Smokefree 2030 goal (<5% of people smoking). Continued investment in stop smoking services and focused support for high prevalence groups will be critical to achieving lasting health improvements.

….

Appendices

Appendix I – Full presentation to be delivered to the City of London Corporation Health and Wellbeing Board

Connor Melia
Senior Public Health Specialist, City and Hackney Public Health

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City & Hackney Tobacco Needs Assessment 2024

Findings, local implementation and recommendations

Mariana Autran, Public Health Analyst
Connor Melia, Senior Public Health Specialist
13 September 2024

Outline of the presentation

1. Context
2. Findings from the Tobacco Needs Assessment for City and Hackney
    a. Local data
    b. The local response
    c. Recommendations
3. Questions for the Board

1. Context

1. Context: why tobacco smoking (a reminder)?

- Tobacco smoking remains the biggest cause of preventable illness and premature death (accounting for almost 75,000 deaths a year in England) and the leading cause of health inequalities (accounting for half the difference in life expectancy between the richest and poorest in society).[1]
- At least one in two long term smokers will die from a smoking-related disease[2] - this risk may now be as high as two in three.[3]
- Nationally, one in five households with a smoker (21%) in the UK were living below the poverty line, amounting to 1 million households. When tobacco expenditure is included in the assessment of poverty, this increases to nearly a third (32%), equivalent to 1.5 million households.[4]
- Children who live with parents or siblings who smoke are up to 3x more likely than children of non-smoking households to become smokers themselves .[5] Each year, at least 23,000 young people in England and Wales are estimated to start smoking by the age of 15 as a result of exposure to smoking in the home.[6]

1. Smoking-related ill health and mortality NHS Digital: Statistics on Smoking, England 2020 (Table 1.4 & 1.5)
2. The Doctors Study" (Doll R, Peto R, Wheatley K, Gray R, Sutherland I. Mortality in relation to smoking: 40 years observations on male British doctors. British Medical Journal 1994; 309:901-911). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2362092/.
3. The Khan review – "Making smoking obsolete". Independent review commissioned by the UK Government into smokefree 2030 policies by Dr Javed Khan OBE, Published 9 June 2022
4. Smoking and Poverty, ASH (2021) https://ash.org.uk/resources/view/smoking-and-poverty-2
5. Royal College of Physicians. Smoking and the young. Tobacco Control. 1992;1:231-235.
6. Leonardi-Bee J, Jere M, Britton J. Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis. Thorax. 2011;66(10):847-855.

2. Findings from the Tobacco Needs Assessment for City and Hackney 2024

CoL smoking prevalence around 11%

Prevalence and equivalent estimated number of adult (18+) smokers, City of London residents

Prevalence		Estimated number	
APS 2021*	GP 2022	APS 2021*	GP 2022
11.5%	10.5%	916	772

Sources: GP data: Clinical Commissioning Group (CEG), East London Database, 2022; APS data: Annual Population Survey (APS) 2021 prevalence applied to ONS mid-year 2021 population aged 18 and over to calculate the estimated number based APS(23). As Census 2021 data was collected during the COVID-19 pandemic when the local resident population may have been temporarily lower, ONS mid-year 2021 population is used in this document. Note: GP data covers the City of London and Hackney residents registered with a GP in North East London (NEL), which includes eight local authority areas: Barking & Dagenham, City of London, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest. The prevalence calculated amongst those with smoking status known in the last 5 years (from 2017/18 to 2021/22) was applied to the whole adult population registered to calculate the estimated numbers. 17 *No prevalence value available for City of London in APS, so London value was used.

- CoL smoking prevalence is around 11%. This is lower than Hackney, London and England.
- The number of smokers in CoL is estimated to range between 772 (APS) and 916 (GP), depending on the source and methodology used.
- Annual Population Survey (APS) data is the ‘official’ published source and used to estimate number of smokers, plus for comparison purposes. No data is available to CoL due to small numbers. Local GP data is used for the detailed inequalities analysis, frequently combined with Hackney due to small numbers.

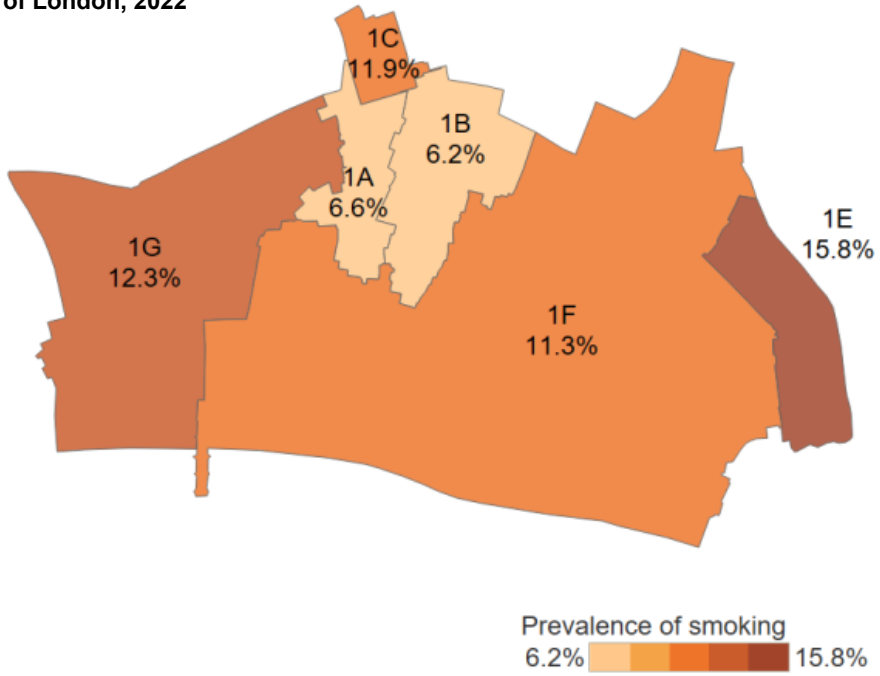
Characteristics of residents with higher smoking rates

Sex (CoL data)	Men (13.3% vs 7.3%)	**Occupation (no CoL data, APS)**	Manual and routine occupations
Age (CoL data)	No reliable data for <18 Smoking prevalence relatively stable up to age 59 (between 9.0% among 18-24 and 12.7% among 40-59) Declines in older age groups (around 7%)	**Housing tenure (no CoL data, APS)**	Social and private renters
Ethnicity (CoL data)	Bangladeshi men (32.8% vs 13.3%) Black men (23.9% vs 13.3%) non-British* white women (9.6% vs 7.3%), which include white European ethnicities, for example.	**Other groups (CoL data, but Gay, lesbian and bissexual people, national data)**	People with severe mental illness (SMI, 20.4%) People who are homeless (71.0%) People engaged in substance use (<5 individuals) Gay, lesbian and bisexual people (National data, heterosexual comp.)
Deprivation (CoL data)	Residents in most deprived areas (15.8% in the most deprived area vs 6.4% in the least deprived areas)		

Data source: Smoking prevalence in adults (18+) - current smokers (APS), OHID Fingertips, 2023 and Clinical Commissioning Group, 2023.

There is some variation in smoking prevalence between different areas in the City of London

GP recorded prevalence of current smokers (18+) by Lower Layer Super Output Areas (LSOAs), City of London, 2022



- The highest % of smokers is recorded in the east of CoL, in Portsken (1E)
- Portsken is a relatively deprived area, with a significant Bangladeshi community.

Data source: Clinical Effectiveness Group, East London Database, 2022.
Notes: Lower Layer Super Output Areas (LSOAs) are small geographical areas consistent in population size (between 1000 and 1500 residents).

Nicotine containing e-cigarettes (vapes)

- In 2023, nationally around 21% of children aged between 11 and 17 had tried vaping, up from 16% in 2022 and 14% in 2020.
- Adults (18+) regular e-cigarette use was estimated at around 7% of the population in 2022.
- Latest evidence recommends e-cigarettes as an effective tool to quit tobacco smoking.
- Government response to consultation on youth vaping recommended to ban disposable vapes, restrict flavours, plain packaging and change how displayed in shops to reduce appeal to children and young people.
- Hackney Trading Standards officer is leading the way in informing the Government's response to enforcement of vapes.

Data source: ASH, Use of e-cigarettes among young people in Great Britain, 2021.

Local insight revealed:

- the use of disposable vapes may be common among young people
- there are common misperceptions locally (as elsewhere) about the relative risks of e-cigarettes vs tobacco smoking, which may be discouraging smokers from trying e-cigarettes as a quit aid.

2b. The local response

City & Hackney Tobacco Control Alliance Partnership Priorities 2023-2026

1	Re-set our **strategic approach** through senior level re-engagement, and ensure alignment of tobacco control priorities with the Health & Wellbeing Strategy implementation plan and City & Hackney Place Based Partnership delivery plan
2	Develop and implement a proactive, coordinated approach to local **communications** about smoking - consistent messaging, maximise use of all available channels, focused on high prevalence communities/groups, measure impact
3	Co-design a new **stop smoking service** that is explicitly focused on reducing stubborn **inequalities** in smoking prevalence and addresses the needs of disadvantaged communities
4	Ensure careful coordination (and effective communication) of NHS and local authority funded **tobacco dependency and stop smoking treatment pathways**
5	Review/refresh our approach to **smokefree environments** - including promotion of smokefree homes (including training and comms) and social housing public spaces, and refresh of NHS and local authority smokefree policies
6	Better enable **young people** to live smoke free by 'denormalising' smoking - targeted comms for parents who smoke, continue work to reduce supply of illegal tobacco (and vapes), education outreach, youth engagement (e.g. system influencers, youth leaders, young black men inspirational leaders)
7	Review and strengthen system-wide action to address **illegal and niche tobacco** use
8	Improve local understanding of how to maximise the benefits and balance the risk of using **e-cigarettes** and agree a partnership position to inform our local communications and service delivery

Treatment, care and support

Local Stop Smoking Service

- Commissioned by Public Health
- In person and remote support
- Range of community settings:
  - GP practices
  - community pharmacies (via walk-in)
  - hospitals
  - other outreach locations.
- Previous service (*ended 30 June 2024*) consistently achieved above average performance compared to London and England - both in terms of the number of smokers setting a quit date and the % who successfully quit at 4 weeks
- Quit rates were broadly similar across different groups of smokers
- **New service launched on 1 July 2024**

Local insight revealed:

- It is important to offer a variety of **options for accessing support** to quit, including different locations and formats (virtual and in person)
- the importance of **self-referral** for many patients
- **peer support following a quit attempt** can help reduce relapse
- a **harm reduction approach** may be more effective than an abrupt quit **for some groups** (e.g. those with SMI)
- **awareness of the service is lower among younger age groups**
- **social media** could be used to **attract** young people to health services

Some groups of smokers were ‘underrepresented’ in the previous City & Hackney stop smoking service

Sex	Men	**Occupation**	Not possible to analyse
Age	Younger adults (18-39)	**Housing tenure**	Not possible to analyse
Ethnicity*	‘other’ white* ‘other’ black ‘other’ Asian and ‘any other ethnicity’	**Other groups**	People with severe mental illness People engaged in substance use is not possible to analyse People who are homeless Sexual orientation is not possible to analyse
Deprivation	Residents in least deprived areas	**Geographic area**	People living in Shoreditch Park and City PCN.

* The main groups within the ‘other white’ category are Turkish, Kurdish or Cypriot (making up more than 40% of this category), followed by people from Eastern Europe (at least 15% of this category) and Western Europe (accounting for more than 12%).

Data sources: Clinical Effectiveness Group, East London Database, 2022. Smokefree City and Hackney, 2023.
Notes: ‘Underrepresented’ groups refer to groups that represent a larger proportion of the local smoker population than the SSS user population.

Introducing the new City & Hackney Stop Smoking Service

Primary aim is to reduce stubborn inequalities

- Reduced annual targets to focus on key populations and entrenched smokers

Focus on community engagement, co-production and outreach

- A centrepiece of the service specification which will continue throughout delivery, in partnership with a (new) dedicated Community Outreach and Engagement Lead, hosted by Hackney Council
- Capacity building to support direct delivery by community partners (focus on VCS but not exclusively)

Strong community presence with virtual options

- See map (next slide); note: LSSSASG plans to increase City community activity

Key Activity in the City

A minimum of 100 quit-dates set p.a
Tailored to City Workers
Targeted activity at key populations
Ongoing access to NHS Swap to Stop Scheme

Target Populations

Turkish/Kurdish
Black Caribbean
Bangladeshi
Eastern European
Vietnamese
Common Mental Illness
Pregnant Women
LGBTQIA+
Homeless

Local Stop Smoking Services and Support Grant

Financial Allocation FY 24/25:
London Borough of Hackney: £327,891 | City of London: £12,087

“Stopping the start: our new plan to create a smokefree generation” sets out the proposed actions the government will take to tackle smoking and youth vaping.

- This allocation is part of the government’s announcement to create a ‘smokefree generation’
- The previous Conservative government committed an additional ring-fenced £70 million per year (for 5 years)
- We have a combined c. £340k per annum (confirmed for 2024/25 only)

Grant Conditions

1. Ring-fenced
2. Enhance existing services/investment
3. Deliver increased number of quits

Grant Management

1. Oversight provided by City & Hackney Tobacco Control Alliance
2. Project proposals agreed and in progress

Office for Health Improvement & Disparities

Other local tobacco control initiatives

Local NHS tobacco dependency treatment (TDT) services

- Homerton Healthcare NHS Foundation Trust (acute and maternity)
- East London Foundation Trust (mental health)

Smokefree commitments

- Hackney Council
- Homerton Healthcare NHS Foundation Trust
- East London Foundation Trust
- GP Confederation

Prevention work in schools

Lessons and teacher resources on the harms of smoking and the use of nicotine vapes

Trading standards - enforcement

Dedicated Senior Trading Standards Officer (Hackney) focused on reducing supply and under-age sales of illicit tobacco, vapes and alcohol - working in close partnership with City of London Trading Standards team

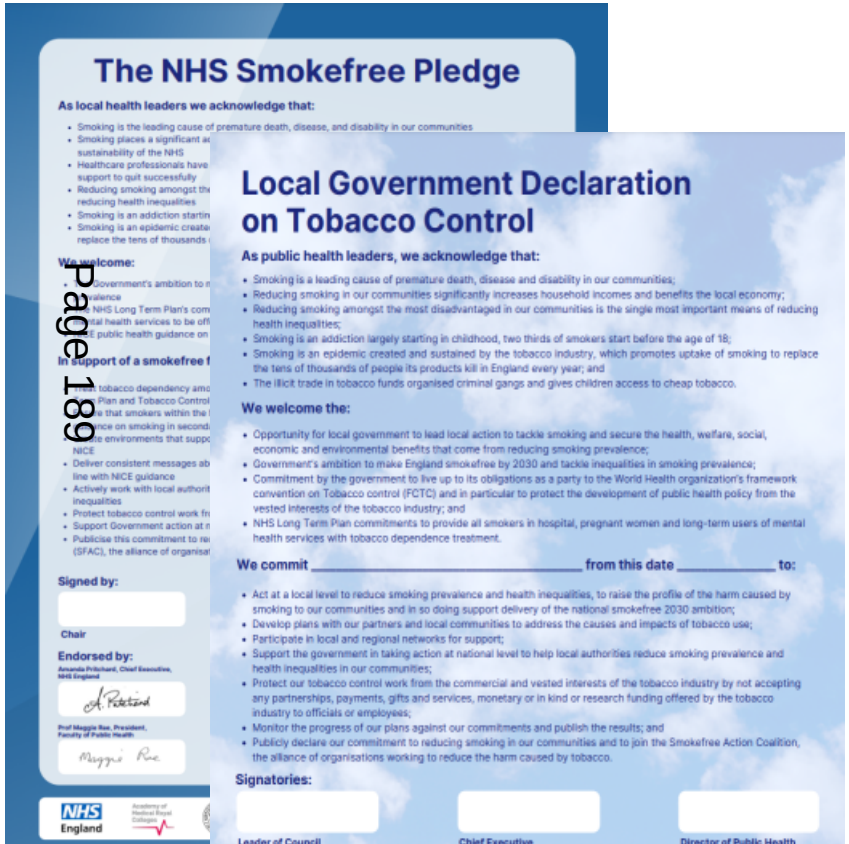
2c. Recommendations

Summary of recommendations from the needs assessment

Addressing smoking inequalities requires strong, sustained collaboration.

1. Prioritise preventing smoking (and vaping) initiation and support young smokers to quit, with focus on whole-school approaches and peer-led initiatives.
2. ‘De-normalise’ smoking through a robust tobacco control plan, advocating for smoke-free public spaces and reaffirming partnership commitments.
3. Tailor support for high-prevalence communities to quit, collaborating with relevant partner organisations to ensure a targeted approach.
4. Continue funding evidence-based community stop-smoking services, offering flexible support, harm reduction and transparent information on vaping.
5. Improve reporting of smoking status in GP records to facilitate targeted very brief advice and referrals to stop smoking services.
6. Sustain investment in enforcement to curb illicit tobacco and e-cigarette supply, preventing underage sales and associated harms.
7. Launch a coordinated campaign to address vaping misconceptions, raise awareness about illicit products and strongly discourage non-smokers and youth from taking up.
8. Implement a comprehensive local comms strategy to increase quit attempts, emphasise tobacco harms and promote all available offers of support to quit.

Declaration of our partnership commitments to tobacco control



The NHS Smokefree Pledge

As local health leaders we acknowledge that:

- Smoking is the leading cause of premature death, disease, and disability in our communities
- Smoking places a significant a… sustainability of the NHS
- Healthcare professionals have… support to quit successfully
- Reducing smoking amongst th… reducing health inequalities
- Smoking is an addiction startin…
- Smoking is an epidemic create… replace the tens of thousands …

We welcome:

- …Government's ambition to r… prevalence
- …NHS Long Term Plan's com… mental health services to be offi…
- …E public health guidance on…

In support of a smokefree f…

- …tobacco dependency amo… Plan and Tobacco Control… e that smokers within the …
- …nce on smoking in second… …e environments that suppo… NICE
- Deliver consistent messages ab… line with NICE guidance
- Actively work with local authorit… inequalities
- Protect tobacco control work fr…
- Support Government action at n…
- Publicise this commitment to re… (SFAC), the alliance of organisat…

Signed by:

Chair

Endorsed by:

Amanda Pritchard, Chief Executive, NHS England

Prof Maggie Rae, President, Faculty of Public Health

NHS England

Academy of Medical Royal Colleges

Local Government Declaration on Tobacco Control

As public health leaders, we acknowledge that:

- Smoking is a leading cause of premature death, disease and disability in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely starting in childhood, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the tens of thousands of people its products kill in England every year; and
- The illicit trade in tobacco funds organised criminal gangs and gives children access to cheap tobacco.

We welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Government's ambition to make England smokefree by 2030 and tackle inequalities in smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health organization's framework convention on Tobacco control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- NHS Long Term Plan commitments to provide all smokers in hospital, pregnant women and long-term users of mental health services with tobacco dependence treatment.

We commit _____ **from this date** _____ **to:**

- Act at a local level to reduce smoking prevalence and health inequalities, to raise the profile of the harm caused by smoking to our communities and in so doing support delivery of the national smokefree 2030 ambition;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities and to join the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories:

Leader of Council | Chief Executive | Director of Public Health

The Local Government Declaration on Tobacco Control is a statement of commitment to take comprehensive action to address the harms from smoking (signed by Hackney Council in 2014).

The NHS Smokefree Pledge similarly sets out an organisational commitment to help smokers to quit and provide smokefree environments in support of this (signed by Homerton, ELFT and GP Confederation in 2018).

<u>Recommendation</u>: Joint City and Hackney partnership commitment to reducing tobacco-related harms

- **City of London Corporation to sign up to the Local Government Declaration on Tobacco Control**
- **Homerton, ELFT, GP Confederation (now City and Hackney Integrated Primary Care CIC) to renew their commitment under the NHS Smokefree pledge**

CITY OF LONDON AND HACKNEY PHIT

Hackney

CITY OF LONDON

3. Questions for the Board

Q1. Does the Board endorse the recommendation for a joint City & Hackney partnership commitment to reduce the harms from tobacco?

Q2. How can the Health and Wellbeing Board - as a collective body and as leaders within your organisations - use its influence to implement the recommendations of the tobacco needs assessment?

Q3. How can we better align our local tobacco control plans with the implementation of the City Health & Wellbeing Strategy priorities (improving mental health, increasing social connection, supporting greater financial security)?

Thank you

For follow-up questions or support around tobacco control, please contact City and Hackney Tobacco Lead:

Connor Melia, **Senior Public Health Specialist**

London Borough of Hackney & City of London Corporation Public Health Team

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1 Hillman Street | London E8 1DY

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Committee(s): Health and Wellbeing Board	**Dated:** 13th September 2024
Subject: Annual Review of Terms of Reference for the Health and Wellbeing Board	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	3, 8, 10
Does this proposal require extra revenue and/or capital spending?	N/A
If so, how much?	
What is the source of Funding?	
Has this Funding Source been agreed with the Chamberlain's Department?	
Report of: Town Clerk	**For Decision**

Summary

This report concerns the annual review the Terms of Reference of the Health and Wellbeing Board, to provide time for considering and discussion of any changes before they are submitted to the Policy & Resources Committee, in time for the annual reappointment of Committees by the Court of Common Council. Therefore, this report is initially being brought before the Board at its September meeting to allow time for proposed changes to be considered and developed at subsequent meetings.

The Terms of Reference for the Health and Wellbeing Board are attached at Appendix 1.

Recommendations

It is recommended that Members consider any changes to the Board's Terms of Reference (set out at Appendix 1).

Main Report

1. The current Terms of Reference, as approved by the Court of Common Council in April 2024, are listed at Appendix 1.

2. There have been no suggestions for changes in the interim to be considered by the Board since its last Annual Review.

3. Following consideration of any changes to the Board's Terms of Reference, the Terms of Reference shall be received by the Board at a future meeting, to be

approved for onward submission to the Policy & Resources Committee, and subsequently the Court of Common Council.

Appendices

- Appendix 1 – Court Order 2024/25 – Health and Wellbeing Board

Rhys Campbell
Governance Officer
E: rhys.campbell@cityoflondon.gov.uk

Appendix 1

HEALTH AND WELLBEING BOARD
Terms of Reference

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

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

3. **Membership 2024/25**

5 (3) Mary Durcan

2 (2) Randall Anderson, Deputy

1 (1) Ceri Wilkins

Together with the Members referred to in paragraph 1 above.

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

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

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

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

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

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

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

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

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

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

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

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

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