Public Document Pack

Health and Wellbeing Board

Date: **FRIDAY, 9 MAY 2025**

Time: 11.00 am

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

Members:

Gail Beer, Healthwatch
Matthew Bell, Policy and Resources Committee
Dr. Stephanie Coughlin, Homerton Healthcare NHS Foundation Trust (External Member)
Simon Cribbens, Safer City Partnership
David Curran, St Bartholomew's Hospital (External Member)
Deputy Helen Fentimen OBE JP, Court of Common Council
Deputy Marianne Fredericks, Port Health and Environmental Services Committee
Judith Finlay, Executive Director, Community and Children's Services
Jed Francique, Borough Director for City & Hackney, ELFT (External Member)
Sarah Gillinson, Court of Common Council
Dr. Sandra Husbands, Director of Public Health
Gavin Stedman, Port Health and Public Protection Director
Tony de Wilde, City of London Police
Deputy Ceri Wilkins, Court of Common Council
Amy Wilkinson, City and Hackney Place Based Partnership and North East London Integrated Care Board

Enquiries: **Callum Southern**
Callum.Southern@cityoflondon.gov.uk

Accessing the virtual public meeting

Members of the public can observe all virtual public meetings of the City of London Corporation by following the below link:
https://www.youtube.com/@CityofLondonCorporation/streams

A recording of the public meeting will be available via the above link following the end of the public meeting for up to one civic year. Please note: Online meeting recordings do not constitute the formal minutes of the meeting; minutes are written and are available on the City of London Corporation's website. Recordings may be edited, at the discretion of the proper officer, to remove any inappropriate material.

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. **ORDER OF COURT OF COMMON COUNCIL**

To receive the Order of the Court of Common Council dated 25 April 2025.

For Information
(Pages 5 - 6)

4. **ELECTION OF CHAIRMAN**

To elect a Chairman in accordance with Standing Order 28.

For Decision

5. **ELECTION OF DEPUTY CHAIRMAN**

To elect a Deputy Chairman in accordance with Standing Order 29.

For Decision

6. **MINUTES**

To agree the minutes of the previous meeting.

For Decision
(Pages 7 - 16)

7. **BETTER CARE FUND PLAN 2025/26**

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

For Decision
(Pages 17 - 76)

8. **BETTER CARE FUND 2024/25 Q3 RETURN**

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

For Decision

(Pages 77 - 98)

9. **HEALTH IMPACTS OF VAPING**

Report of the City and Hackney Director of Public Health.

For Information
(Pages 99 - 152)

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

Report of Healthwatch, City of London.

For Information
(Pages 153 - 256)

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

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

13. **EXCLUSION OF PUBLIC**

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

For Decision

Part 2 - Non-Public Reports

14. **SEXUAL HEALTH SERVICES IN THE CITY OF LONDON**

Report of the Director of Public Health.

For Information
(Pages 257 - 280)

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

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

KING, Mayor	**RESOLVED:** That the Court of Common Council holden in the Guildhall of the City of London on Friday 25th April 2025, doth hereby appoint the following Committee until the first meeting of the Court in April, 2026.

HEALTH & WELLBEING BOARD

1. **Constitution**
A Non-Ward Committee consisting of,
- three Members elected by the Court of Common Council (who shall not be members of the Health and Social Care Scrutiny Sub-Committee)
- the Chairman of the Policy and Resources Committee (or his/her representative)
- the Chairman of Community and Children's Services Committee (or his/her representative)
- the Chairman of the Port Health & Environmental Services Committee (or his/her representative)
- the Director of Public Health or his/her representative
- the Director of the Community and Children's Services Department
- a representative of Healthwatch appointed by that agency
- 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 2025/26**

1 (1) Sarah Gilliinson *for one year*

1 (1) Helen Fentimen OBE, Deputy *for two years*

2 (2) Ceri Edith Wilkins, Deputy

Together with the Members referred to in paragraph 1 above.

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

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

a) carrying out all duties* conferred by the:- Health and Social Care Act 2012, 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.

HEALTH AND WELLBEING BOARD

Friday, 7 February 2025

Minutes of the meeting of the Health and Wellbeing Board held at Committee Rooms - 2nd Floor West Wing, Guildhall on Friday, 7 February 2025 at 11.00 am

Present

Members:

Mary Durcan (Chairman)
Helen Fentimen OBE JP (Deputy Chairman)
Gail Beer
Deputy Marianne Fredericks
Dr Sandra Husbands
Gavin Stedman
Deputy Randall Anderson
Matthew Bell
Judith Finlay
Deputy Ceri Wilkins
Dr Stephanie Coughlin

In Attendance

Ike Kanya – Public Health Project Manager, Hackney Council

Officers:

Ellie Ward	-	Community and Children's Services
Froeks Kamminga	-	Community and Children's Services
Sarah Lawson	-	Community and Children's Services
Swati Vyas	-	Community and Children's Services
Hannah Dobbin	-	Community and Children's Services
Shetal Parmar	-	Bart's Health NHS Trust
Sarah Latham	-	Homerton Healthcare NHS Foundation Trust
Carolyn Sharpe	-	City and Hackney
Ratidzo Chinyuku	-	City and Hackney
Preet Desai	-	Town Clerk's Department
Rhys Campbell	-	Town Clerk's Department
Deborah Bell	-	Strategic Education & Skills Director
Emmanuel Ross	-	City and Hackney

1. **APOLOGIES FOR ABSENCE**

There were no apologies.

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 15 November 2024 were approved as a correct record.

4. **HEALTH AND WELLBEING BOARD DEVELOPMENT**

The Board received a joint report of The Executive Director of Community and Children's Services and the Director of Public Health in respect of the proposed way forward for the development of the City of London Health and Wellbeing Board.

Officers advised the Board that work had been undertaken in coordination with the Local Government Assembly (LGA) and the Health and Wellbeing Board would focus more closely on addressing health inequalities, improving health and wellbeing of the local population, improving mental health, improving financial resilience and tackling social isolation. It was identified that these issues required a partnership approach rather than a single-agency approach.

Although there was a clear co-relationship with the Health and Social Care Scrutiny Committee and its role being to scrutinize health and social care services, the Board was reminded that its role as a partnership was to tackle health inequalities and improving health and wellbeing.

The Deputy Chair wanted officers to provide clarity on links between the Health and Wellbeing Board from the Health and Social Care Scrutiny Committee and how the Health and All policies would be implemented. Officers advised that they would assess these policies and update the Board at a future meeting.

A Member highlighted to the Board that the functions of the Board remained an integral part of the Corporate Strategy as well as community strategies. She encouraged more City of London Boards and Committees to be aware of the Board's work to help deliver its objectives. The Executive Director, Community and Children's Services agreed with this and advised that within some committee reports a health and wellbeing section existed and it was here that the work of the Health and Wellbeing Board could be included.

RESOLVED, that – Members approved the proposed way forward for the Board.

5. **ANNUAL REVIEW OF THE HEALTH AND WELLBEING BOARD'S TERMS OF REFERENCE**

The Board received a report of the Town Clerk in respect of the Annual Review of the Health and Wellbeing Board's Terms of Reference.

The Deputy Chair believed that there should be more consideration from the Board on how to become more open and inclusive to members of the public. More public engagement was recommended and the Board discussed how best

to do this such as allowing members of the public to attend meetings and put forward questions in advance. A Member agreed and asked if it was possible to have two informal meetings of the Health and Wellbeing Board where members of the public and stakeholders could attend with the view that this would help feed it relevant work streams.

A recommendation was also made which would involve moving the venue of a Health and Wellbeing Board meeting to an area where the Board may be able to engage with service users on an informal basis. The Executive Director acknowledged that she had seen this work well in other areas but given the size of the City population and the existence of City Question Time, she advocated a 'subset' of City Question Time to focus on specific issues relating to the work of the Board. The Chair agreed that these ideas could be implemented to facilitate public engagement, and it was agreed that authority would be delegated to the Town Clerk, in consultation with the Chair and Deputy Chair, to approve these recommendations.

RESOLVED, that – Members agreed to delegate authority to the Town Clerk, in consultation with the Chair and Deputy Chair of the Health and Wellbeing Board, to incorporate these changes regarding public engagement into the Board's Terms of Reference.

6. **ANNUAL DIRECTOR OF PUBLIC HEALTH REPORT**

The Board received a report of the Director of Public Health in respect of the Annual Director of Public Health Report.

Officers asked the Board to consider ways in which the recommendations listed within the report could be implemented across the partnership and suggestions of potential stakeholders who'd consider getting involved in the subject matter 'Health Weight'. The Board was reminded of Social Capital and its relationship with health and the data within the report highlighted there was a strong foundation to build on in City and Hackney. The report recommended an evaluation of community engagement, open spaces and the supporting of the voluntary and community sector.

A focus on healthy weight was expected in the next report submitted to Board since it was a priority at both the local and national level. Locally, a needs assessment had been published which highlighted the scale of obesity across the City and Hackney with two in five children leaving school above a healthy weight. Officers intended to create a whole system's approach with a particular focus on food environment, as well a whole life approach from pre-conception into older age.

A Member asked for further details regarding the Community Infrastructure Levy Neighbourhood Fund (CILNF) and its application process. Officers advised that the City Corporation could not access the fund directly but instead would be able to work with the community and voluntary sector to enable them to make the best use of the CILNF. Work with Hackney Council on a project named CVS Squared had already been conducted which sought to identify projects conducted by

voluntary sector organisations within the City. A Member, having worked with CVS squared, informed the Board that he had assisted in securing three spaces allocated for voluntary work, with help from livery companies and local organisations, and given that the voluntary sector was seeking more spaces to conduct their work he wondered if the Board could provide a single space which could be used for voluntary sector work purposes. Officers advised that the City Corporation would need to determine what type of space could be made available but agreed to investigate further. However, officers did suggest pop up spaces in different parts of the City as a potential idea. Members were aware of several planning applications in community spaces and believed that planning developers could be approached to provide such a space and work could be done with developers to advise them of local voluntary groups and to encourage the need for voluntary workspaces when submitting a planning application.

A Member advised the Board that there were livery companies which could be approached who would assist in offering spaces and agreed to share further information with DCCS. It was suggested that the Chair of the Livery Committee should be contacted also.

On the issue of open space, a Member highlighted to the Board that the Planning and Transportation Committee were delivering roof gardens and pocket parks and identified the need to maximise what space was available to help improve health and wellbeing in the City and Hackney. Officers advised that when community-led needs assessments are undertaken, communities would be questioned on how they would like to use the space.

The Deputy Chair asked officers to take responsibility for coordinating an action plan and reporting back to the Board. The Director of Public Health agreed to take responsibility of an action plan arising from the Social Capital report but not for mapping out all community spaces, however it was agreed that the latter would require more time and identifying voluntary sector groups seeking space within the City should be prioritised which DCCS agreed to undertake.

The Director of Public Health thanked Delani Harath and Tony Blisset for their work undertaken on this report.

RESOLVED, that – the report and its contents be noted.

7. NEL MATERNITY & NEONATAL DEMAND AND CAPACITY

The Board received a joint report of the Associate Director of Midwifery Newham University Hospital and Director of Midwifery & Lead for Neonatal Nursing, Homerton Healthcare NHS Foundation Trust in respect of the Northeast London (NEL) Maternity & Neonatal Demand & Capacity Case for Change.

Members were advised that report sought to increase pathways within services across the Northeast London sector, most notably preconception, and this involved education for women and families prior to pregnancy to encourage conversations surrounding health outcomes for BAME women and the inequalities which existed across local authorities. It was identified that the local

population around East London had varying complexities and this was increasing year on year, particularly in Northeast London there were a large amount of mothers with diabetes and cardiovascular issues. Pathways were being used to support these women and understand their health inequalities, and work was being done to ensure that the delivery of healthcare services could be understood in a variety of languages. The Maternity Women Voice Partnership Lead assisted with this in terms of feedback from women to ensure services were continuously improved.

A trend was identified in which poorer outcomes existed for BAME women and the NEL Trust would provide them with personalised care plans pertinent to their health which aimed to support these women through their pregnancy. Educational classes for all women were also being held. Officers informed the Board that there had been a rise in the percentage of induced labours within London which consequently caused caesarean section rates to increase which added to the complexities and recovery period for women.

The Deputy Chair highlighted the lack of mentioning of fathers and birthing partners within the report and asked officers to provide further information on this. Officers noted this comment and advised the Board that all fathers and birthing partners were welcome to educational learning sessions and participate at workshops.

A discussion about digital platforms was held and officers informed the Board that the development of a digital platform for mothers and birthing partners was being considered.

RESOLVED, that – the report and its contents be noted.

8. **PUBLIC HEALTH CONTRACTS**

The Board received a report of the Director of Public Health for the City and Hackney in respect of the use of the City of London ring-fenced public health grant and the current arrangements under the present combined Service Level Agreement (SLA) between the City of London Corporation (the City Corporation) and the London Borough of Hackney (LBH).

The Director of Public Health provided an update on public health contracts, explaining the allocation of funds in City and Hackney and the impact of reductions on services such as the Falls Clinic and the Mental Health Wellbeing Network. During the discussion Members were informed that at the time of writing the grant allocation for 2025/26 had been announced and an uplift of £127,000 was confirmed. It was identified that there were potential savings from the Hackney grant which were being redistributed to other areas of the council in relation to health and policies work.

Regarding the continuation of the Falls Clinic, the Director explained to the Board that negotiations with the service provider had taken place and they would be no longer able to continue the service if their funding was reduced but options for alternative funding, as an interim measure, were being sought whilst the falls

pathway review was being conducted. It was confirmed that the service would continue until the end of March 2025 but additional funding would need to be secured to maintain the service beyond this date.

In respect of the Mental Wellbeing Network, the Board were advised that the reduction in funding for the network would primarily affect therapy services, and request for the NHS to take further responsibility. The supportive social elements of the network would continue and access to all available programmes for City residents would still be available. The Chair asked if there were any other areas in which the NHS should be providing funding and the Director explained that whilst not all were a result of a legacy of transfer from the NHS in 2013/14, such as the falls clinic, the network did not fall into this category and services in NEL were not providing funding for services which the NHS were responsible for. A Member acknowledged that large cuts to therapy services in the NHS had occurred and if there was no funding secured then there would be no therapy services, however the Director explained that the conditions of the public health grant would not allow for funding of services which were the responsibility of the NHS and not City and Hackney. The Deputy Chair raised a concern regarding overall mental health services and its source funding, and advised that further work regarding mental health needed to be undertaken which included businesses contribution in supporting their employees' mental health.

A concern was raised regarding ELFT and if any assistance could be provided however the Director explained that funding remained the outstanding issue and mental health wellbeing was not adequately funded despite the increase in mental health issues, and the service hadn't been expanded to meet this need. However, improvements within the current envelope could be sought.

RESOLVED, that – the report and its contents be noted.

9. **CITY AND HACKNEY IMMUNISATIONS STRATEGIC ACTION PLAN (2024-2027)**

The Board received a report of the Director of Public Health in respect of City and Hackney Immunisations Strategic Action Plan (2024-2027).

Officers advised the Board of their concern of declining trend in immunisation coverage nationally and locally and had developed a strategic action plan to improve immunisation coverage across all populations with a focus on reducing inequalities in populations that were expected to have lower uptake. The strategic objectives of this plan were to reach high-risk groups with vaccinations in community spaces, co-create resources and campaigns with local communities using better data to plan and deliver services, making sure services were efficient and evidence-based and training staff to ensure that at every interaction there was an opportunity to promote vaccinations. The lack of granular level of data and the uncertainty regarding devolved commissioning arrangements for immunisations, as well as funding, were identified as a potential risks to this plan.

Members were made aware that the Covid and Flu data had not gone through to the Neaman Practice or Richmond Road so it appeared that there was a lower

rate of Covid and Flu immunisations since many individuals were vaccinated outside of Richmond Road. Better advertisements of viruses were encouraged as well as ensuring that NHS staff delivering healthcare were well informed about the importance of vaccinations.

RESOLVED, that – the report and its contents be noted.

10. **ANNUAL REPORT ON IMPLEMENTATION OF THE CITY & HACKNEY SEXUAL AND REPRODUCTIVE HEALTH STRATEGY AND ACTION PLAN**

The Board received a report of the Director of Public Health in respect of the annual update on implementation of the City and Hackney Sexual and Reproductive Health strategy adopted by the board in February 2024.

Officers advised that an easy-read version of the strategy was to me made available to the public after review and this was presented this to the Board for further feedback. The overarching initiatives had been a communications campaign and there had been substantial efforts made in regards to men's sexual health, in particularly heterosexual men's sexual health, and a positive sex campaign had been instigated to identify areas of engagement such as beer mats and posters that could be distributed to pubs, bars and places of sport.

Delivery plans were drafted in response to the action plan and engagement with young people had been listed as an area of focus. Officers advised the Board that Health Spot had opened in September 2024 and there was clinic available for young people and engagement with neighbourhood programmes had also taken place. Self-referral for long-term contraception was available in some places and work with the Super Youth Hub in relation to the condom distribution scheme had continued. Regarding HIV, the participation of an opt out HIV testing in health checks within City and Hackney practices had taken place. A toolkit had been prepared which could be shared with other practices to increase the offer of HIV testing in their own local authorities.

Officers highlighted the work of Healthwatch and Hackney with steps users, formerly rough sleepers, in which they were asking for their priorities in relation to healthcare priorities and their preferred method of communication.

RESOLVED, that – the report and its contents be noted.

11. **THE SEND NEEDS ASSESSMENT AND THE SEND AND ALTERNATIVE PROVISION STRATEGY**

The Board received a Joint Report of The Director of Community and Children's Services and The Director of Public Health in respect of key findings and recommendations of the City and Hackney Health Needs Assessment (HNA) for Children and Young People with SEND 2024, and the SEND and Alternative Provision Strategy 2025-29 for information.

In relation to key findings and recommendations of the City and Hackney Health Needs Assessment (HNA) officers highlighted to the Board that in addition to data and qualitative insights key areas of recommendations had been noted such as communication information and advice diagnosis early intervention, access to services, addressing inequalities, data and records and social determinants of health.

In respect of the SEND and Alternative Provision Strategy 2025-29, an easy-read version had been produced along with an action plan, equality impact assessment and a summary of engagement and consultation.

RESOLVED, that – the report and its contents be noted.

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

The Board received a report of Healthwatch, City of London in respect of the Healthwatch City of London Progress Report.

The Chair, Healthwatch highlighted the Digi Apps report which was being launched imminently and that NHS healthcare apps used within the City were being reviewed and officers were concerned about digital exclusion and recommended that further investigation, particularly across Northeast London, into how digital apps could be more accessible and user-friendly should be considered.

RESOLVED, that – the report and its contents be noted.

13. **FINALISED CITY OF LONDON AIR QUALITY STRATEGY 2025-2030**

The Board received a report of the Executive Director, Environment in respect of the Finalised City of London Air Quality Strategy 2025-2030.

RESOLVED, that – the report and its contents be noted.

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

There were no questions.

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

The Chair thanked officers and Members of the Board for all their work in support of the Health and Wellbeing Board.

Members of the Board thanked the Chair for her work undertaken as Chair of the Health and Wellbeing Board.

16. **EXCLUSION OF PUBLIC**

17. **NON PUBLIC MINUTES**

RESOLVED, that – the non- public minutes of the previous meeting held on 15 November 2024 were approved as a correct record.

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

There were no non-public questions.

19. **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 urgent items of business.

The meeting ended at 12.50 pm

Chairman

Contact Officer: Emmanuel.Ross@cityoflondon.gov.uk - Agenda Planning
rhys.campbell@cityoflondon.gov.uk - Governance Officer/Clerk to the Board

This page is intentionally left blank

City of London Corporation Committee Report

Committee: Health and Wellbeing Board	**Dated:** 09/05/2025
Subject: Better Care Fund Plan 2025 / 26	**Public report:** For Decision
This proposal: • **delivers Corporate Plan 2024-29 outcomes** • **provides statutory duties**	Delivering excellent services
Does this proposal require extra revenue and/or capital spending?	No
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 of Community and Children's Services	
Report author: Ellie Ward, Head of Strategy and Performance	

Summary

The Better Care Fund (BCF) programme supports local systems to deliver the integration of health and social care in a way that supports person centred care, sustainability and better outcomes for people and carers. The Fund is based on a pooled budget of funding from Integrated Care Boards (ICBs) and local authorities. Local systems are required to produce plans for the BCF which have to be signed off by local Health and Wellbeing Boards.

The plans are governed by a policy framework and requirements set out by the Department of Health and Social Care (DHSC). The latest requirements are for plans for 2025/26 and these were submitted on 31 March 2025. 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 2025/26

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. City of London Corporation plans were submitted to DHSC on 31 March 2025 as per the requirements. All plans must be approved by the local Health and Wellbeing Board (HWB).

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

Current Position

6. For 2025/26, the pooled budget is £1,505,755 consisting of an NHS contribution of £960,444 and a City of London Corporation (City Corporation) contribution of £445,311 as required. The City Corporation does not put in any additional funds but this year, an underspend on Improved Better Care Fund (iBCF) has been included as a carry forward and this has been recorded as an additional contribution in the summary table in Appendix 2.

7. A range of schemes are funded through the BCF, as set out in Appendix 2. Of the pooled budget for 2025/26, £374,076 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 £179,544 required.

8. The City of London schemes in the 2025/26 plan remain broadly the same as the previous year.

9. Proposed plans are attached as Appendices 1 and 2 and include a narrative plan, which is a joint local system plan for the City Corporation. A City Corporation template for 2025/26 is also included with details of income, expenditure and schemes.

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

11. The Health and Wellbeing Board is asked to approve the revised plans for 2025/26 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 other than any carried forward underspend.

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

Resource implications

None

Legal implications

None

Risk implications

None

Equalities implications

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

Climate implications

None

Security implications

None

Conclusion

12. The Health and Wellbeing Board is asked to approve revised BCF plans for 2025/26.

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

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

Appendices

- Appendix 1 – BCF Narrative Plan for City of London Corporation
- Appendix 2 – City Corporation template for 2025/26

Ellie Ward
Head of Strategy and Performance

T: 020 7332 1535
E: ellie.ward@cityoflondon.gov.uk

Better Care Fund 2025-26
Narrative plan

	HWB area 1
HWB	City of London
ICB	North East London ICB

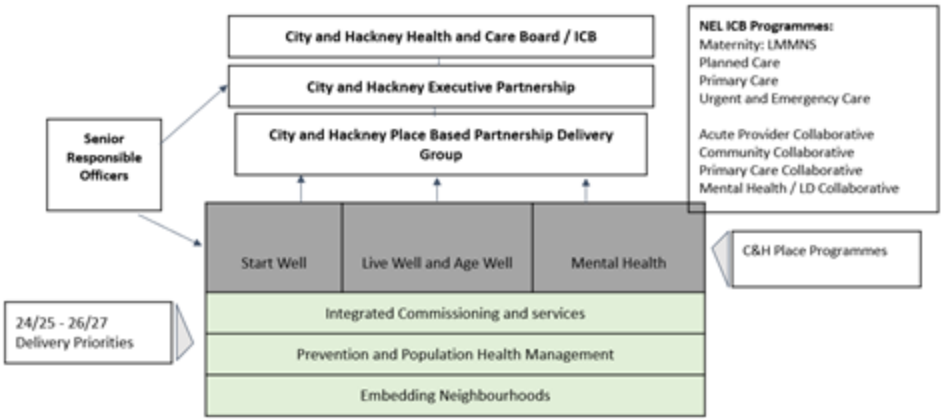
Contents

Overview

- Priorities for 2025-26
- Key changes since previous BCF plan
- Approaches to the development of the plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Alignment with plans for improving flow in urgent and emergency care services
- Priorities for developing for intermediate care (and other short-term care).

System Structures: BCF within a larger context

- BCF plans don't sit in a vacuum outside of the wider plans and targets for improving NHS services and adult social care services.
- 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.
- City & Hackney Place-based Partnership is in the process of developing its 2025-27 Integrated Delivery Plan. This includes three programmes working to deliver on three priorities. BCF services sit within the Live Well and Age Well programme. The strategic focus area for this programme is 'Preventing and Improving outcomes for people with long term health and care needs'.



High Level Priorities for 2025-26

Area	Aim	Activities

Falls pathway review & revision	Prevention and management of falls to support individuals to maintain independence.	• Coordination of a partnership group to undertake a review of the falls pathway:
		  ◦ Reassess need – JSNA
		  ◦ Review current provision and consider how best to meet local needs (and respond to national policy & guidance)

Disabled Facilities Grant	Make most effective use of DFG funding	• Work with new Home Improvement Agency • Implement new Housing Assistance Policy to support those who wouldn't qualify for a DFG
Brokerage	Efficient and effective spot purchases of residential and nursing home placements	• Implementation of new brokerage processes and monitoring
Neighbourhood Working	Further development of our Neighbourhoods Programme and integrated neighbourhood teams.	• See slides further in presentation

High Level Priorities for 2025-26

Area	Aim	Activities
Development of the Transfer of Care Hub	To improve clarity, efficiency, and accountability in management of discharges, thereby reducing the time patients remain in hospital past their discharge ready date.	• Develop the hub from a focus on out of borough Trusts to fully include Homerton patients within a single referral pathway. • Collaboration between adult social care, acute and community teams to agree structures, roles, and responsibilities, including senior / joint oversight. This includes developing clarity on roles and responsibilities between the teams that feed into the hub and the core hub members. • Consideration of optimal location for hub team physical location for co-location (City staff wouldn't co-locate but interface with staff). • Establish accurate data collection and reporting (data dashboard) to support visibility of flow, reasons for delays & management of performance.

Key changes since previous BCF plan

Area of Change	Change made
Discharge Support	Additional Occupational Therapy Resource
Carers	New Carers Support Service mainstreamed (was previously a pilot) and funded for 3 years

A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process

- Senior officers at the Corporation, London Borough of Hackney and NHS NEL take the lead developing and monitoring our narrative, financial and capacity and demand plans.
- The NEL BCF lead also chairs our Homeless Health Partnership group.
- There is a bi-monthly Homerton Hospital Discharge Group which is comprised of system partners, including service users and carers, Healthwatch and Age UK, in addition to statutory partners in ASC, health, and homeless prevention. This group monitors any challenges within discharge pathways, and reviews progress against the NHS Discharge Policy and related BCF Metrics.
- Draft BCF plans have been taken to the City and Hackney Executive Partnership Board and the City and Hackney Health and Care Board for discussion.
- City of London specific governance includes the Integration Programme Board which consists of relevant City of London Officers and invites relevant system partners to discuss specific system and integration initiatives to explore the specific City context and position
- DFG in the City of London Corporation is governed through the Adult Senior Management Team and reported to Health and Wellbeing Board through quarterly BCF monitoring

Alignment with plans for improving flow in urgent and emergency care services - draft NEL ICB UEC Objectives

Objective	What does this mean / what will we do?
Prioritising alternative pathways through out of hospital care and alternative Care Offers	Delivering on operating plan demand management and access to urgent care outside of hospital priorities. • Improving same day access care (extended GP services, 111, Single point of access, pharmacy) • Working with social care and place promote A&E alternative pathways, including virtual wards
Proactive population health management to keep people well in community including digital and AI innovation	Delivering on operating plan performance priorities (waiting times) and discharge to assess principles. • Improving productivity and quality from front door to discharge • Agreed priorities for UTC, acute frailty, long waits in ED, discharge delays, system escalations, data and clinical leadership
Optimising flow and discharge through hospital & Mental Health	Delivering on operating plan care outside of hospital priorities, working collaboratively and addressing inequalities. • Engagement in the population health programme to analyse demand, improving our understand of current capacity positions against future needs and facilitate appropriate risk stratifications through local programmes • Increase the use of established community based urgent care services including urgent community response (looking to drive productivity, reduce variation) • Continue to build on AI and Digital innovation as part of our core offer including promotion of NHS App. • Tailored projects/interventions for children, mental health, people with learning disabilities and complex needs.
Improve performance, productivity quality and safety of services	Delivering on operating plan performance priorities (A&E and ambulance), improving productivity and quality. • Use of data across the system to improve understanding, leverage change and inform decisions • Contract and pathway review, standardising care, agreeing core offers and implementing best practice • Support the delivery of financial plan through transformation system

Alignment with plans for improving flow in urgent and emergency care services – Place plans

Our UEC plans are about maximising integrated care within the community through many of the services that are funded by the BCF. We want to increase accessibility and optimise our use of non-emergency department urgent care so patients access care at home/in the community. This will support in clearing ED's for emergency patients and enable better use of London Ambulance Services.

1. **Develop and embed virtual wards – exploring opportunity for increased capacity & capability through**
    - Introduction of technology and diagnostics
    - Collaboration with Community services, VSO and other neighbourhood assets
    - Integration with emerging SPOA to maximise utilisation

Develop robust integrated urgent care pathway for C&H –

- Review current provision across 24/7
- Collaborate with partners to identify opportunity for improvements – for patient and system
- Align & respond to related work at NEL
- 111 reprocurement
- SDA – fuller
- LiS review

3. **Agree local model / approach for delivering Single Point of Access**
    - Work with acute and community partners to consider scope and opportunity
    - Develop short / medium / long term options for making improvements & meeting requirements
    - Align / respond to NEL programme on this
4. **Development of the transfer of care hub as outlined earlier.**

Priorities for developing for intermediate care (and other short-term care)

- We are exploring development of a Multidisciplinary Meeting to include colleagues from Tower Hamlets Practices where City of London patients are registered. This allows us to have a full range view of all City of London residents and identify any complex cases that may require an integrated approach. This would include looking at discharge cases and the provision of intermediate care services.
- Short term care is provided through our rapid response service which is funded through BCF. This provides care for up to 72 hours to facilitate Discharge to Assess but also acts as an admission avoidance scheme.
- Where someone has an existing package of care, we can scale this up as required. We can also spot purchase a care home bed as required to provide intermediate care. We are currently monitoring the demand for intermediate care to identify if some block booking would be beneficial over the winter months in the future.

11

National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness to prevention; and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a “home first” approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money

- Core BCF schemes are monitored by commissioners to demonstrate value for money and are modified based on learning.
- Many health schemes take a secondary prevention approach.
- Review of local learning and best practice has lead to planned changes for the use of the Disabled Facilities Grant (further details in a following slide).

Developments of the Transfer of Care hub is based on best practice, NEL ICS and placed-based learning. Through effective planning and linking to our community services, we should see a reduction in re-admissions supporting a shift to care at home.

- Our Neighbourhoods Programme has evolved annually through local learning and review of national best practice. It works closely with our statutory services, the voluntary sector and local residents to take a population health management approach. The programme will support a shift from sickness to prevention and hospital to home (more detail in slides below as it is a significant focus for change).

Neighbourhoods Programme: Integrated Neighbourhood Teams

NEL Vision for INTs

Everyone in north east London lives in a neighbourhood which supports and actively contributes to their physical and mental health and wellbeing

As partners across the system we will work closely together in local neighbourhoods. This means **creating an environment in which a range of assets, facilities and services are available to enable local people to start, live and age well and healthily.**

Our Vision

Based in and for local geographic communities

Coordinated and joined up

Strengths based – building on the assets of the individual, family and the local community

A culture of prevention in all interactions

Use the hyper local footprint to address local need

Targeting and seeking to reduce health inequalities

Our Approach

Use data to target our resources on those in most need

Build on existing integration work

Co-produce with communities

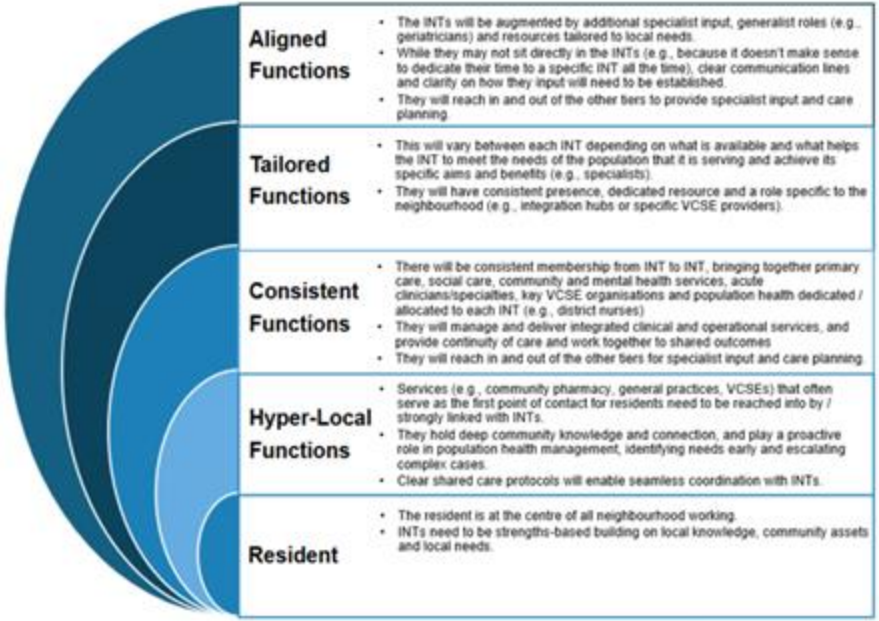
Recognise that this is a cultural change that will require new ways of working

This vision can be summarised into four strategic goals and desired outputs

Goal	Desired outputs
Work with and for local communities	1. Care delivery in a community settings wherever possible 2. Enable individuals and families to take greater agency over their health and wellbeing 3. Work effectively with local communities to co-produce solutions to the health and wellbeing issues which matter to them 4. Work in a strengths-based approach to build capacity in individuals, families and communities, enabling resilience 5. Leverage local assets, including community networks and partners, to support holistic wellbeing
Work in a proactive, preventative way to address rising need	1. Use data to identify and target resources for individuals and groups at the highest risk of health decline / deterioration 2. Prioritise early intervention, preventative and proactive care to address health needs before they escalate
Deliver integrated, accessible care	1. Neighbourhood to provide timely and coordinated interventions 2. Promote continuity of care for individuals with long term or complex needs 3. More targeted support for families and the highest users of services 4. Deliver care aligned with the Good Care Framework, ensuring services are trustworthy, accessible, competent and person centred
Support service sustainability	1. Consider aligned financial incentives to support the quality and financial sustainability of core services ensuring the most effective role for general practice at the heart of neighbourhood services 2. Address current and future workforce pressures through workforce and care pathway transformation

Developing a core team

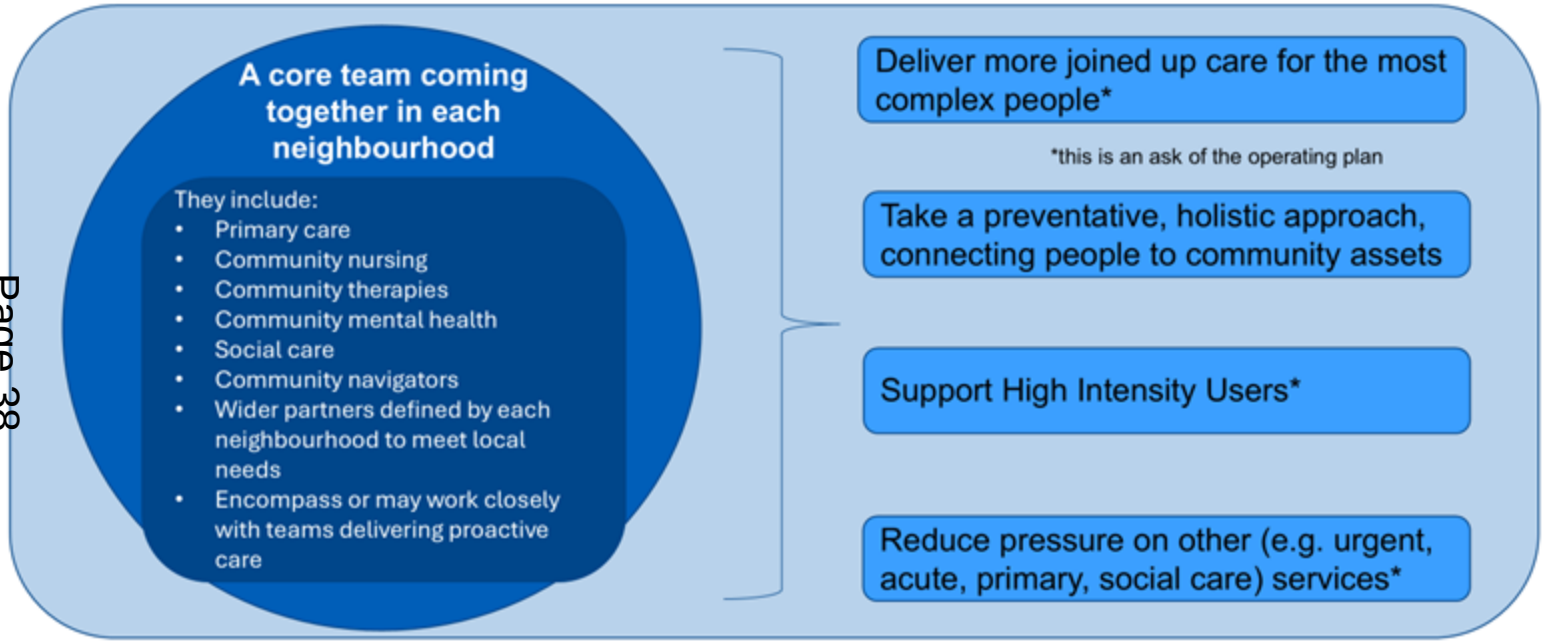
There will be a level of consistency across the core team, however, we will see variation in how the neighbourhoods connect to their communities and meet specific population health needs



Taken from the London Target Operating Model, but applies to our system approach

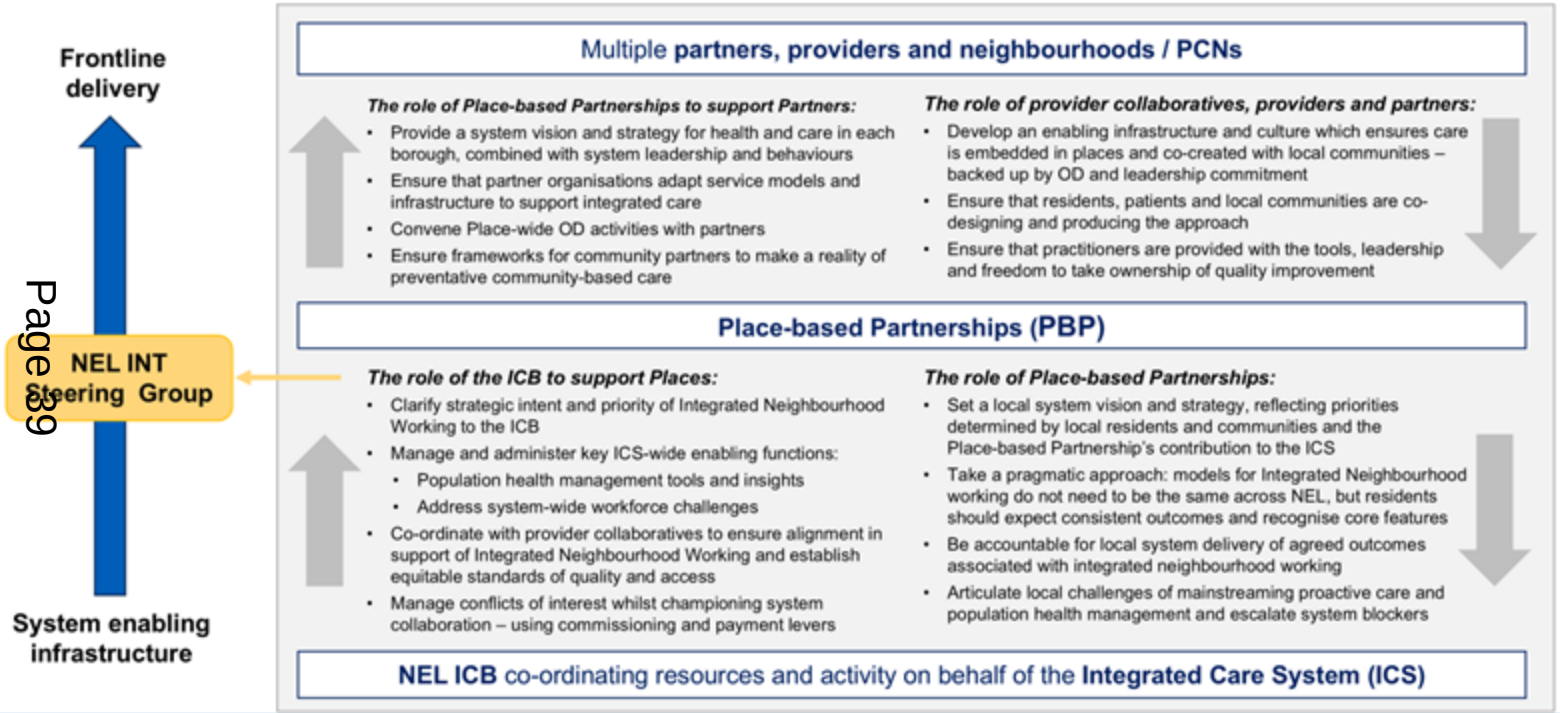
Developing a core team

Each neighbourhood will implement a core team coordinating care for high intensity users with rising needs – the team will be strongly rooted in its neighbourhood and will be well connected to local communities and community assets, It will take a PHM approach.



Places will lead delivery of neighbourhoods, enabled by system wide actions

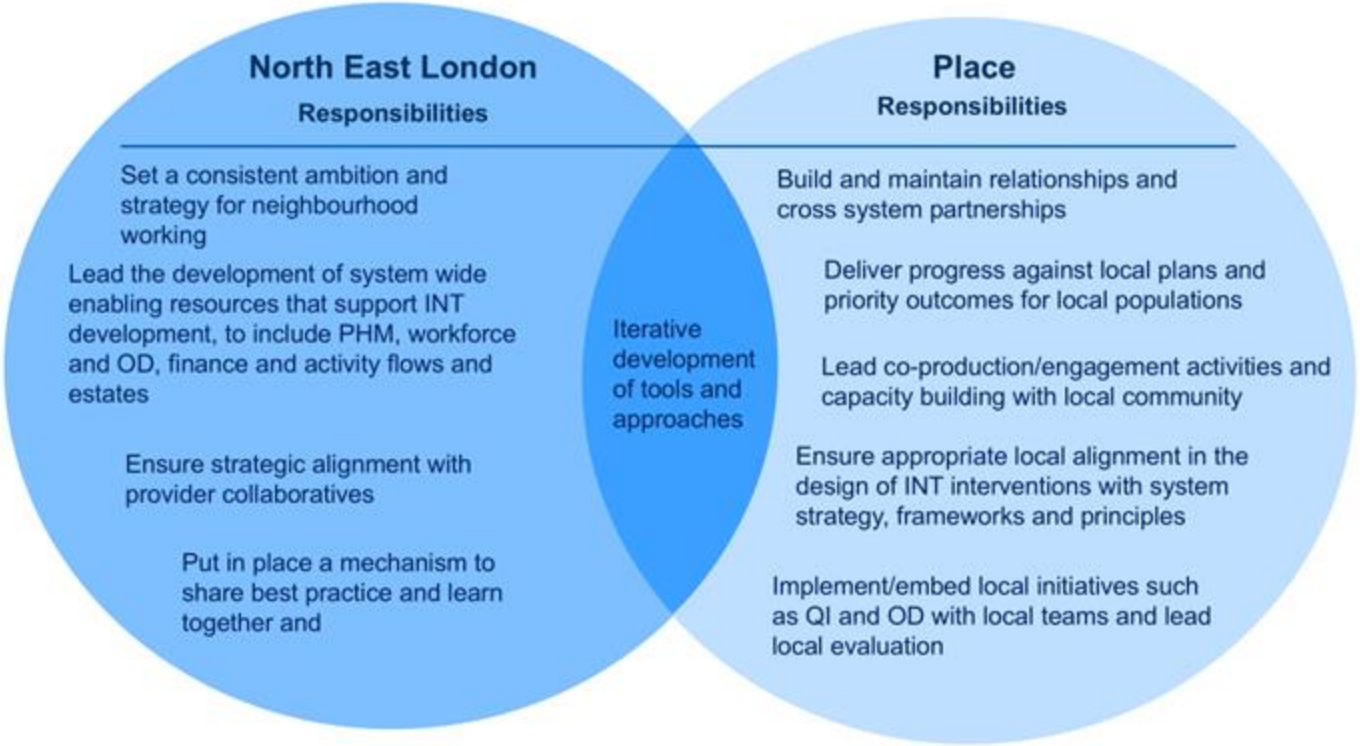
How do different elements of the system support each other to deliver integrated neighbourhood working?



There will be a number of system enablers to support delivery of our vision

Enabler	What will this enable / problem it will solve	Action Required Now	System Role NEL or Place
Co-production and engagement	• Consistent framework or enabling structure for co-production and engagement while allowing flexibility for local innovation where communities and stakeholders are active partners in INT delivery and design.	• Consolidate and provide resources on good practice and offer a consistent, collective ambition.	**NEL:** Set a consistent ambition and provide resources. **Place:** Locally driven, responsible for building and maintaining relationships.
Workforce – QI & OD	• This is a major cultural change that will require new ways of working for many staff. We also need to consider how the model will address existing workforce shortages	• Define and work with relevant system teams to develop overarching OD and QI frameworks.	**NEL:** Support place-level training and development. **Place:** Embed QI practices into local teams.
Financial flows, commissioning and contracting	• Clarity on routes for funding to flow around the system and on contracts that could be aligned to population needs and outcomes.	• Establish an ICB led working group to understand financial flows and explore outcomes and incentives.	**NEL:** Lead development of principles **Place:** Responsible for aligning with principles.
Integrated data, systems & analysis that support a PHM approach, including evaluation	• Integrated data systems/infrastructure enabling access to patient and population, real time analytics and dashboards as well as seamless data sharing across organisations. • Embedded PHM approaches (e.g. segmentation model outputs) available at place and INT driving a data led, preventative, person-centred approach to care, tailored to population needs • Reducing health inequalities.	• Requires a dedicated resource/project. • Linked to PHM strategy, stakeholders and workstream	**NEL:** Lead strategy and training. **Place:** Apply strategy locally and design appropriate INT interventions.
Estate Solutions	• Fit-for-purpose estate that supports integrated working and makes efficient use of existing resources.	• This is a medium term priority, medium term actions to link to the development of the estate strategy.	**NEL:** Lead system wide estate strategy. **Place:** Work with ICB to identify and address gaps in estate capacity.

Summary of NEL and Place responsibilities for enablers



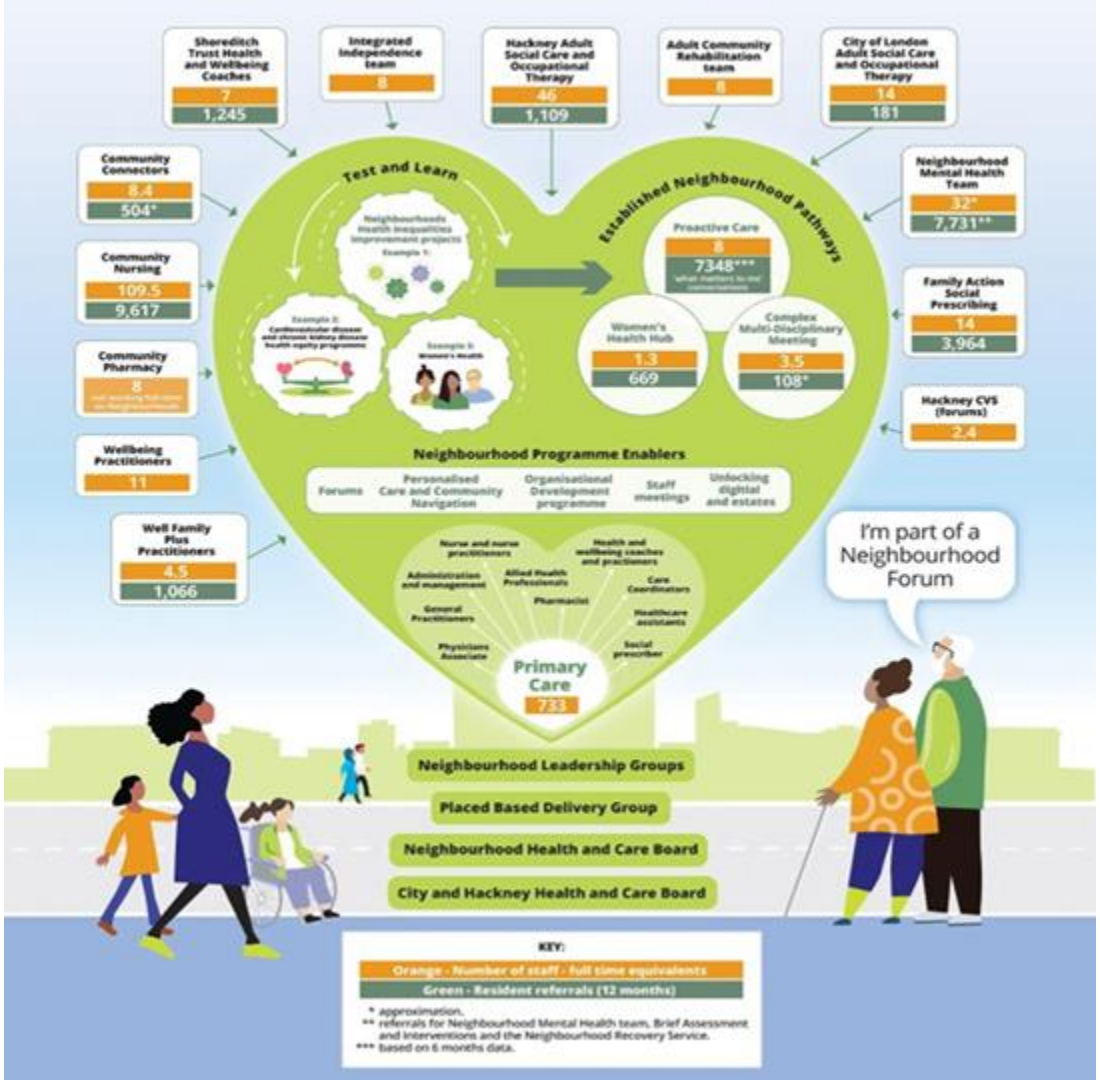
C&H Neighbourhoods - Where are we now?

- Neighbourhoods are a fundamental part of our system at place - providing the essential building blocks for hyper local community engagement and service delivery
- Infrastructure for community and resident engagement is in place via VCS led neighbourhood forums and regular insight gathering.
- Regular series of health promotion events planned through forums - focusing on health inequalities and what matters to residents
- Structural change has happened - many services are now organised around or linked into neighbourhoods
- A widespread OD programme has helped staff to get to know each other, their neighbourhoods, and learn new skills
- We have examples of teams working jointly to support residents

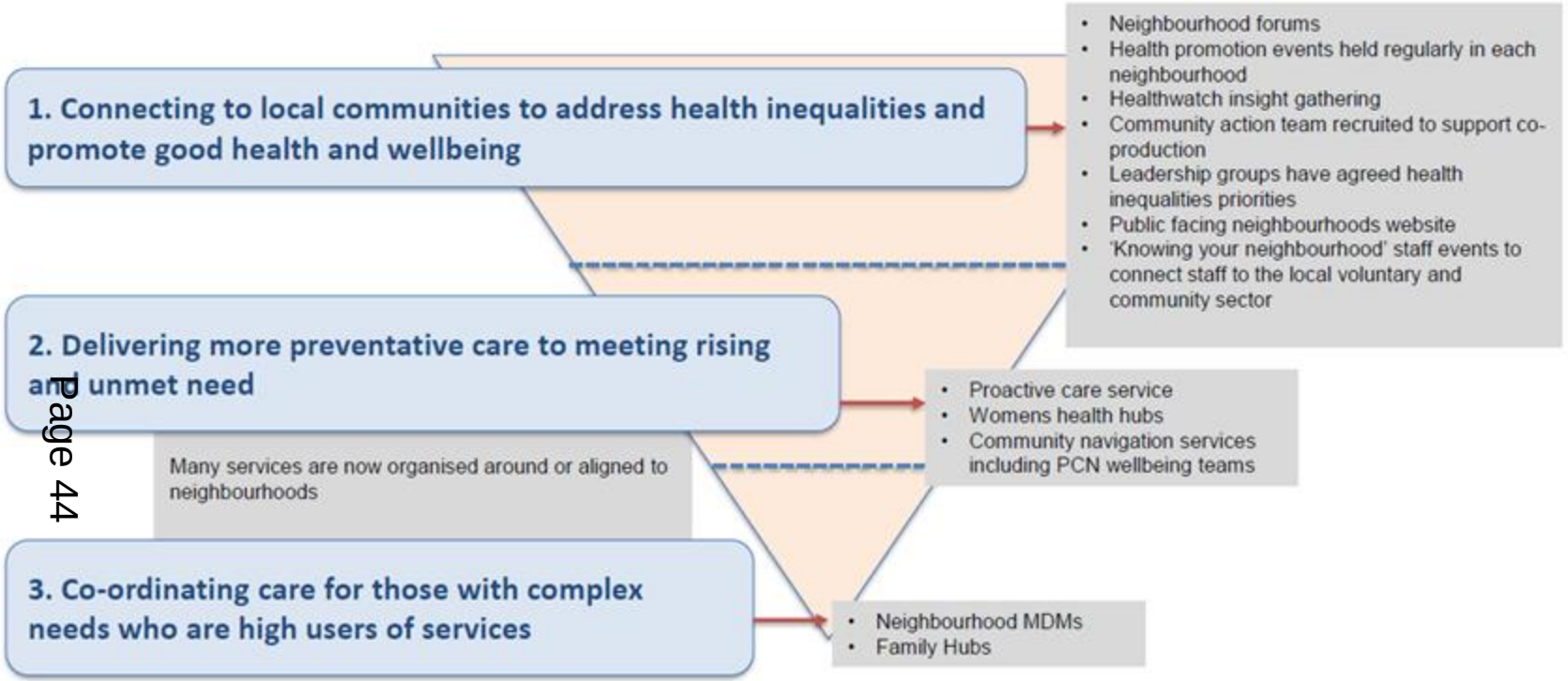
C&H Neighbourhoods

Many community and primary care services in City and Hackney are organised around the eight neighbourhoods across the place. The info-graphic shows the number of staff currently working in neighbourhoods and the existing neighbourhood pathways (or teams) that have been developed.

The neighbourhood forums bring together residents, VCS and staff to identify priorities and address local health inequalities



What are we doing against these aims?



To fully deliver ambitions 2 and 3, we need to support teams to work together more closely and in a more preventative way

Reflection on the case for change in 2025 - What problem could we solve through closer working in neighbourhood teams?

Traditional services are not always meeting residents needs

- We are seeing growing pressures on all services, but seen most starkly in CAMHS, social care, urgent care and primary care
- All services are seeing acute workforce challenges; for example 42% of GPs unlikely to be working in general practice in 5 year's time (pan London). Social care is facing similar challenges.
- More people are presenting to services with wider social needs- **loneliness, financial pressures, low level mental health & housing** being the most common drivers
- There is a cohort of people in C+H (12,000) who appear on more than one community caseload and are the top 10% of high users of primary care – just over 1000 of these people appear on 3 or more community caseloads
- There is a huge amount of unmet need in our population – the proactive care service demonstrated improved outcomes for people with mild to moderate frailty

Closer working in Neighbourhood team(s) could:

- Provide care co-ordination for people on multiple case-loads
- Deliver a preventative model of care for people with rising needs and social needs – through improved care co-ordination and connecting people to local community assets
- Better support high users of primary care and urgent care, delay or reduce intensity of need in social care
- Allow each team to be flexible to respond to the needs of each Neighbourhood – with scope to adapt roles and approaches
- Allow us to build a team that is future proofed to workforce challenges, by diversifying the workforce and creating more fulfilling roles

Metrics

Target	Performance goals	Schemes that support delivery
Emergency admissions to hospital for people aged 65+ per 100,000 population	5 years of data was reviewed to guide the number of monthly admissions for the boroughs across NEL. For each spell, the patient postcode has been mapped back to the respective local authority. The plan for submission has been replicated from activity in the last 12 months of available data. We are not increasing capacity, but are aiming to optimise existing services capacity, and development of integrated neighbourhood teams should help improve performance. We have included a static position for the plan, but this includes the ambition to manage the expected 2% growth.	• Carers' support • Adult Cardiorespiritory Enhanced and Responsive Service (ACERS) • Bryning Day Unit/Falls Prevention • Asthma Service • St Joseph's Hospice • Paradoc • Adult Community Rehabilitation Team • Adult Community Nursing • GP out of hours home visiting service • Out of hours rapid response end of life care service • Neighbourhood Programme

Metrics

Target	Performance goals	Schemes that support delivery
Average length of discharge delay for all acute adult patients This calculates the % of patients discharged after their DRD, multiplied by the average number of days)	We don't have full confidence in these numbers yet. The records kept by adult social care track all City residents across P0-P3 but are different to the national figures and we don't know why. The City has no local hospital but their staff work closely with main referring hospitals and would be surprised if they are not alerted to a City resident being in hospital. We are developing the TOCH and want to have greater links with ASC staff to ensure collective visibility of data to better manage flow. The proportion and average days delay were set using 11 months of local data for 24-25 rather than the national data from September to November 2024. This is a stretch target to account for any growth in the demand, although we hope to increase performance.	• Care Navigator Service • Brokerage • Discharge Scheme • Rehab and reablement services • Domiciliary care • Residential care • St Joseph's Hospice • Adult Community Nursing • Adult Community Rehabilitation Team

Metrics

Target	Performance goals	Schemes that support delivery
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	We are able to keep people at home for longer and people tend to enter residential or nursing care when they are older and for shorter periods. Because these figures are based on need and we have a small population it can vary year to year. Currently we have 21 people in residential care and 10 in nursing care (244 and 116 per 100,000k respectively). We usually have been 7 and 10 admissions a year but there have been higher numbers during 2024/25 with 12 (139.5 per 100,000k)	• Carers' support • Domiciliary care • Rehab and reablement services • Adult Cardiorespiritory Enhanced and Responsive Service (ACERS) • Bryning Day Unit/Falls Prevention • Asthma Service • St Joseph's Hospice • Paradoc • Adult Community Rehabilitation Team • Adult Community Nursing • GP out of hours home visiting service • Out of hours rapid response end of life care service • Neighbourhood Programme

Demonstrating a “home first” approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care

We adopt a home first approach and as noted above, we can keep people at home longer with entry to long term residential care being later and for shorter periods. There are several approaches we use to facilitate this:

- A rapid response service to provide care for up to 72 hours to facilitate Discharge to Assess and Admission Avoidance. The care provider providing this service also provides our reablement service so there are good links across services, seamless handovers and it is informed by robust knowledge of the individual
- There is an agility to flex existing care packages to respond to changing needs especially when coming out of hospital

Discharge Fund Consolidation

Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

- We intend to keep funding existing services with the same value of funding that came from the discharge fund and do not plan to shift expenditure away from discharge services.

Capacity and Demand

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

How 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)

- We have looked at activity across 2024-25 and have applied 2% growth to forecast demand for 2025-26.
- Domicilliary care is commissioned on a flexible contract and can flex as demand goes up and down (it is not commissioned for a set number of packages of care). Residential and nursing care are spot purchased which allows us flexibility to meet need and demand.

How capacity plans take into account therapy capacity for rehabilitation and reablement interventions

- We spot purchase in-patient rehabilitation, generally via North Central London ICB providers. Our demand has risen over the years, but NCL has opened more beds up to us and the length of days waiting for admission has reduced since 2023-24.
- Over the last few years we have topped up capacity in our Rapid Response and Home Treatment therapy team via Ageing Well funding to increase therapy capacity. We have had approval to commission this recurrently from 2025-26.

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

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

Promoting Equality and Reducing Inequalities

- All social care practitioners at the City of London use the Strengths Based Approach which empowers people and aims to help tackle inequalities.
- The Carers Service has appointed a wellbeing co-ordinator that speaks Syhleti to reach out and support carers on the east side of the City of London who are part of the Bangladeshi community.
- Working to reduce health inequalities is a key function of the work of the ICS and the ICB has a specific targeted set of work being delivered through health inequalities funding. The Shoreditch Park and City Neighbourhood is using its health inequalities funding to tackling health inequalities for carers by improving the primary care offer to carers.
- Healthwatch Hackney has been commissioned by the Neighbourhoods Programme to produce annual Insight Reports for each of the eight neighbourhoods. This includes Shoreditch Park & the City. The reports provide a holistic view of the health and care needs of residents in each neighbourhood. They have been designed to support teams in City and Hackney neighbourhoods to have accessible data on a local level, be able to identify opportunities to collaborate and to contribute towards services meeting the needs of residents.

To engage or consult with residents

Healthwatch Hackney & Healthwatch City of London with system partners have developed a Co-production charter for health and social care in City and Hackney. All activities to develop or review services aim to consult if not co-produce services together with our residents. Examples include:

- The Frailty Awareness Training resource has been co-designed and co-produced by the University of East London and City and Hackney to residents and is a resource for everyone who lives, works or volunteers in City and Hackney.
- Healthwatch has pulled together a group of approximately 8 service users/carers to support the work of our discharge steering group. Two of the residents are from the City. While this is largely focused on the Homerton, residents speak about experiences across London hospitals.
- As part of the community stroke rehabilitation review it is key that stroke survivors are listened to and codesign any future developments to the services. We held a stroke care listening event which was attended by 49 City and Hackney Stroke survivors and their carers and 20+ staff and students from across the stroke pathway.
- The Personalised Care road map has been developed with local residents and NHS services, the Voluntary Community Sector, the wider Place Based Partnership and North East London Integrated Care Board. The programme collaborated with residents from the onset, in partnership with Healthwatch Hackney. Seven steering groups were completed, both online and in person, with different topics for each session reflecting different elements of the framework.
- The City of London and Healthwatch City of London is developing an Adult Social Care advisory group to work with service users to shape and inform Adult Social Care Services

A system-wide commitment to better discharge: from insights to action

- Within our discharge steering group (DSG), we have eight public representatives from diverse backgrounds across Hackney and the City of London, ensuring a rich tapestry of perspectives. These representatives play a crucial role, providing patient feedback, contributing to new ideas, and actively participating in planning initiatives. The group's methodology is rooted in collaboration and open dialogue.
- Bi-monthly meetings provide a platform for discussions, but it was the "Fishbowl" focus group that truly catalysed change. This session, attended by representatives and system professionals (pharmacists, deputy chief nurse, therapists, discharge staff, social workers and a commissioner), facilitated an honest exchange about the challenges and shortcomings of the existing discharge process.
- One significant outcome was the identification of gaps in the existing discharge form. Recognising the need for improvement, system leads took the initiative to work with the reps to co-produce a new Discharge Form for the Homerton Hospital.
- The summary of the session has been presented widely around the Trust. Everyone is keen to improve the experience of discharge for patients looking forwards, and it has been put as one of the Trust’s Quality Account Priorities for the next 4 years.
- The discharge group continues to monitor actions.
- This collaborative effort demonstrates the group's commitment to translating insights into tangible improvements. By fostering a culture of collaboration and continuous improvement, the Discharge Steering Group has laid the foundation for a more patient-centered discharge process. The focus on smooth discharges directly contributes to reducing local health inequalities, ensuring that all patients receive coordinated care as they transition back into the community.

Looking ahead: a 6-month pilot for enhanced discharge experiences

- In 2025, the DSG Reps will launch a comprehensive 6-month pilot programme across City and Hackney (C&H) to directly gather resident feedback on their hospital discharge experiences. This initiative will serve as the cornerstone for refining and improving the discharge process, ensuring it meets the diverse needs of our community.
- Community-Centric Feedback Collection: The pilot will prioritise direct engagement with residents through a series of accessible, community-based feedback sessions. These sessions will be strategically located in key areas across C&H, including GP surgeries, schools, community centers, and shelters for vulnerable populations, ensuring diverse voices are heard.
- Data-Driven Insights Through Resident Experiences: The pilot will utilise a structured survey to gather detailed feedback on critical aspects of the discharge process, such as preparedness, medication management, aftercare planning, and overall experience. This data, coupled with demographic information, will enable the group to dentify trends, disparities, and areas for targeted improvement.
- Focus on Inclusivity and Accessibility: A key focus of the pilot will be reaching and gathering feedback from harder-to-reach communities, including elderly patients, individuals with long-term conditions, and those experiencing homelessness. Tailored approaches and accessible formats will be employed to ensure these vital perspectives are captured and integrated into the improvement process

Duty to Support and Involve Unpaid Carers

- A new Carers Strategy was agreed in December 2023. This was co-produced with carers and one of the first major actions of the strategy was to re-commission the Carers Support Service. Carers attended the committee where the Strategy was agreed and shared some of their experiences.
- The Carers Support Service was previously a pilot service. This was recommissioned during 2024 with the involvement of carers in shaping the specification, assessing bids and interviewing prospective providers. The new provider is now in place for 3 years and carers will be involved in contract monitoring. The service provides advice and support and is looking at how it can work in partnership or secure grant funding to provide additional wellbeing activities such as massage and tai chi.
- The Shoreditch Park and City Primary Care Network has used health inequalities funding to fund a carers project. This focuses on primary care – supporting them to identify carers more easily and being able to signpost to relevant support
- Locally, the ICS is using Accelerating Reform Funding to roll out a hospital carers support project to identify and support carers within acute settings.

Disabled Facilities Grants

- The City of London has low take up of Disabled Facilities Grants due to its economic and housing profile. Most of the housing in the Square Mile is social housing and Barbican Housing (leaseholder properties). There are few general private rented homes. Most DFG applications come from housing association properties.
- There has also been a low take up of DFGs recently as we moved towards appointment of a new Home Improvement Agency. This is now in place.
- It was recognised that there were many people who could benefit from the support of HIA type services for adaptations to their home but were not eligible for this as they fall outside the financial thresholds applied to DFGs.
- Given this and the funds we have available through DFGs we have developed a Housing Assistance Policy that will assist those who fall outside the financial thresholds for a DFG to have the project management support to undertake adaptations to help prevent needs developing or escalating.

Better Care Fund 2025-26 Planning Template

2. Cover

Version 1.5

Please Note:
- The BCF planning template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. 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 Better Care Exchange) 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 (MHCLG, DHSC, NHS England) 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.

Governance and Sign off

			Complete:
Health and Wellbeing Board:	City of London		Yes
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	No		Yes
If no indicate the reasons for the delay.	Cycle of meetings		Yes
If no please indicate when the HWB is expected to sign off the plan:	Fri 09/05/2025	<< Please enter using the format, DD/MM/YYYY	Yes

Submitted by:	Ellie Ward	Yes
Role and organisation:	Head of Strategy and Performance, City of London Corporation	Yes
E-mail:	ellie.ward@cityoflondon.gov.uk	Yes
Contact number:	020 7332 1535	Yes
Documents Submitted (please select from drop down) **In addition to this template the HWB are submitting the following:**	Narrative	Yes
	C&D National Template	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation	
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Member	Helen	Fentiman	Helen.fentiman@Cityoflondon.gov.uk		Yes
	Health and Wellbeing Board Chair						
Named Accountable person	Local Authority Chief Executive	Mr	Ian	Thomas	Ian.Thomas@cityoflondon.gov.uk		Yes
	ICB Chief Executive 1	Ms	Zina	Etheridge	nelondonicb.ceo@nhs.net	NHS NEL	Yes
	ICB Chief Executive 2 (where required)						

	ICB Chief Executive 3 (where required)						

Finance sign off	LA Section 151 Officer	Mr	Mark	Jarvis	mark.jarvis@cityoflondon.gov.uk		Yes
	ICB Finance Director 1	Mr	Henry	Black	nelondonicb.cfo@nhs.net	NHS NEL	Yes
	ICB Finance Director 2 (where required)						
	ICB Finance Director 3 (where required)						

Area assurance contacts	Local Authority Director of Adult Social Services	Ms	Judith	Finlay	judith.finlay@cityoflondon.gov.uk		Yes
	DFG Lead	Mr	Chris	Pelham	chris.pelham@cityoflondon.gov.uk		Yes
	ICB Place Director 1	Ms	Charlotte	Pomery	charlotte.pomery@nhs.net	NHS NEL	Yes
Please add any additional key contacts who have been responsible for completing the plan	ICB Place Director 2 (where required)	Ms	Amy	Wilkinson	amy.wilkinson@hackney.gov.uk	NHS NEL	
	ICB Place Director 3 (where required)						

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response	
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	Yes		Yes
National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	Yes		Yes

National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	Yes		Yes
	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	Yes		Yes
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	Yes		Yes

Data Quality Issues - Please outline any data quality issues that have impacted on planning and on the completion of the plan	
We don't have full confidence in the discharge ready date figures yet. The records kept by adult social care track all City residents across P0-P3 in detail but national figures do not match this. The City has no local district hospital but the care navigator works closely with the main hospitals that they get referrals from and would be unusual if they are not alerted to a City resident being in hospital. We are developing the TOCH and want to have greater links with ASC staff to ensure collective visibility of data to better manage flow.	Yes

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. Income	Yes
5. Expenditure	Yes
6. Metrics	Yes
7. National Conditions	Yes

Better Care Fund 2025-26 Planning Template

3. Summary

Selected Health and Wellbeing Board: City of London

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£46,024	£46,024	£0
NHS Minimum Contribution	£960,444	£960,444	£0
Local Authority Better Care Grant	£399,287	£399,287	£0
Additional LA Contribution	£100,000	£100,000	£0
Additional ICB Contribution	£0	£0	£0
Total	**£1,505,755**	**£1,505,755**	**£0**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26
Minimum required spend	£179,544
Planned spend	£374,076

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	1,076	1,076	1,435	1,076	717	1,793	1,435	1,435	1,076	1,076	717	1,076

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	1,076.0	143.5	143.5	286.9	286.9

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: City of London

Complete:

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
City of London	£46,024
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£46,024**

Local Authority Better Care Grant	Contribution
City of London	£399,287
Total Local Authority Better Care Grant	**£399,287**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	No	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding	
City of London	£100,000	Carry forward iBCF as agreed with DHSC	Yes
Total Additional Local Authority Contribution	**£100,000**		

NHS Minimum Contribution	Contribution
NHS North East London ICB	£960,444
Total NHS Minimum Contribution	**£960,444**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	No

Yes

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£960,444**	

Yes

	2025-26
Total BCF Pooled Budget	**£1,505,755**

Funding Contributions Comments Optional for any useful detail
Nothing additional to add

Yes

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: City of London

<< Link to summary sheet

Running Balances	2025-26 Income	Expenditure	Balance
DFG	£46,024	£46,024	£0
NHS Minimum Contribution	£960,444	£960,444	£0
Local Authority Better Care Grant	£399,287	£399,287	£0
Additional LA contribution	£100,000	£100,000	£0
Additional NHS contribution	£0	£0	£0
Total	**£1,505,755**	**£1,505,755**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26 Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£179,544	£374,076	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Discharge support and infrastructure	Care Navigator Service. Supports safe hospital discharge and link up of services for City residents who attend	5. Timely discharge from hospital	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 60,000	
2	Support to carers, including unpaid carers	Carer's Support. Contributes to wider commissioned carers support service	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 60,000	
3	Discharge support and infrastructure	Brokerage Support. Resources to provide capacity to secutre placements	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 65,000	
4	Discharge support and infrastructure	Comprehensive Discharge Scheme	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 189,076	This combines a few schemes that were previously funded via different pots of money. • LA part of minimum contribution - £163,000 • NHS minimum contribution (previously described as system pressures - £9283) • ICB discharge allocation (£8881) •Social care uplift in minimum contribution (£7912)
5	Long-term home-based community health services	Adult Cardiorespiritory Enhanced and Responsive Service (ACERS)	1. Proactive care to those with complex needs	Other	NHS Acute Provider	NHS Minimum Contribution	£ 23,033	Service is part of Homerton acute contract but works across primary and secondary care.
6	Wider local support to promote prevention and independence	Bryning Day Unit/Falls Prevention	1. Proactive care to those with complex needs	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 14,356	

7	Long-term home-based community health services	Asthma Service - This service will lead asthma management in primary care working closely with the lead asthma respiratory consultant at the Homerton Hospital.	1. Proactive care to those with complex needs	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 1,422	
8	End of life care	St Joseph's Hospice - includes a community-based palliative care team and residential hospice care.	4. Preventing unnecessary hospital admissions	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 86,111	
9	Urgent community response	Paradoc - The service aims to prevent unnecessary hospital admission and ED attendance by providing urgent assessment and provision of intermediate community care by a GP and related community services.	4. Preventing unnecessary hospital admissions	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 21,213	
10	Long-term home-based community health services	Adult Community Rehabilitation Team	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 163,823	
11	Long-term home-based community health services	Adult Community Nursing	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 218,759	
12	Long-term home-based community health services	GP out of hours home visiting service	4. Preventing unnecessary hospital admissions	Primary Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 10,744	Social enterprise
13	End of life care	Out of hours rapid response end of life care service	4. Preventing unnecessary hospital admissions	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 3,998	
14	Evaluation and enabling integration	Neighbourhood Programme - A fundamental part of our system at place - providing the essential building blocks for hyper local community engagement and service delivery. Plans include further development of integrated neighbourhood teams.	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 19,792	
15	Discharge support and infrastructure	Transfer of Care Hub	5. Timely discharge from hospital	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 17,642	
16	Disabled Facilities Grant related schemes	Disabled Facilities Grant	2. Home adaptations and tech	Other	Local Authority	DFG	£ 46,024	Held within Adult Social Care and recently appointed new Home Improvement Agency from private sector
17	Wider local support to promote prevention and independence	Variety of social care schemes to promote prevention and independence - supporting reduction in hospital admissions and need for long term residential care	6. Reducing the need for long term residential care	Social Care	Local Authority	Local Authority Better Care Grant	£ 323,660	
18	Discharge support and infrastructure	Part of our overall discharge scheme	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 75,627	
19	Wider local support to promote prevention and independence	Carry forward iBCF.This funding is used to support the three priorities of the iBCF. It is used flexibly and includes funding for additional placements and staff capacity in areas such as OT.	6. Reducing the need for long term residential care	Social Care	Local Authority	Additional LA Contribution	£ 100,000	This funding is used to support the three priorities of the iBCF. It is used flexibly and includes funding for additional placements and staff capacity in areas such as OT.

20	Long-term home-based community health services	Primary Care	1. Proactive care to those with complex needs	Primary Care	NHS	NHS Minimum Contribution	£ 5,475	

5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

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

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:
1. Scheme ID:
- Please enter an ID to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. Description of Scheme:
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.
4. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
6. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the NHS or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:
Any further information that may help the reader of the plan. You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description
1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	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	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

3	DFG related schemes	DFG related schemes	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.
4	Wider support to promote prevention and independence	Prevention/early intervention	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 wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes 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
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term 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.
7	Long-term home-based social care services	Personalised care at home	Long-term 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 or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	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'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	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.
10	Long-term residential or nursing home care	Residential placements	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.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	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.
14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, 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. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.
15	Urgent Community Response	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.

16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: City of London

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 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.	Complete:
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,076	1,076	1,435	1,076	717	1,793	1,435	1,435	n/a	n/a	n/a	n/a	5 years of data was reviewed to guide the number of monthly admissions for the boroughs across NEL. For each spell the patient postcode has been mapped back to the respective local authority.	Yes
	Number of Admissions 65+	15	15	20	15	10	25	20	20	n/a	n/a	n/a	n/a		
	Population of 65+*	1,394	1,394	1,394	1,394	1,394	1,394	1,394	1,394	n/a	n/a	n/a	n/a		
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	The plan for submission has been replicated from activity in the last 12 months of available data.	
	Rate	1,076	1,076	1,435	1,076	717	1,793	1,435	1,435	1,076	1,076	717	1,076		
	Number of Admissions 65+	15	15	20	15	10	25	20	20	15	15	10	15	We are not increasing capacity, but are aiming to optimise existing services capacity, and development of integrated neighbourhood teams should help improve performance.	Yes
	Population of 65+	1,394	1,394	1,394	1,394	1,394	1,394	1,394	1,394	1,394	1,394	1,394	1,394	We have included a static position for the plan but this includes the ambition to manage the expected 2% growth	

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 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.	
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.89	0.16	2.29	n/a	n/a	n/a	n/a	There is currently a difference in data produced nationally and that kept locally. This is an area that is being investigated. As a result there is some caution about the national figures. Given the very small numbers in the City of London, any delays impact significantly on our average discharge delayed days. In 2024/25, most delays were	Yes
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	77.1%	94.7%	80.6%	n/a	n/a	n/a	n/a		

For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	3.9	3.0	11.8	n/a	n/a	n/a	n/a	discharge delayed days. In 2024/25, most delays were attributable to health delays / changes and friends and family choice.	
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	We are developing the TOCH and will have greater links with ASC staff to ensure collective visibility of data to better manage flow and help manage health delays.	
Average length of discharge delay for all acute adult patients	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84		
Proportion of adult patients discharged from acute hospitals on their discharge ready date	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	We used local data for 11 months of 2024-25 to set these targets. These are stretch targets and will be impacted by overall numbers next year. They account for any growth in demand but also based on improving performance through support provided around friends and family	Yes
For those adult patients not discharged on DRD, average number of days from DRD to discharge	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00		Yes

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	Yes	Yes
Local data on average length of delay by discharge pathway.	Number of days	Yes	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 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.	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	215.2	717.4	1076.0	143.5	143.5	286.9	286.9		Given our small numbers this is based on actual numbers. We have fluctuations between years and between quarters which makes it hard to forecast accurately. Please also note that mid year estimates are not reliable for the City. It is more accurate to use actual 2021 census data.	Yes
	Number of admissions	3	10	15	2	2	4	4			Yes
	Population of 65+*	1,394	1,394	1,394	1,394	1,394	1,394	1,394			

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	Yes	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	Yes	Yes

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: City of London

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes			Yes
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	Yes			Yes
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes			Yes
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care					
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes

This page is intentionally left blank

City of London Corporation Committee Report

Committee: Health and Wellbeing Board	**Dated:** 09/05/2025
Subject: Better Care Fund 2024/25 Quarter 3 return	**Public report:** For Decision
This proposal: • **delivers Corporate Plan 2024-29 outcomes** • **provides statutory duties**	Delivers excellent services
Does this proposal require extra revenue and/or capital spending?	No
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	
Report author: Ellie Ward, Head of Strategy and Performance	

Summary

The Better Care Fund 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 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. Quarterly reports on progress of the plans and metrics are required and these must be signed off by the Health and Wellbeing Board. This report seeks approval for the Q3 2024/25 Better Care Fund return.

Recommendation(s)

Members are asked to:

- Approve the Better Care Fund Quarter 3 2024/25 return

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

3. The City Corporation is required to report quarterly on progress with the plans and these progress reports must be approved by the Health and Wellbeing Board (HWBB).

Current Position

4. The pooled budget for 2024/25 was £1,435,838. The City Corporation does not put in any additional funds.

5. A range of schemes are funded through the BCF and 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.

6. The BCF Quarter 3 report can be found at Appendix one and sets out progress against certain mandatory conditions and metrics. All the mandatory conditions are met. With regard to the metrics, there are no specific areas of concern and it can be noted that between quarters, due to our small cohort sizes, there can be vast differences in these metrics. In some areas, there also needs to be further investigations to understand the data in greater detail.

7. There is a section on expenditure but the pre populated template only contains certain schemes. However, it is confirmed that for all City of London Corporation schemes, the funding is being utilised and will not be overspent.

8. Members of the Health and Wellbeing Board are asked to approve the return.

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

9. The City of London HWBB is asked to approve the BCF 2024/25 Q3 return.

Appendices

- Appendix 1 – BCF Q3 report

Ellie Ward

Head of Strategy and Performance
Department of Community and Children's Services

T: 020 7332 1535
E: ellie.ward@cityoflondon.gov.uk

Better Care Fund 2024-25 Q3 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Please submit this template by 14 February 2025

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.

Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2024-25 has been pre-populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- On track to meet the ambition
- Not on track to meet the ambition
- Data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns M and N only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.

Activity
For reporting across 24/25 we are asking HWBs to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D H1 Actual Activity".

5.1 C&D Guidance & Assumptions

Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the quarter, and any support needs particularly for managing winter demand and ongoing data issues.

5.2 C&D H1 Actual Activity

Please provide actual activity figures for this quarter, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.
The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure from all 3 quarters to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation.
Underspend - Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 6a.

Please use the Discontinue column to indicate if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent.

If you would like to amend a scheme, you can first 'discontinue' said scheme, then re-enter the scheme new data into the 'add new schemes' section.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

Better Care Fund 2024-25 Q3 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: City of London

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions			
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:**	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 Q3 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: City of London

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q2 (For Q3 data,please refer to data pack on BCX)	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans - ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan*	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	52.3	49.7	47.2	44.8	20.4	On track to meet target	N/A	Data only includes October, but currently the indicator is 10.2, with only one spell. Total year to date i s 4 people.	N/A	N/A	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.8%	96.6%	94.5%	93.6%	92.9%	On track to meet target	N/A	We achieved 93.18% for Q3 which is slightly below target but an increase from Q2. Small numbers of patients can have a great impact on percentages but largely people are returning home.	N/A	N/A	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				733.6	317.2	Not on track to meet target	Data only includes October, but currently the indicator is 114, with only one spell. The direction of travel is positive as it has dropped from 8 falls in Q1 to 4 falls in Q2.	N/A	The year to date data shows an indicator value of 1024.74; however the total number of falls is only 13.	A local falls group has been established with consultants and service leads to review the C&H falls pathway. Public Health will cease funding for a community strength and balance falls prevention service at the end of March 2025. Pathway mapping work is underway to identify gaps in the pathway, and data review of the potential impact on other services. C&H Place Team working with partner organisations to consider ways to mitigate the impact, redesign the pathway and explore ways resources could potentially be redeployed to support existing services. Data is broken down at PCN and practice level and shows falls for the Neaman Practice, which is the only GP within the City of London.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				575	not applicable	On track to meet target	N/A	N/A	N/A	N/A	Yes

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: City of London

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
Our overall activity isn't significantly different than planned. What was surpising was the number of people requiring admission to residential care just before Christmas. There were some complex needs and it took longer to place than normal, resulting in delays to discharge. This isn't a trend we expect to continue.	Yes
2. Do you have any capacity concerns for Q4? Please consider both your community capacity and hospital discharge capacity.	
We do not have any capacity concerns for Q4.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
Not Applicable.	Yes
4. Do you have any specific support needs to raise for Q4? Please consider any priorities for planning readiness for 25/26.	
We do not have any support needs to raise.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- Actual demand in the first 9 months of the year
- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Better Care Fund 2024-25 Q3 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: City of London

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			Checklist
Service Area	Metric	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	Complete:
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	5	4	5	8	4	6	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	1	1	1	0	0	0				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	1	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	0	0	2	0	0	0	1	0	1	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	6	0	7				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	0	0	0	9	0	7	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	0	0	0	0	0	5	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	0	0	0				Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan			Actual activity:			Checklist
Service Area	Metric	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	Complete:
Social support (including VCS)	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes
Urgent Community Response	Monthly activity. Number of new clients.	8	7	8	5	4	4	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	0	0	1	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes

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 ten 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 Q3 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: City of London

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£40,457	£0	0.00%	£40,457
Minimum NHS Contribution	£943,650	£746,463	79.10%	£197,187
iBCF	£323,659	£323,659	100.00%	£0
Additional LA Contribution	£43,563	£0	0.00%	£43,563
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£75,627	£75,627	100.00%	£0
ICB Discharge Funding	£8,881	£8,881	100.00%	£0
Total	**£1,435,837**	**£1,154,630**	**80.42%**	**£281,207**

Comments if income changed

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	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£247,339	£438,606	£0
Adult Social Care services spend from the minimum ICB allocations	£172,763	£295,708	£0

Checklist	Column complete:	Yes	Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	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	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent)	Comments
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	0		Social Care	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 60,000	£45,000		
2	CoL-Carers' support	To provide specialist indpendent support, information and advice for	Carers Services	Other	Provides specialist independent	80	88	Beneficiaries	Social Care	0	LA			Charity / Voluntary Sector	Minimum NHS Contribution	£ 60,000	£45,000		
3	Brokerage pilot (one-year)	To provide a more efficient and effective commissioning of placements including for	Residential Placements	Other	Commissioning	12	2	Number of beds	Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 65,000	£65,000		
4	CoL-Discharge Scheme	To prevent hospital admissions and provide an intensive discharge to assess	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	0		Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 163,000	£140,708		
5	Disabled Facilities Grant	To support Diasbled people to live more independently in their own homes	DFG Related Schemes	Adaptations, including statutory DFG grants		5	0	Number of adaptations funded/people supported	Social Care	0	LA			Private Sector	DFG	£ 40,457	£0		
6	iBCF	Meeting adult social care needs by delivering a targeted, preventative,	Care Act Implementation Related Duties	Other	Adult social care support		0		Social Care	0	LA			Local Authority	iBCF	£ 323,659	£323,659		
7	Adult Cardiorespiritory Enhanced and	ACERS Respiratory Service is a 7 day service, that provides care and support to anyone	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		0	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 23,033	£17,736		
8	Bryning Day Unit/Falls Prevention	The Bryning Unit is a multidisciplinary team running a weekly programme	Prevention / Early Intervention	Other	Physical health and wellbeing	0	0		Acute	0	NHS			NHS Acute Provider	Minimum NHS Contribution	£ 14,356	£11,054		
9	Asthma	This service will offer asthma expertise in the community in order to train health	Community Based Schemes	Other	Education and training of HCP and patients.	0	0		Acute	0	NHS			NHS Acute Provider	Minimum NHS Contribution	£ 1,422	£1,095		
10	St Joseph's Hospice	Community-based and inpatient palliative care services	Personalised Care at Home	Physical health/wellbeing		0	0		Other	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 86,111	£64,776		
11	Paradoc	The service provides an urgent GP and paramedic response service to patients	Urgent Community Response			0	0		Primary Care	0	NHS			NHS Acute Provider	Minimum NHS Contribution	£ 21,213	£16,334		
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	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 163,823	£126,898		
13	Adult Community Nursing	To provide an integrated, case management service to patients living within the	Personalised Care at Home	Physical health/wellbeing		0	0		Community Health	0	NHS			NHS Community Provider	Minimum NHS Contribution	£ 218,759	£169,197		
16	DES Supplementary Care Homes	GP enhanced services within older adults care homes.	Personalised Care at Home	Physical health/wellbeing		0	0		Primary Care	0	NHS			NHS	Minimum NHS Contribution	£ 5,475	£4,106		
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	0		Primary Care	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 10,744	£8,484		
19	Local authority discharge funding	Support hospital discharge	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Social Care	0	LA			Local Authority	Local Authority Discharge	£ 75,627	£75,627		

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	0	LA			Local Authority	ICB Discharge Funding	£ 8,881	£8,881		
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	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 9,283	£0		
22	Out of hours rapid response end of life care service	Rapid response overnight support, information and crisis internvention to	Personalised Care at Home	Physical health/wellbeing		0	0		Other	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 3,998	£2,999		
23	Neighbourhood Programme	Neighbourhoods is our major transformation programme for the redesign of	Community Based Schemes	Integrated neighbourhood services	0	0	0		Other	0	NHS	0		NHS	Minimum NHS Contribution	£ 19,792	£14,844		
24	Care Transfer hub	Health and Social Care staff to work together to support discharge.	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Community Health	0	NHS	0		NHS Acute Provider	Minimum NHS Contribution	£ 17,642	£13,232		
25	DFG carry forward	DFG allocation now confirmed and 23/24 allocation carried forward	DFG Related Schemes	Adaptations, including statutory DFG grants	0	5	0	Number of adaptations funded/people supported	Social Care	0	LA	0		Private Sector	Additional LA Contribution	£ 43,563	£0		

This page is intentionally left blank

City of London Corporation Committee Report

Committee(s): City of London Health & Wellbeing Board	**Dated:** 09/05/2025
Subject: Health Impacts of Vaping	**Public report:** Public
This proposal: City of London Corporation's Corporate Plan 2024-2029	Providing excellent services
Does this proposal require extra revenue and/or capital spending?	No
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 City and Hackney Director of Public Health
Report author:	Nickie Bazell Senior Public Health Specialist Ann McNeill Professor of Tobacco Addiction, Kings College of London

Summary

Tobacco smoking remains the biggest cause of preventable illness and premature death and the leading cause of health inequalities. Local work to tackle the harms of smoking are informed by the latest best practice guidance, which recommends use of legal vapes as a cessation tool among smokers age 18+.

However, use of nicotine vapes is not risk free, which is why we are implementing a range of measures to prevent and discourage their use among children and young people and all non-smokers.

Keeping abreast of the latest evidence around the relative health harms of vapes is essential to informing our local tobacco control plans.

This report summarises the eighth independent evidence review on vaping, led by King's College London and international collaborators, and commissioned by the Office for Health Improvement and Disparities (OHID).

The report offers a comprehensive, systematic review of the health risks of nicotine vaping. It will be presented by Professor Ann McNeill, lead author and researcher, who will provide updated evidence.

The main areas covered include:

- health risks
- harm perceptions
- role of vaping in smoking cessation.

The report also describes the key components of a new City and Hackney vaping position statement (informed by the latest evidence), which was recently developed and endorsed by the local Tobacco Control Alliance.

Recommendation(s)

Members are asked to:

- Note the content of this report (and the more detailed presentation that will be made to the Board), highlighting the latest evidence on vaping.
- Consider and respond to the following questions:
    1. Does the Board endorse the evidence-based City and Hackney vaping position statement, which was co-developed with the local Tobacco Control Alliance (TCA)?
    2. How can the Health and Wellbeing Board, as a collective body and as leaders within your organisations, support implementation of the City and Hackney vaping position statement and reinforce the messages contained within the statement?

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 TCA. To maximize the potential for reducing smoking-related harms, it is essential that the TCA's efforts are guided by the latest evidence and regulatory/legislative framework.

1.3. National policies and guidance now support the use of vaping as a smoking cessation aid for adults, due to significant evidence regarding its effectiveness and lesser harm compared to smoking. For example, the latest NICE guidance recommends nicotine vapes as a 'first line' treatment as part of an evidence-based stop smoking service offer. And the government's "Swap to Stop" scheme aims to improve national health and lower smoking rates by motivating up to one million smokers to transition from cigarettes to vapes.

1.4. In line with these efforts, the Tobacco and Vapes Bill represents one of the most significant public health interventions in a generation. It aims to create the first smokefree generation by making it illegal to sell tobacco products to anyone born on or after January 1, 2009, ensuring that those turning 15 this year or younger can never legally purchase tobacco. The Bill also targets youth vaping through new powers to

restrict vape flavours, packaging and point-of-sale displays, while extending similar restrictions to non-nicotine vapes and nicotine pouches. It will also empower trading standards officers in England and Wales to take immediate action against underage tobacco and vape sales, strengthening enforcement.

1.5. On 26 March 2025, MPs voted overwhelmingly in favour of advancing the Bill and it is currently at the second reading stage in the House of Lords.

1.6. The importance of evidence-based policymaking in shaping these efforts is underscored by the comprehensive findings in a recent OHID report (McNeill, et al, 2022), which has been integrated into the TCA's plans. Updated evidence, which will further inform these discussions, will be presented to the Board by Professor Ann McNeill. The key conclusions of the OHID report are summarized below.

2. Health risks

2.1. In the short and medium term, vaping poses a small fraction of the risks of smoking.

2.2. Whilst long-term data are not yet available, biomarkers can be used as intermediate indicators of harm. Data on these suggest that the long-term health impacts of vaping are lower compared to smoking.

2.3. Toxicants were of a similar or higher level in people who vaped compared to those not using nicotine products (absolute risk) indicating that vaping is not risk-free, particularly for those who have never smoked.

2.4. Six studies have looked at the health risks of secondhand exposure to vapes. The evidence suggests there is no significant increase in toxicant biomarkers after short-term secondhand exposure to vaping.

2.5. Fires, explosions and poisonings are risks from vape use. These risks are serious but rare. Fires are much more likely to be caused by cigarettes than vapes - in London between 2017 and 2021, cigarettes were the source of ignition for over 5,000 fires, vapes for 15.

3. The role of vaping in smoking cessation

3.1. Vaping products remain the most common aid used by people to help them stop smoking.

3.2. Misinformation persists on vaping harms and can influence people's subsequent vaping and smoking behaviour.

3.3. Communicating accurate information about the relative harms of vaping can help to correct misperceptions of vaping, particularly among adults.

3.4. Interventions on absolute harms of vaping that aim to deter young people need to be carefully designed so they do not misinform people (particularly people who smoke) about the relative harms of smoking and vaping.

McNeill, A., Brose, L. S., Calder, R., & Hitchman, S. C. (2022). Nicotine vaping in England: 2022 evidence update. Office for Health Improvement and Disparities.

https://assets.publishing.service.gov.uk/media/633469fc8fa8f5066d28e1a2/Nicotine-vaping-in-England-2022-report.pdf

4. Current Position

4.1. The City and Hackney TCA has applied the latest evidence on vaping in co-developing a vaping position statement, to inform local policy and action to minimise the risks and to maximise the benefits of vaping.

4.2. The TCA vaping position statement includes the following principles, with further details laid out in the statement document appended to this report:

a. harms of tobacco use
b. relative harms of vaping
c. effectiveness of vapes as harm reduction tools
d. prevention
e. unacceptable marketing practices
f. commitment to ongoing review

4.3. Principle f. commits the TCA to review this position statement on a regular basis, in response to emerging evidence on relative harms and to ensure it continues to align with national policy and regulatory frameworks.

5. Options

N/A

6. Proposals

6.1. The primary recommendation is for members of this Board to familiarise themselves with the latest evidence on the health harms of vaping, as summarised in this report and to be presented by Professor Ann McNeill at the Board meeting on 9 May.

6.2. The Board is also asked to consider how they can support implementation of the City and Hackney TCA vaping position statement (which is based on the latest evidence), including reinforcing the messages contained within the statement.

7. Key Data

7.1. In stop smoking services in England in 2020 to 2021, quit attempts involving a vaping product were associated with the highest success rates (64.9% compared with 58.6% for attempts not involving a vaping product).

7.2. Research from University College London suggests that vapes could help up to an extra 70,000 smokers quit in England.

7.3. In 2021, only 34% of adults who smoked *accurately* believed that vaping was less harmful than smoking. Only 11% of adults who smoked knew that none or a small proportion of the risks of smoking were due to nicotine. Inaccurate perceptions need to be addressed in order to reduce the significant harm caused by tobacco smoking.

8. Corporate & Strategic Implications

8.1. **Strategic Implications -** As the leading cause of poor health and inequalities, comprehensive tobacco control is crucial to the success of the Health and Wellbeing Strategy. To maximise the potential for reducing smoking-related harm, the City and Hackney TCA's efforts must be informed by the latest evidence, ensuring equitable access to proven support for quitting. The TCA's vaping position statement directly contributes to a key outcome of the Corporate Plan: the delivery of excellent services.

9. **Financial implications** - N/A

10. **Resource implications** - N/A

11. **Legal implications** - N/A

12. **Risk implications** - N/A

13. **Equalities implications**

13.1. Tobacco use continues to be the leading preventable cause of death, disease, and disability in our communities. Reducing smoking rates among disadvantaged groups is the most effective way to tackle health inequalities.

13.2. By implementing a vaping position statement that maximises the benefits and minimiaes the risks of vaping within local City smoking cessation programs, the TCA will help reduce smoking prevalence and alleviate the health burden caused by tobacco use, particularly among the most vulnerable populations

14. **Climate implications**

14.1. 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. An important amendment to the Tobacco and Vapes Bill was proposed to ban all filters for cigarettes.

14.2. The single use vape ban goes into effect on June 1, 2025, a significant success given the environmental impact from improper disposal. Ensuring the safe disposal and recycling of vapes is critical to mitigate their environmental impact and reduce harm to the climate. The TCA vaping position statement directs all retailers to fulfill their legal duty to provide recycling facilities for used and unwanted vape products.

15. **Security implications** - N/A

16. **Conclusion**

16.1. Although significant progress has been made in addressing tobacco smoking both nationally and locally in recent years, it remains the leading cause of preventable disease and death, and continues to be one of the most significant contributors to health inequalities. Offering effective smoking cessation programs, based on the latest evidence and including the use of vapes to aid in quitting, is essential to reducing smoking-related harm - as part of a broader tobacco control strategy.

17. Appendices

Appendix 1: Full presentation by Professor Ann McNeill to be delivered to the City of London Corporation Health and Wellbeing Board

Appendix 2: City and Hackney Tobacco Control Alliance Vaping Position Statement

Nickie Bazell

Senior Public Health Specialist

E: nickie.bazell@cityandhackneyph.hackney.gov.uk

Vaping Position Statement

City and Hackney Tobacco Control Alliance

The City and Hackney Tobacco Control Alliance (TCA) is committed to protecting public health, adhering to the WHO Framework Convention on Tobacco Control and ensuring compliance with all national tobacco and vaping laws, guidelines and policies.

Vaping can be an effective tool to help adult smokers to quit, however the message for non-smokers is clear - **if you don't smoke, don't vape**.

The rising use of vapes among children and young people is a concern. This statement outlines our joint position and the guiding principles contained within it will inform local policy and action, with the primary aim to protect the health and wellbeing of our local communities.

In our approach to vaping, we recognise the following principles:

1. **Harms of tobacco use:** Tobacco use remains the leading preventable cause of death, disease and disability in our communities, and reducing smoking among disadvantaged groups is the most effective way to address health inequalities. The City and Hackney TCA remains focused on tackling the harms from tobacco.

2. **Relative harms of vaping**: Current evidence indicates that nicotine vapes are substantially less harmful than using tobacco, although they are unlikely to be risk-free. Vaping exposes users to far fewer toxins, significantly reducing health risks compared to smoking tobacco. In the short and medium term, vaping poses a small fraction of the risks of smoking, but we must remain vigilant to the additional risks of using illicit vapes which may contain unregulated ingredients.

   We acknowledge the environmental harm caused by improper and unsafe disposal of vapes, particularly disposable vapes. We expect all retailers to fulfill their legal duty to provide recycling facilities for used and unwanted vape products.

3. **Effectiveness of vapes as harm reduction tools:** Nicotine vapes are the most popular stop smoking aid in England and research shows that they are highly effective in helping smokers to quit. Alongside behavioral support, the City and Hackney TCA endorses the use of legal (MHRA-approved) nicotine vapes and other evidence-based smoking cessation aids as tools to reduce tobacco-related harms. Vapes provided through stop smoking services will not be sourced from the tobacco industry.

4. **Prevention**: We strongly discourage non-smokers, particularly children and young people, from taking up any form of vaping. It is critical to prevent individuals who have never smoked from being introduced to vaping and to avoid the potential for future smoking and other harmful behaviors.

5. **Unacceptable marketing practices**: Marketing strategies targeting children, young people and never-smokers are unacceptable and detrimental to public health. City and Hackney TCA strongly opposes such practices, and upholds ethical standards in line with the WHO Framework Convention on Tobacco Control by implementing measures to prevent industry interference and protect against exploitative marketing.

6. **Ongoing review commitment**: The TCA will review this position statement on a regular (at least annual) basis, in response to emerging evidence on relative harms and to ensure it continues to align with national policy and regulatory frameworks.

Evidence on vaping

Presentation to City & Hackney (draft)

Ann McNeill
May 2025

Conflicts of interest

- My salary is paid for by King's College London
- My funding comes from a variety of governmental & non-governmental sources
- I do not take funding from tobacco or vaping companies

Summary

- Introduction & context
- Evidence - what do we know about vaping:
  - Risks
  - Do they help people to stop smoking?
  - Impact on adolescents & adolescent smoking
- What is the best regulatory framework for vaping?

Introduction & context

Tobacco smoke is uniquely deadly

- >7,000 chemicals in tobacco smoke
- >250 known to be harmful, including hydrogen cyanide, carbon monoxide & ammonia
- ~70 known to cause cancer including arsenic, benzene & cadmium

Globally:

~ 1.1 billion smokers

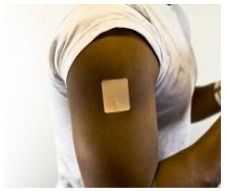
~ 7 million die every year from a smoking related disease

Separating the nicotine from the tobacco smoke

"Smokers smoke for the nicotine, but die from the tar"

Professor Mike Russell, Maudsley Smokers Clinic, 1979

Different nicotine products


Skin patch


Gum


Lozenges


Inhalator


Microtabs


Nasal spray


Mouth Spray

Licensed nicotine replacement therapies


'Cigalikes'


'Tanks'


'Mods'


'Pods'


'Puff' bars

E-cigarettes/nicotine vaping products

Other types include Heated Tobacco Products, Nicotine Pouches etc

Vaping

Smoking

CONTAINS	CONTAINS
Propylene glycol &/or vegetable glycerine	Tobacco
Flavouring	Additives
Nicotine*	**Nicotine**
Heated	**Burned**
100-250 ºC	600-900 ºC

*Not all e-liquid contains nicotine

Government-commissioned evidence updates

2022

Nicotine vaping in England: an evidence update including health risks and perceptions, 2022

A report commissioned by the Office for Health Improvement and Disparities

Published 29 September 2022

Authors

Ann McNeill, Erikas Simonavičius, Leonie Brose, Eve Taylor, Katherine East, Elizabeth Zuikova, Robert Calder, Debbie Robson

2015
E-cigarettes: an evidence review

2018
Evidence review of EC & HTP
Focus on cessation and health risks

2019
Vaping in England
Focus on SE indicators

2020
Vaping in England
Focus on mental health & pregnancy

2021
Vaping in England
Focus on smoking cessation

Updated by RCP in 2024

What do we know about vaping? Risks

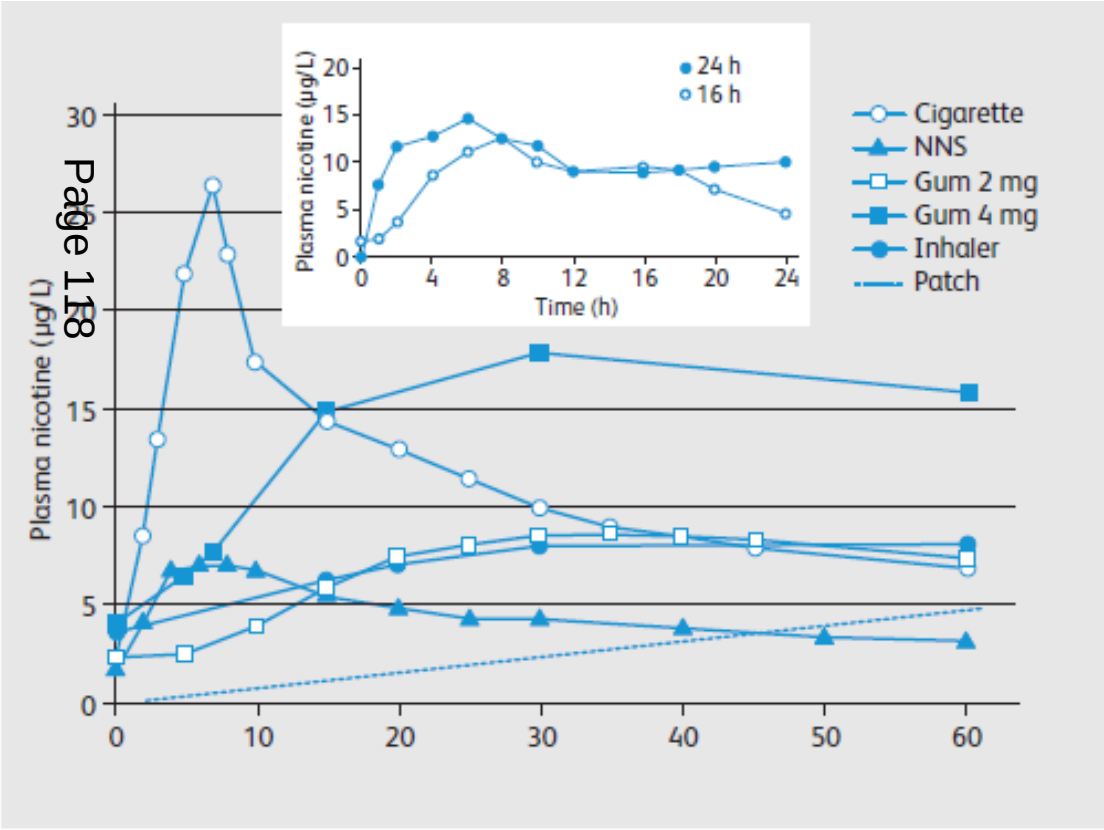
Nicotine dependence

Addictive, depending on
How it's delivered
How ***fast*** nicotine reaches the brain
In what ***form*** it's delivered
What it's ***mixed*** with
If its **burned**

Dependency of nicotine depends on the delivery system: speed of delivery & dose

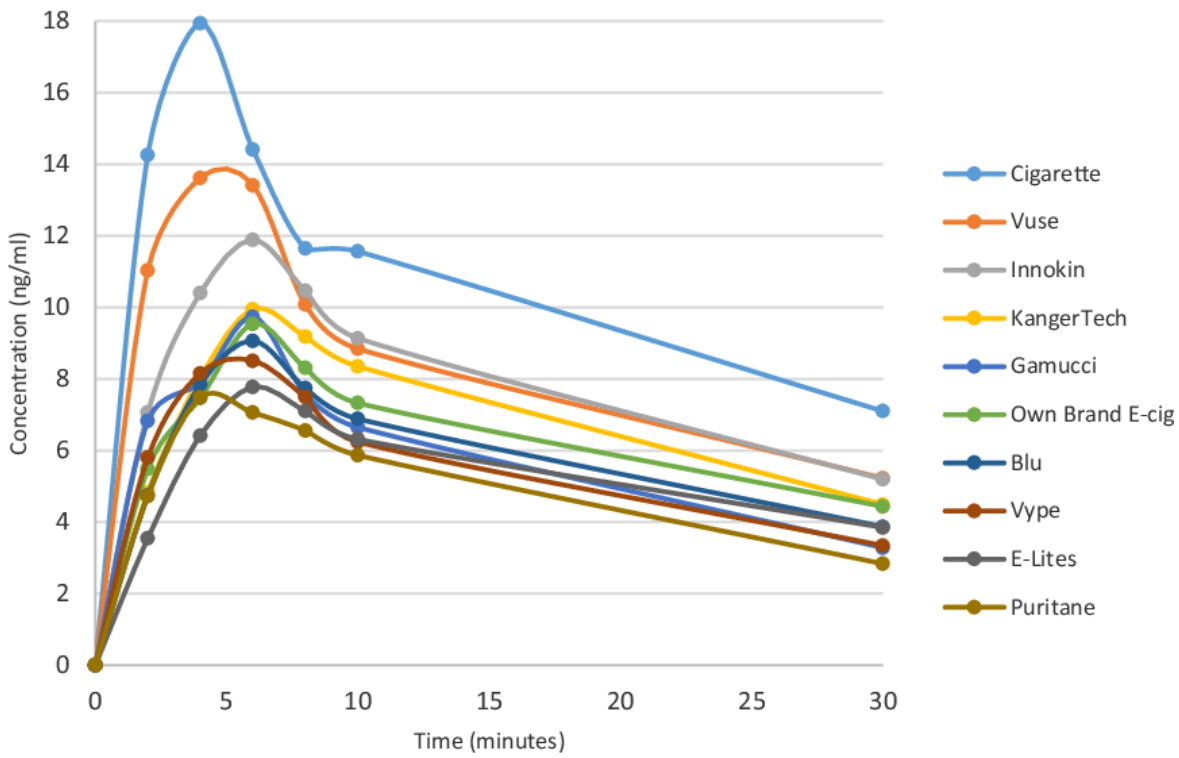
(RCP Nicotine without smoke report, 2016)

Cigarettes & NRT



NNS= nicotine nasal spray; inset = nicotine transdermal patch

Cigarettes & E-cigarettes



Hajek,P et al (2016) Nicotine delivery to users from cigarettes and from different types of e-cigarettes, Psychopharmacology. doi: 10.1007/s00213-016-4512-6

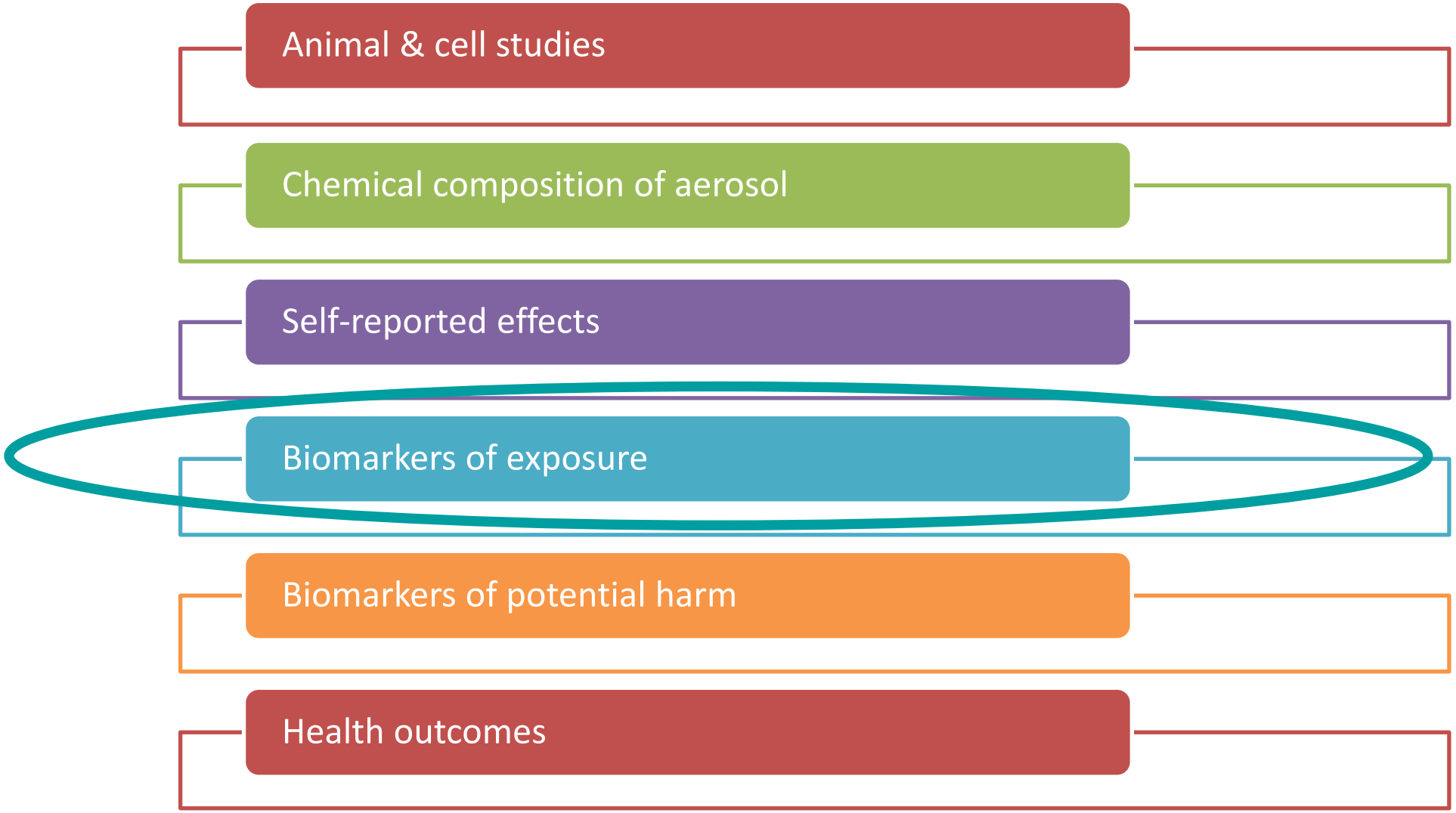
Nicotine dependence

Addictive, depending on

- ***How*** it's delivered
- How ***fast*** nicotine reaches the brain
- In what ***form*** it's delivered
- What it's ***mixed*** with
- If its **burned**

- Sustains tobacco addiction, but…..
- Nicotine **does not** cause cancer
- Does not cause respiratory problems
- Temporarily increases heart rate by ~8bpm

Assessing health risks of vaping – hierarchy (*McNeill et al, 2018*)



OHID

Searched & reviewed literature published
Aug 2017 to July 2021

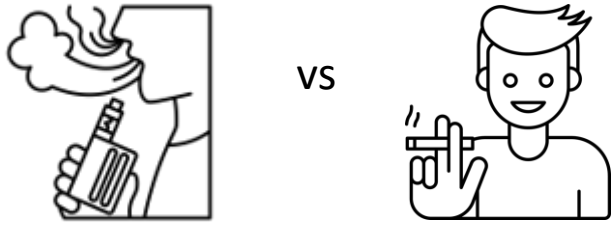
231 human biomarker studies

RCP

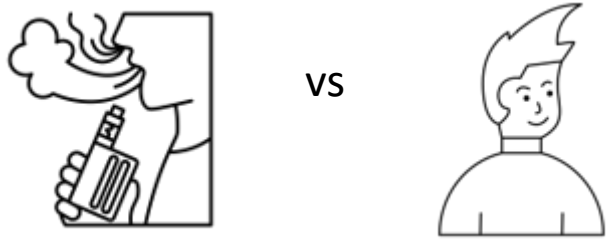
Searched & reviewed literature published
Aug 2021 to Feb 2023

30 human biomarker studies

Relative risks



Absolute risks



Biomarker of exposure

A measure of how much of a substance (toxicant), or its metabolite is in the body (in urine, saliva, blood or hair)

WHO biomarkers of priority toxicants (& metabolites) for *tobacco* (WHO Study Group on Tob Prod Reg, 2019)					
Nicotine	**Carbon Monoxide**	**Tobacco-specific nitrosamines**	**Volatile organic compounds**	**Metals**	**Other potential toxicants (eg PAHs)**

Metabolites (toxicants)	Vaping vs Smoking (relative risk)	Vaping vs Non-use (absolute risk)
Tobacco-specific nitrosamines		
NNAL (NNK)	↓	↑
NNN	↓	–
NAB	↓	↑
NAT	↓	↑
Volatile organic compounds		
AAMA (Acrylamide)	=	=
GAMA (Acrylamide)	↓	=
CEMA (Acrolein)	=	=
3-HPMA (Acrolein)	↓	=
CNEMA (Acrylonitrile)	↓	↑
S-PMA (Benzene)	=	=
MU (Benzene)	=	–
MHBMA (1,3-Butadiene)	↓	=
DHBMA (1,3-Butadiene)	=	=
HMPMA (Crotonaldehyde)	↓	=
S-BMA (Toluene)	=	=
Carbon monoxide	↓	–

Illustrative results from meta-analyses

↓ significantly lower

↑ significantly higher

= no significant difference

– not enough data to meta-analyse

Biomarkers of exposure to potential toxicants summary

Significantly lower among people who vaped than smoked

Similar or higher among people who vaped than non-users

Biomarkers of exposure to toxicants related to specific diseases

	Cancer Exposure to carcinogens	Respiratory disease Exposure to respiratory related toxicants	Cardiovascular disease Exposure to CVD related toxicants
Vaping vs smoking	Significantly lower	Significantly lower	Significantly lower
Vaping vs non use	Similar Higher for some	Similar for most	Similar

Secondhand exposure

8 studies across both reports:

- 2 studies exposed people to atypically high levels of vaping emissions
- Typically lack of secondhand smoking exposure for comparison

Acute secondhand exposure to vaping aerosol resulted in **non-significant changes** in toxicant **biomarkers of exposure**

One newer study of at least some daily second-hand exposure to vaping over a year found a significantly higher level of an inflammatory cytokine among those exposed.

Poisonings

- Incidents of poisonings can be serious but are rare

Explosions

- Incidents of exploding batteries can be serious but are very rare

Fires: London Fire Brigade (2017-2021)

	Cigarettes	Vaping products
Ignition source	5706	15
Injuries	676	0
Fatalities	46	0

Overall findings

Vaping poses only a small fraction of the risks of smoking in the short to medium term

Vaping is not risk-free, particularly for people who have never smoked

Methodological limitations across the studies – need more research

More recent reviews from Canada

Addictive Behaviors 163 (2025) 108243

Contents lists available at ScienceDirect

Addictive Behaviors

journal homepage: www.elsevier.com/locate/addictbeh

Evidence update on e-cigarette dependence: A systematic review and *meta*-analysis

Anasua Kundu [a], Sherald Sanchez [a], Siddharth Seth [a], Anna Feore [b], Megan Sutton [c], Kyran Sachdeva [d], Nada Abu-Zarour [e], Michael Chaiton [a,f,g], Robert Schwartz [f,g,h,*]

Systematic review

Cardiovascular health effects of vaping e-cigarettes: a systematic review and meta-analysis

Anasua Kundu [1], Anna Feore,[2] Sherald Sanchez,[1] Nada Abu-Zarour,[3] Megan Sutton,[4] Kyran Sachdeva,[5] Siddharth Seth,[1] Robert Schwartz,[6,7] Michael Chaiton[6,7]

Heart: first published as 10.1

Tobacco Induced Diseases

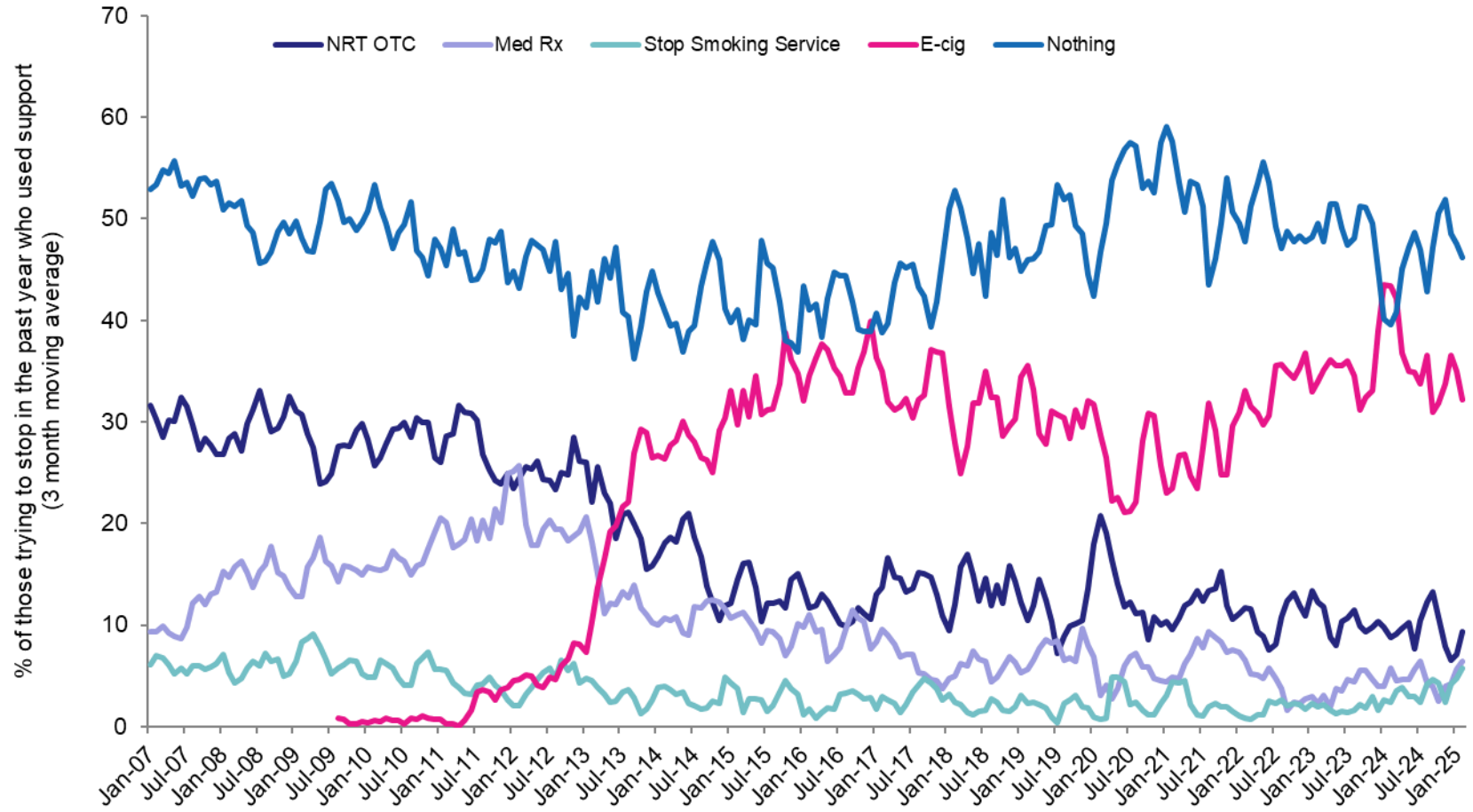
Review Paper

Evidence update on the cancer risk of vaping e-cigarettes: A systematic review

Anasua Kundu[1], Kyran Sachdeva[2], Anna Feore[3], Sherald Sanchez[1], Megan Sutton[4], Siddharth Seth[2], Robert Schwartz[5,6], Michael Chaiton[1,5,6]

What do we know about vaping? Do they help people to stop smoking?

Support used in quit attempts



NRT OTC: Nicotine replacement therapy bought over the counter; Med Rx: Prescription medication; : E-cigarette. Method is coded hierarchically with smokers using more than one method classified into most intensive by the following scheme: 1. Nothing, 2. NRT OTC, 3. E-cigarette, 4. Med Rx, 5. SSS. In updates until June 2015, NRT OTC was coded above e-cigarette - earlier figures have now been revised.

Cochrane Library

Cochrane Database of Systematic Reviews

Electronic cigarettes for smoking cessation (Review)

Lindson N, Butler AR, McRobbie H, Bullen C, Hajek P, Begh R, Theodoulou A, Notley C, Rigotti NA, Turner T, Livingstone-Banks J, Morris T, Hartmann-Boyce J

88 studies
47 RCTs
~27,000 ppts

There is high-certainty evidence that e-cigarettes with nicotine increase quit rates compared to licensed nicotine replacement therapies

Comment

https://doi.org/10.1038/s41591-022-02201-7

Nicotine e-cigarettes as a tool for smoking cessation

Kenneth E. Warner, Neal L. Benowitz, Ann McNeill & Nancy A. Rigotti

Check for updates

There is abundant evidence that e-cigarettes can help some individuals to quit smoking, so they should be more widely recommended as smoking cessation aids.

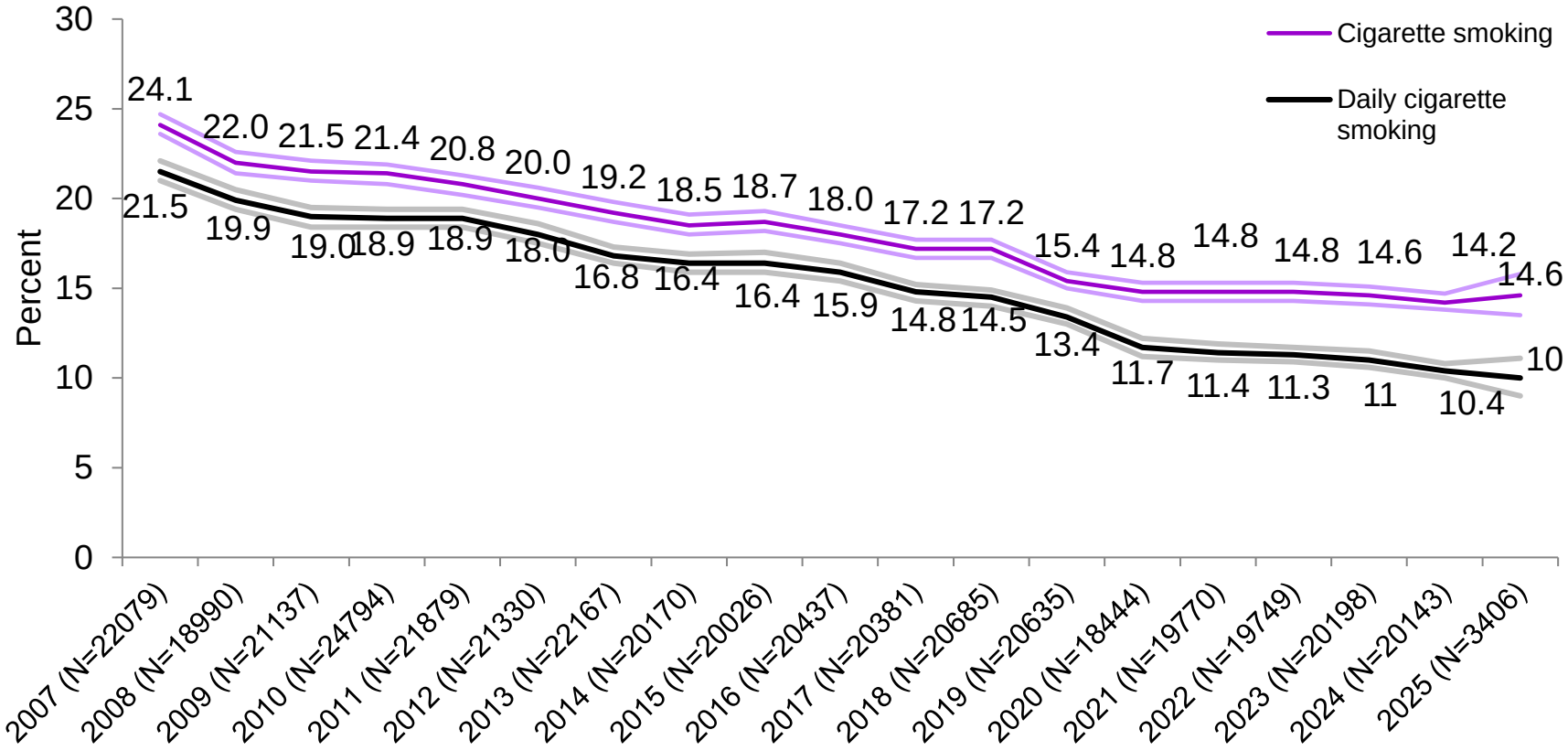
was high certainty that [smoking] quit rates were higher in people randomized to nicotine [electronic cigarettes] than in those randomized to nicotine replacement therapy". The authors also found evidence of cessation benefits when comparing nicotine e-cigarettes with non-nicotine e-cigarettes, and with behavioral support or no treatment.

Population studies support the randomized controlled trial find-

Vapes – additional quits every year

In the UK, vapes may have helped an additional 30-50,000 additional quits every year since they became popular in 2013

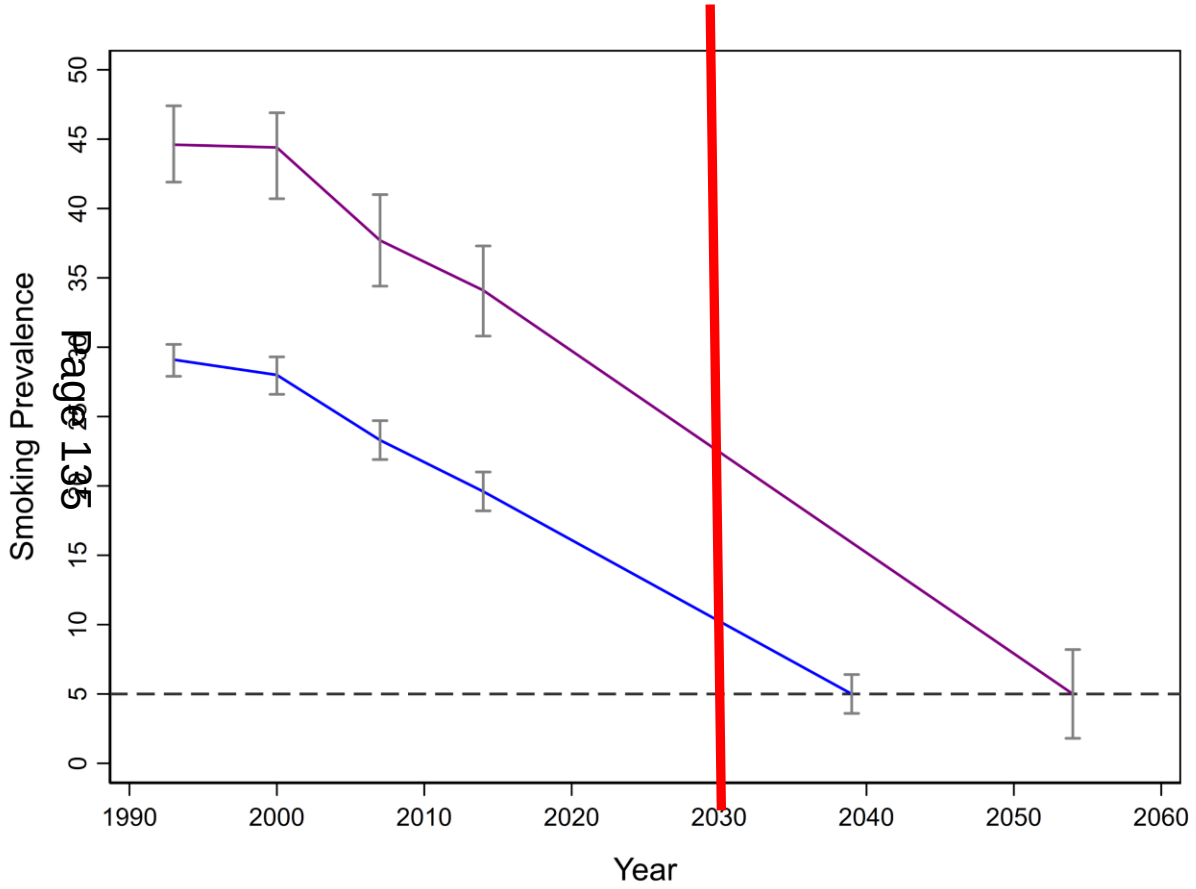
Cigarette smoking prevalence



Base: Adults (16 and over till Feb 20; 18 and over from April 20; 16 and over from Jan 22)

Graph shows prevalence estimate and upper and lower 95% confidence intervals

E-cigarettes are also attractive to more disadvantaged smokers - Smokefree 2030 for all?



Without a mental health condition

With a mental health condition

Assuming no change - based on mean annual percentage point (i.e. not percentage rate) decrease in smoking prevalence estimated using weighted APMS data from Great Britain overall

No mental health condition[1]: smoking prevalence in this group will **reach 5% in *2039*** (18 years from 2020; 95% CI: 17.6 to 20.4 years).

Mental health condition[2]**:**, smoking prevalence in this group will reach **5% in *2054*** (34.3 years from 2020; 95% CI: 31.1 to 37.5 years).

[1]Based on 0.60% percentage-point decrease in smoking prevalence per year for non-MHC group and [2]0.74% percentage-point decrease in smoking prevalence per year for MHC group

Richardson & Robson (2021) Adapted from Richardson, McNeill & Brose (2019) Smoking and quitting behaviours by mental health conditions in Great Britain (1993-2014) Addictive Behaviours 90:14-10

What do we know about vaping? Impact on adolescents & adolescent smoking

Do e-cigarettes lead to cigarette smoking?

O'Brien *et al. BMC Public Health* (2021) 21:954
https://doi.org/10.1186/s12889-021-10935-1

BMC Public Health

RESEARCH ARTICLE Open Access

Association between electronic cigarette use and tobacco cigarette smoking initiation in adolescents: a systematic review and meta-analysis

Doireann O'Brien[1], Jean Long[1*], Joan Quigley[1], Caitriona Lee[1], Anne McCarthy[1] and Paul Kavanagh[2]

Adolescents who have **never smoked** at baseline, subsequently smoking & initiating smoking at f/u

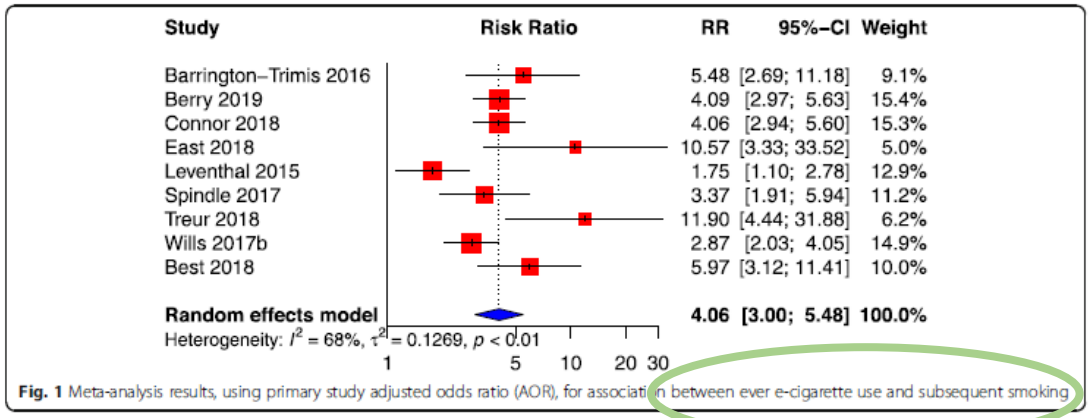


Fig. 1 Meta-analysis results, using primary study adjusted odds ratio (AOR), for association between ever e-cigarette use and subsequent smoking

'We identify a 4-fold increased likelihood between e-cigarette use & initiating smoking tobacco cigarettes in adolescents in a combined analysis of 9 cohort studies conducted with follow-up periods between 4 & 24 months'

But.. cigarette smoking also leads to vaping & using vapes to stop smoking

Journal of Adolescent Health 62 (2018) 539–547

ELSEVIER

JOURNAL OF ADOLESCENT HEALTH
www.jahonline.org

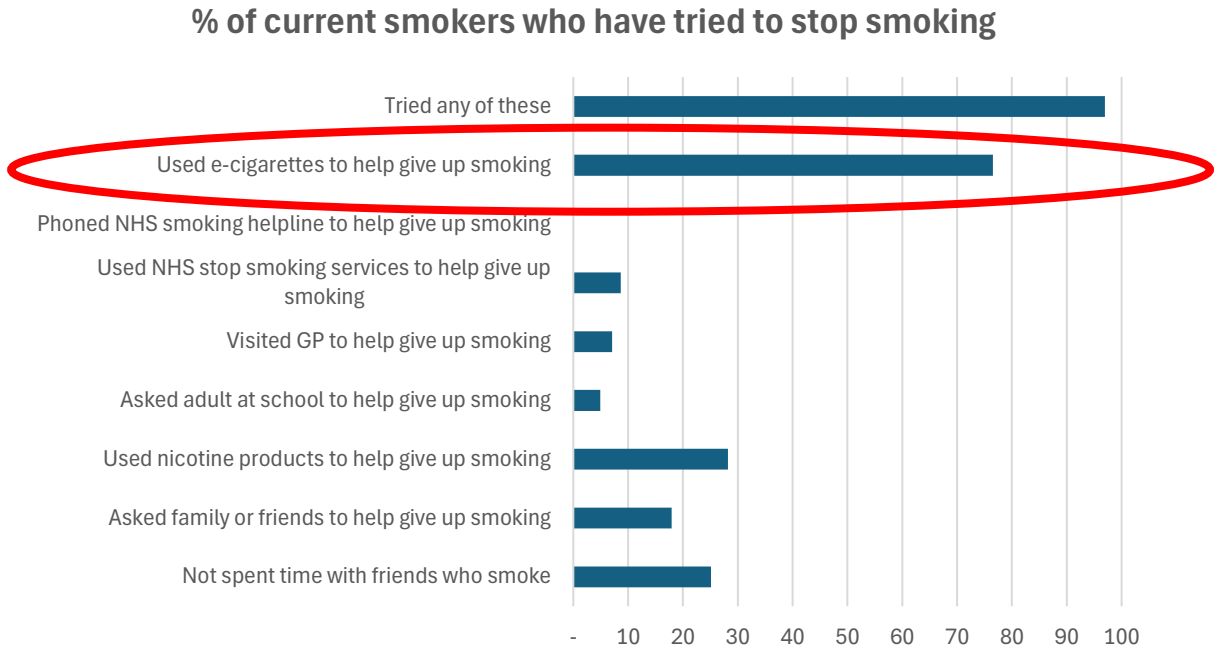
Original article

The Association Between Smoking and Electronic Cigarette Use in a Cohort of Young People

Katherine East, MS.c. [a,b,*], Sara C. Hitchman, Ph.D. [a,b], Ioannis Bakolis, Ph.D. [c,d], Sarah Williams [e,f], Hazel Cheeseman, MS.c. [f], Deborah Arnott, M.B.A. [f], and Ann McNeill, Ph.D. [a,b]

[a] Addictions Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK
[b] UK Centre for Tobacco and Alcohol Studies, Clinical Sciences Building, University of Nottingham, Nottingham, UK
[c] Department of Biostatistics and Health Informatics, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK
[d] Centre for Implementation Science, Department of Health Services and Population Research, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK
[e] Public Health England, London, UK
[f] Action on Smoking and Health UK, London, UK

Article history: Received July 7, 2017; Accepted November 28, 2017
Keywords: Smoking; Electronic cigarettes; E-cigarettes; Young people; Youth; Adolescent; Longitudinal studies; Nicotine; Tobacco



‘In conclusion, this study provides further support for the association between ever e-cigarette use and smoking initiation, **& additionally finds that ever smoking is associated with e-cigarette initiation, among young people’**

Sources of help to stop smoking among 11-15 year olds who smoke or recently smoked in England

Smoking, Drinking and Drug Use among Young People in England, 2024 (Information from NHS England, licenced under the current version of the Open Government Licence)

Received: 24 September 2024 | Accepted: 16 December 2024

DOI: 10.1111/add.16773

REVIEW

ADDICTION SSA

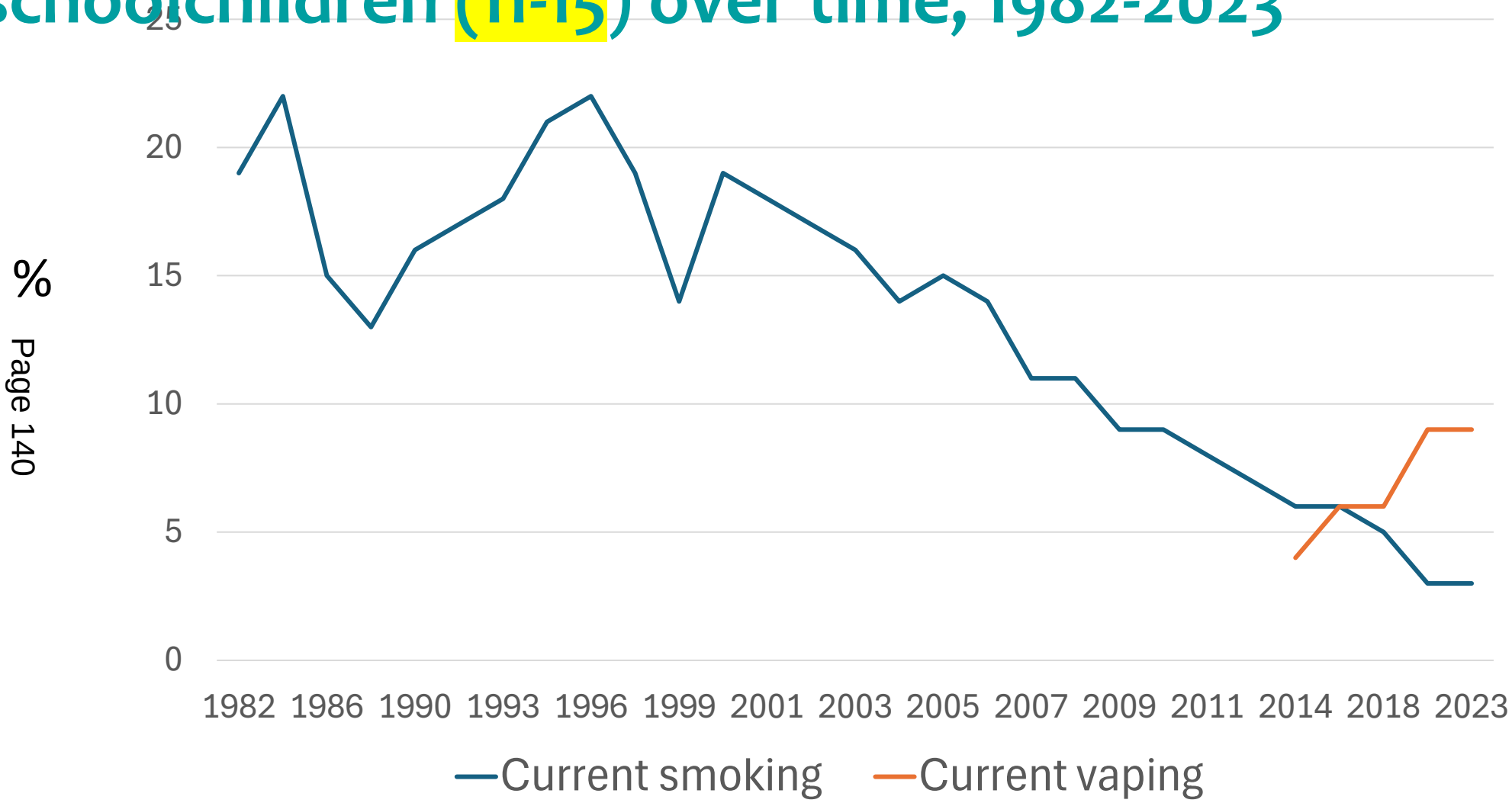
Electronic cigarettes and subsequent cigarette smoking in young people: A systematic review

Rachna Begh[1] | Monserrat Conde[1] | Thomas R. Fanshawe[1] | Dylan Kneale[2] | Lion Shahab[3] | Sufen Zhu[1] | Michael Pesko[4] | Jonathan Livingstone-Banks[1] | Nicola Lindson[1] | Nancy A. Rigotti[5] | Kate Tudor[6] | Dimitra Kale[3] | Sarah E. Jackson[3] | Karen Rees[7] | Jamie Hartmann-Boyce[8]

Very low certainty evidence suggests that youth vaping & smoking could be inversely related

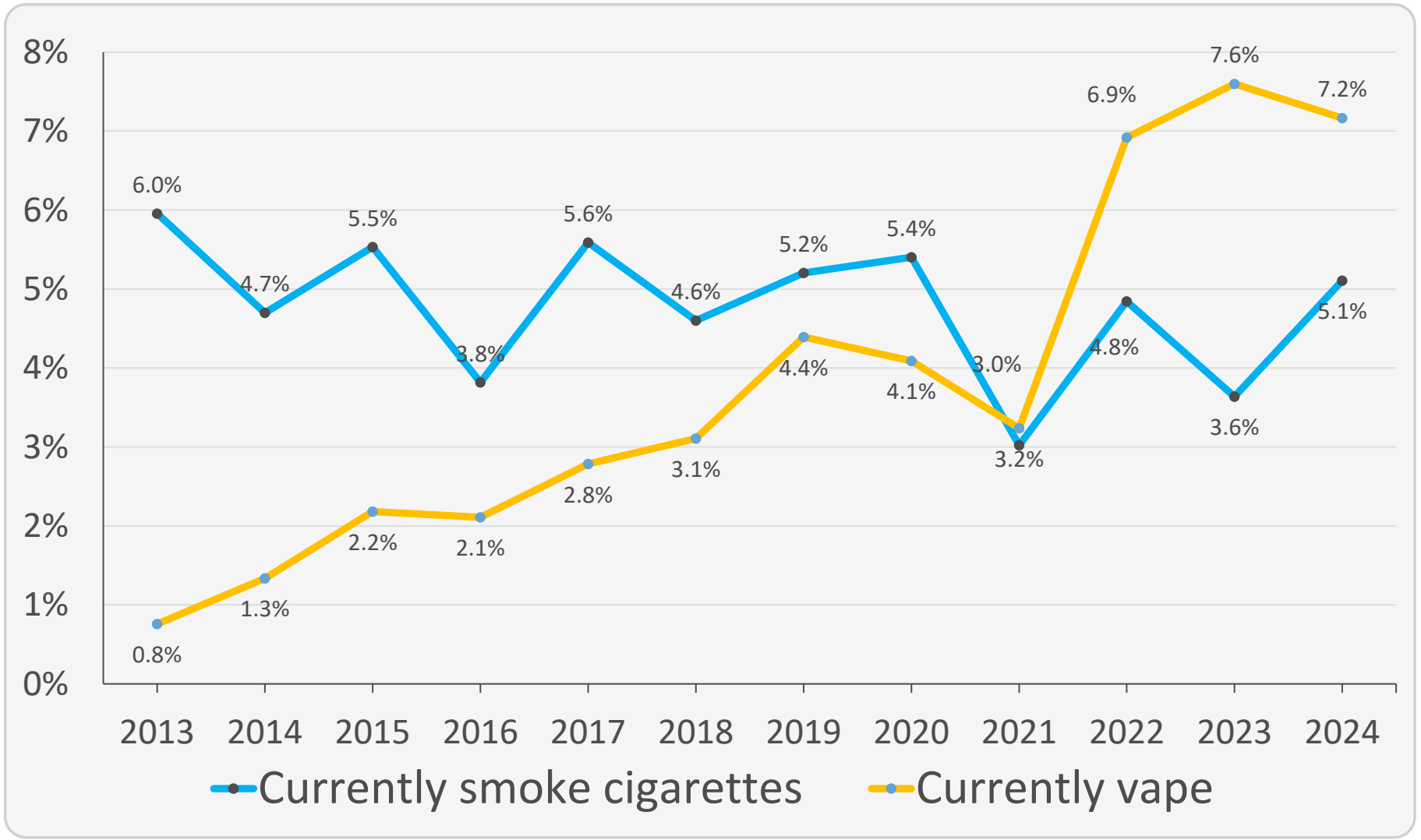
126 studies
98 from US

Current use of cigarettes & vapes by England schoolchildren (11-15) over time, 1982-2023



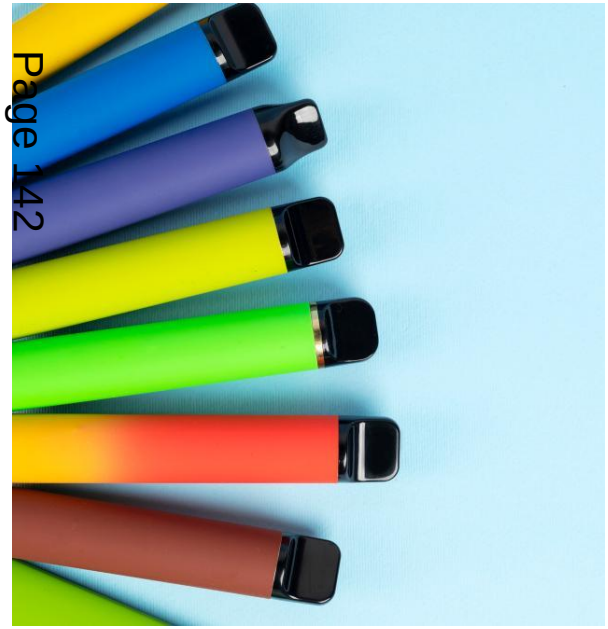
Smoking, Drinking and Drug Use among Young People in England, 2023. (Information from NHS England, licenced under the current version of the Open Government Licence)

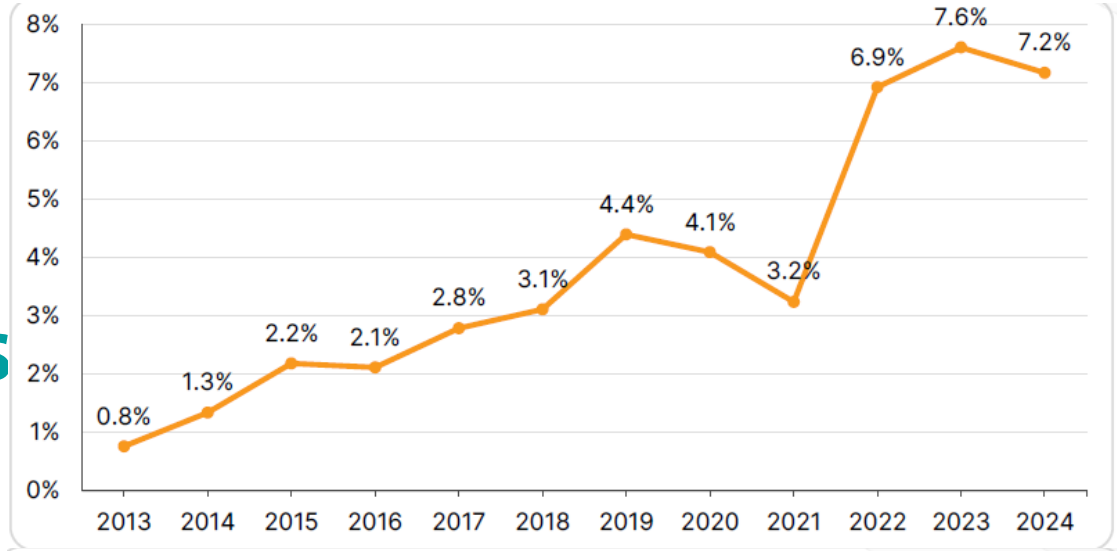
Current use of cigarettes and vapes by GB youth (11-17), 2013-2024



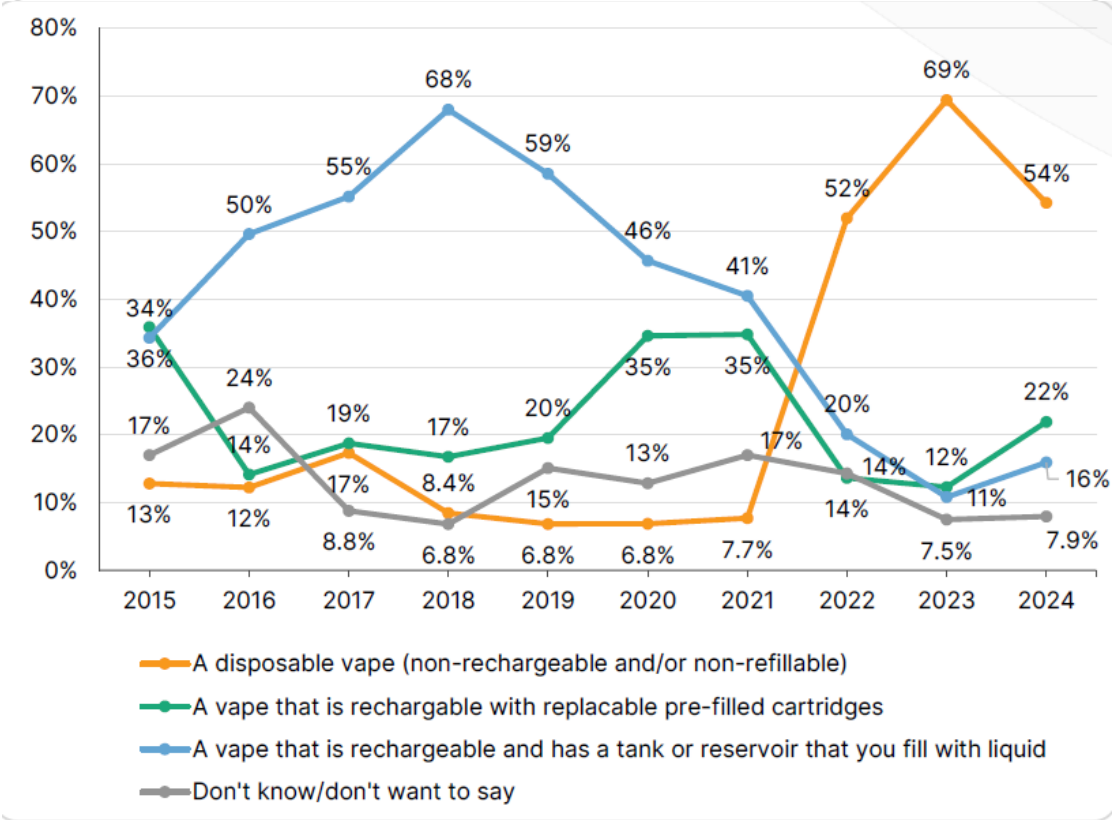
Action on Smoking and Health (ASH). Use of vapes (e-cigarettes) among young people in Great Britain. 2024.

In GB, rise in 11-17 yr old vaping associated with arrival of new disposables





Current vaping

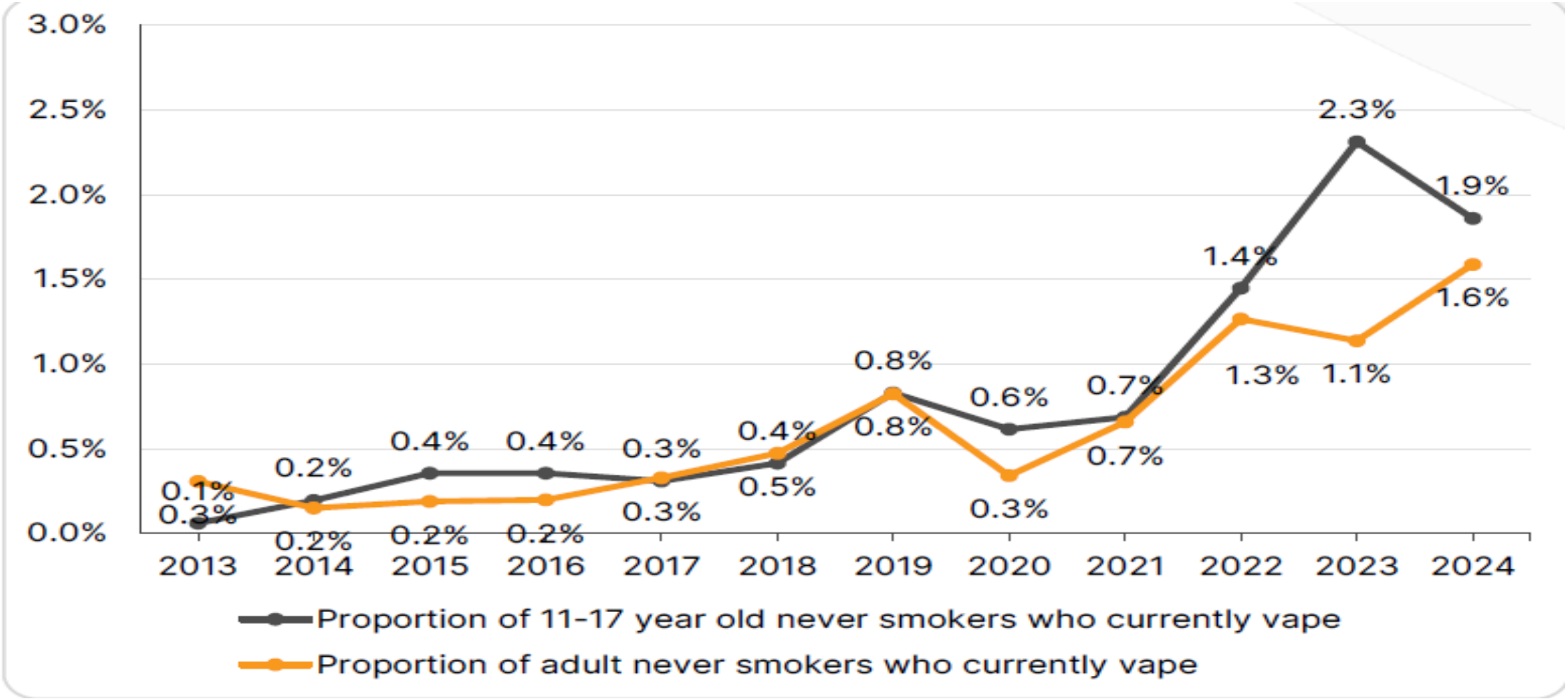


Use of different e-cigarette models in current vapers

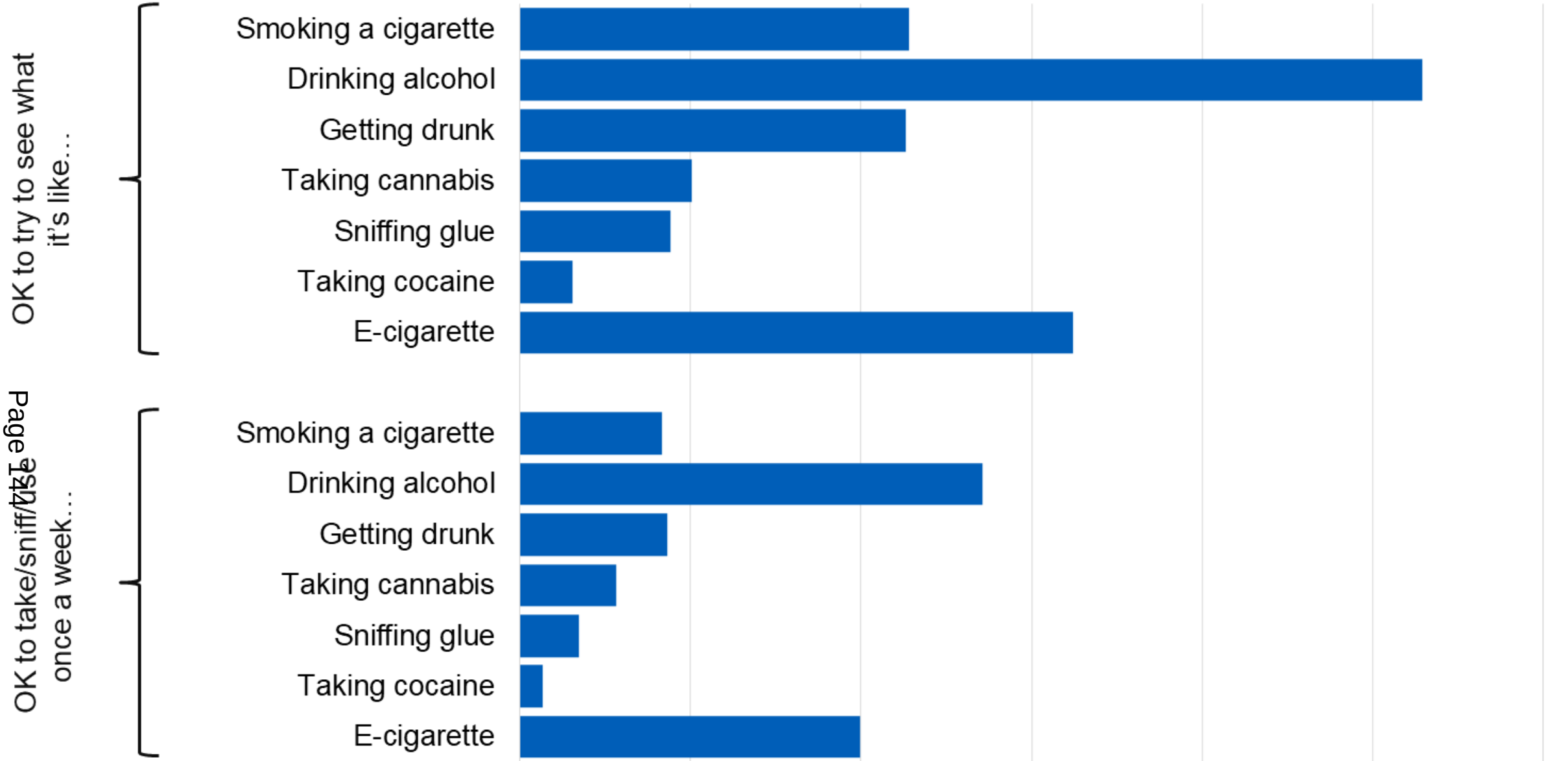
Vaping devices: © Yaroslav Litun / Getty Images / iStock.

Action on Smoking & Health (ASH). Use of vapes (e-cigarettes) among young people in Great Britain 2024. https://ash.org.uk

Never smokers who currently vape, GB, 2024 (mostly experimental)

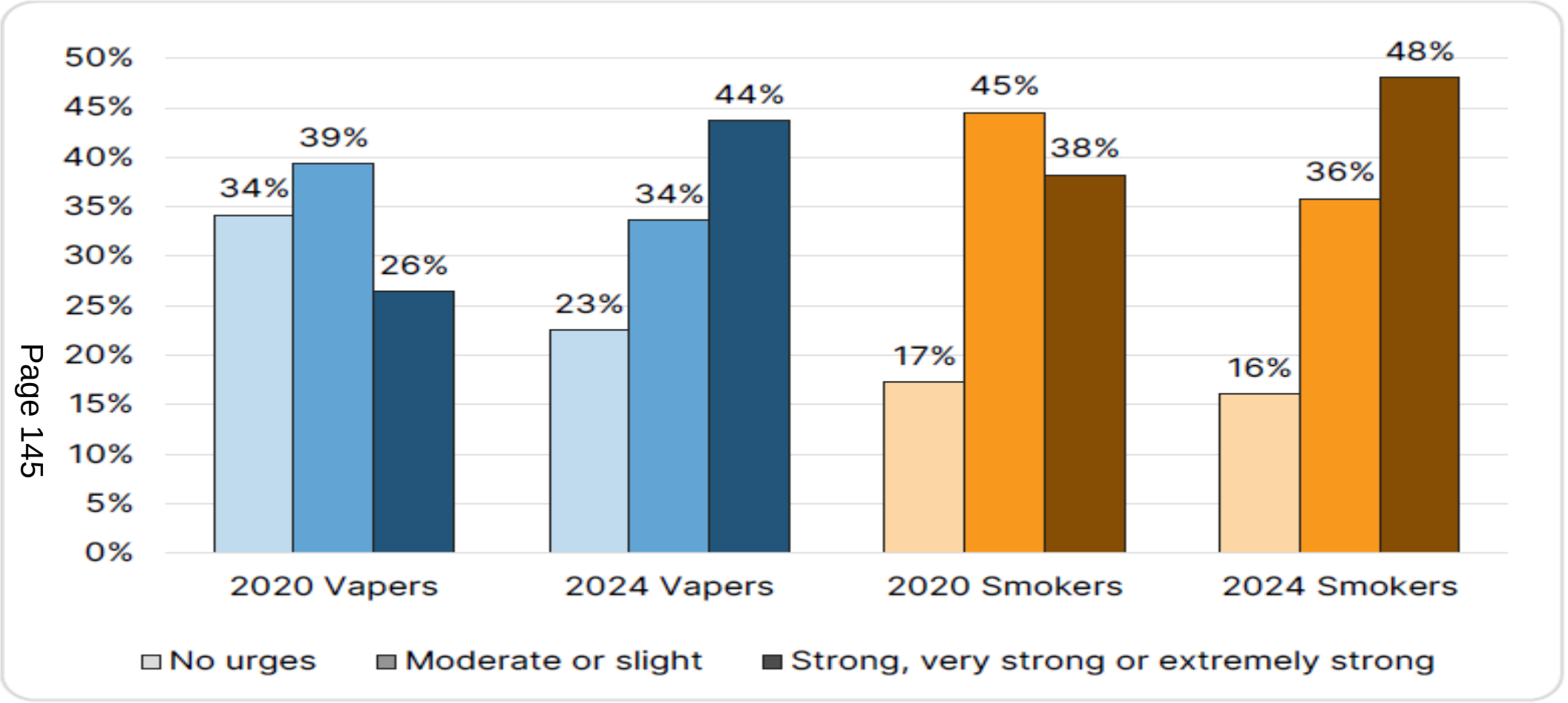


https://ash.org.uk/resources/view/use-of-e-cigarettes-among-young-people-in-great-britain



Source: https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2021

Figure 12. Reported urge to vape among vapers and reported urge to smoke among smokers, GB youth (11-17), 2020 & 2024



ASH Smokefree GB Youth Survey, 2024. *Unweighted base: 11–17-year-olds, (current vapers 2020=94, current vapers 2024=213, current smokers 2020=76, current smokers 2024=138)*

Recent papers on youth nicotine & toxin exposure

JAMA Network | Open

Original Investigation | Substance Use and Addiction

Nicotine Exposure From Smoking Tobacco and Vaping Among Adolescents

David Hammond, PhD; Jessica L. Reid, MSc; Maciej L. Goniewicz, PhD; Ann McNeill, PhD; Richard J. O'Connor, PhD; Danielle Corsetti, MSc; Ashleigh C. Block, MS; Leonie S. Brose, PhD; Deborah Robson, PhD

CANCER EPIDEMIOLOGY, BIOMARKERS & PREVENTION

ABOUT ARTICLES FOR AUTHORS ALERTS NEWS CANCER HALLMARKS WEBINARS

RESEARCH ARTICLE | MARCH 19 2025

Biomarkers of Toxicant Exposure among Youth in Canada, England, and the United States Who Vape and/or Smoke Tobacco or Do Neither

David Hammond; Jessica L. Reid; Maciej L. Goniewicz; Ann McNeill; Richard J. O'Connor; Danielle Corsetti; Leonie S. Brose; Bradley Schurr; Deborah Robson

Overall findings

Review evidence suggests e-cigarettes unlikely to be a gateway to smoking (more common liability)

Young people's vaping increased, with some increase among never smoking youth, but much is experimental

Evidence that some young people who vape are dependent

What is the best regulatory framework for vapes?

One that maximises the benefits, minimises the risks

Maximise smoking cessation

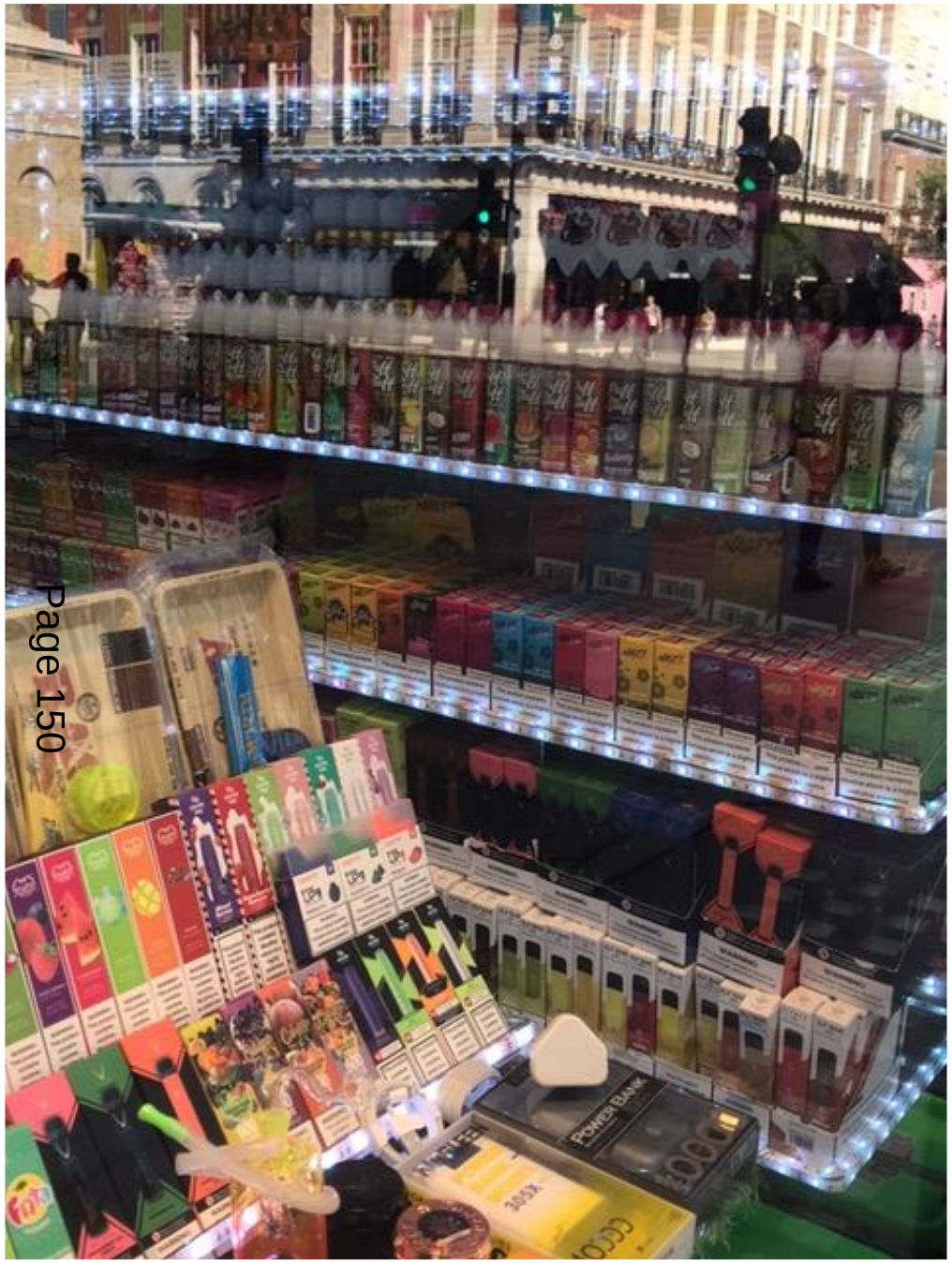
Ensure use of regulated, legal vapes

Minimise youth & never smoker uptake

Minimise use of illicit vapes

Minimise risks of vape products

Addictiveness? Affordability? Appeal? Accessibility?



Geek Bar Disposable Pod – £2.99

THE e-CIG STORE

£2.99 ~~£5.99~~

GET THIS DEAL

New legislation & regulations UK should drive down youth smoking but also limit attractiveness of vapes to young people

TOBACCO & VAPES BILL

THE ENVIRONMENTAL PROTECTION (SINGLE-USE VAPES) (ENGLAND) REGULATIONS 2024

VAPING PRODUCTS TAX

Thank you for listening!

Thanks to King's Nicotine Research Group & other co-authors of evidence updates & Dr Debbie Robson for several slides

ann.mcneill@kcl.ac.uk

City of London Corporation Committee Report

Committee(s): Health and Wellbeing Board – For information	**Dated:** 09/05/2025
Subject: Healthwatch City of London Progress Report	**Public report:** For Information
This proposal: Provides progress information.	
Does this proposal require extra revenue and/or capital spending?	No
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:	Healthwatch City of London
Report author:	Gail Beer, Chair, Healthwatch City of London

Summary

This report details the work of Healthwatch City of London for Q4 2024/25

Recommendation(s)

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 first contract for Healthwatch came into being in September 2019 and was awarded to a new charity Healthwatch City of London (HWCoL).

HWCoL is registered on the on the Charities Commission register of charities as a Charitable Incorporated Organisation and is Licenced by Healthwatch England (HWE) to use the Healthwatch brand. The current contract for Healthwatch City of London was awarded in September 2024.

HWCoL's vision is for a Health and Social Care system truly responsive to the needs of the people who live, work and study in 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.

Current Position

1.1 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.

The team are fully staffed and have a team of volunteers.

Public Board Meetings

1. Board Meeting in Public 14th March 2025

HWCoL held a Board meeting in public on 14th March 2025. This meeting was held online. The agenda covered an update on recently launched projects including the PALS, Digi App reports and output of the Barts Health and Neaman Practice Enter and Views. The team's work around Falls Prevention and attendance at the Health Mela event were also highlighted.

A financial update was also given.

The memorandum of understanding with NEL ICB around public and patient engagement was ratified.

Unfortunately, only one member of the public attended. It is acknowledged that the public response is improved when guest speakers are invited, and future meetings will have guest speakers.

Projects

1. Digital Apps in Healthcare

HWCoL has launched the digital apps report 'Digital Apps: A help or hindrance? Understanding and accessing digital healthcare apps'

The report was produced by the HWCoL team, Matt James, Associate Professor, Bioethics and Emerging Technologies, St Mary's University, Twickenham, and some

of our local residents. The report investigates how people in the City are impacted by the increase in digitisation of health care. It explores what is on offer to patients in the local area, how they work and whether they were easy to use.

The report highlights that local residents find that accessing digital apps can prove difficult and confusing. The findings and recommendations focus on what needs to be improved to reduce the issues and barriers that patients and carers are facing.

The launch event in February was for service providers and the guest speaker was Professor Julia Manning, Dean of Education at the Royal Society of Medicine, and an Honorary Professor of Practice in Computer Science at UCL. Julia has long championed the use of technology but is mindful of accessibility, and the pitfalls of limiting access to digital only. We were joined by Chief Information Officers and Digital leads from the NHS including from the Integrated Care Board (the commissioners of services), Homerton University Hospital and the Primary Care Network to discuss the findings in our report and to explore what we can do locally to make access easier for all not just those who are technologically savvy and for whom English is not a first language.

HWCoL have also shared the report with Healthwatch England research and policy team who will use it alongside similar studies nationally to influence feedback to the NHS and inform Government policy.

In April HWCoL were due to hold a launch lunch with the attendees of the focus group and the digital lead from the Homerton. HWCoL will keep this important issue at the forefront of discussion with CIOs and Digital Leads from across NEL NHS hospitals and service providers by attending the Digital Enabler Board.

The report is attached

2. PALS Report

In March HWCoL launched the ‘Patient Advice and Liaison Service (PALS) A review of PALS services available to City of London residents’ report.

Each NHS trust is required to provide a PALS service to support patients and their carers with health-related questions, help to resolve concerns or problems when using the NHS and to provide information on how to get more involved in one’s own healthcare.

To produce the report the team and a HWCoL volunteer carried out desk-based research looking at how accessible and easy to find the online information on PALS is, and what information was available. It found that the level of information is vastly different between the hospitals.

The team also visited each hospital to physically see the PALS offering at each hospital, again it found the information varied, some hospitals have external signage pointing to the PALS office, whilst others had none. This can also be said of the staff knowledge of PALS and its location.

In our report HWCoL have listed out our recommendations, which surround improving the current accessibility and communication that PALS provides, such as, improving the PALS web page to enhance its accessibility features and improving ways patients are able to get in touch with PALS. It is also essential that hospital staff are aware of PALS, where it is located and how patients and family members can access the service.

The report is attached

Support to the City of London Corporation

1. Adult Social Care Advisory Group

HWCoL have agreed to set up and manage an Adult Social Care Advisory group following a request from the City of London Corporation. The terms of reference for the group will be agreed at the first meeting which was scheduled for 13th March. Requests to join the group were sent via mail to the recipients of social care however there were no volunteers. The team are working with the CoL to review next steps,

2. Adult Social Care Annual Survey

HWCoL also offered support for the ASC annual survey by providing help to users to complete the survey.

3. City Advice re-tender

HWCoL advertised the City Advice survey to understand what residents want from the service and their experience of the current service.

Enter and View Programme
Healthwatch have a statutory function to carry out Enter & View visits to health and care services to review services at the point of delivery.

3. Barts Health NHS Trust

The Barts Cardiology Enter and View report is now complete. HWCoL are planning to launch the report with David Curran (Chief Nurse) and Professor Charles Knight at a Public Board in Q1/2.

The Enter and View at St Bartholomew's Hospital was undertaken as a result of feedback from patients about poor levels of communication, in particular in the cardiology department. Ranging from lack of details on appointment letters, including crucial information such as dates, times, or the location of where the appointment is being held, it was identified that there was a need to find out the cause of the problems. Patients have also received both a text message and a letter with contrary details and with no information on who to call to confirm their appointment.

The team spoke to both managers and staff at St Bartholomew's Hospital who are responsible for the communications and administration of cardiology appointments. The team also spoke directly to patients, both in waiting areas and in the wards, which, along with the survey previously distributed, highlighted the areas for improvement. The team followed the initial visit with a secondary visit to talk to more cardiology patients in their outpatient's department.

The report gives recommendations for improved patient experience which have been responded to by the Trust.

The report is attached.

2. Neaman Practice Enter and View

HWCoL undertook an Enter and View visit to the Neaman Practice on 13th February 2025. The visit was carried out by the HWCoL staff team and a Board member. The report is currently being written and should be published in Q1.

Communications and Engagement

4. Patient Panels

Patient panels are designed as information sessions for residents to attend on topics of concern or interest to them. They also are for residents to give feedback on those services and share ideas for improvements. HWCoL's patient panel series attract new residents at every event. Reports from all Patients Panels are published on the HWCoL website. These are now a recognised and useful way of drawing providers and receivers of care together.

1.1 Patient Panel January Neaman Practice Booking System

Dr Hillier, Partner, Neaman Practice gave an overview of the new appointment booking system that has been adopted by the Practice. The Practice rolled out the new system with very little patient engagement or communication. Therefore, HWCoL set up a patient panel for residents to join to understand the new system. We will continue to monitor the effectiveness of this change.

1.2 Patient Panel February Falls Prevention Service

Sarah Lawson, Public Health Registrar and Peter Senior, Manager, Unplanned Care, City & Hackney Place Based Partnership, NHS North East London gave an overview of the present Falls Prevention Pathway and of the review being carried out by the Public Health Team.

City residents were able to share their experiences, highlight current and potential challenges, and propose ideas in order to improve the falls pathway.

More details of this project can be found later in this report.

5. Patient Panel March CPR Training

Unfortunately, this popular session had to be cancelled due to the trainer being unwell.

1. Neighbourhoods Engagement Involvement

2.1 City Action Group

HWCoL attended the second City Action Group meeting in March. The City Action Group is a separate group formed from the Shoreditch Park and City Neighbourhood forums which specifically focus on residents in the City. The lively discussion with residents and the Neighbourhood coordinators ended in agreement that the group should have set terms of reference and awareness of the neighbourhood programme

needs promoting across the City. Despite this being talked about at the last meeting this has not materialised.

It was agreed that a meeting for residents would be held in Q1/2 to inform residents about the priorities for the Neighbourhood. We remain concerned that City don't feel consulted with and feel that they are being told what the priorities are without enough rationale.

3. Falls Prevention Engagement

As reported HWCoL raised at the Health and Wellbeing Board and the City of London Corporation that Public Health will be stopping the Staying Steady Course in the City provided by MRS Independent Living. The Public Health team are currently planning a full falls prevention programme that will be rolled out across both City and Hackney. HWCoL now sit on the steering group. HWCoL have held a Patient Panel exploring the Falls Pathway within City and Hackney, conducted a survey for residents to tell us their concerns around falling, what services they have used or are currently using to prevent further falls and what they would like to see.

The team also visited AGE UK City of London group, and gained some first-hand feedback on the service, and also attended the Older Peoples Reference Group open meeting to hear feedback.

The results of this engagement will be used to feedback to the City and Hackney Public Health team to inform their decisions on the future provisions in the Falls Prevention pathway.

4. Health Mela Event

In February, NHS North East London in partnership with Healthwatch City of London and Healthwatch Hackney held a Health Mela event at the Portsoken Community Centre to promote staying well and warm in winter primarily in the Bangladeshi community.

HWCoL helped to host the event, along with other health service providers and organisations working to help residents of the City. The event had health advice, the food pantry, vaccine information and blood pressure checks. As a result of this event the team met local residents from the Portsoken Area, volunteer groups as well as court of common councillors. This event was a successful event for us to attend, it has given us the opportunity to open the discussion with Portsoken Councillors on how to better engage with Portsoken residents on their health needs. A meeting has been arranged for HWCoL to meet with the Councillors in Q1. The Population Health Hub are also looking into improving engagement with residents in the area, so there is a possibility of this work being co-produced. Rachel Cleave is meeting with the programme manager in Q1 to discuss.

5. Annual Survey

HWCoL launched its annual survey on its service delivery in April for residents. The stakeholder survey will be launched after the Easter break.

6. Pharmaceutical Needs Assessment

HWCoL supported the distribution and advertising of the City and Hackney Pharmaceutical Needs Assessment. HWCoL's Chair, Gail Beer, is on the steering group overseeing this work.

7. Objectives review and Annual Business Plan

The HWCoL Board and Team met in early April to have the annual review of objectives and local priorities. It was agreed that both the objectives and priorities will have slight changes made to them but on the whole will remain the same. In Q1 HWCoL will produce a workplan and updated business plan that will be shared in the next report to this Board.

8. NHS Funding

Due to the recent announcements on the abolishment of NHS England and the cuts to NHS and ICB funding there will inevitably be changes to some areas to the work carried out in partnership with the NEL ICB and Healthwatch. The public rep programme which is currently managed by Healthwatch Hackney will no longer receive funding. This programme provides public reps from both the City and Hackney for engagement with NHS Services.

HWCoL are in conversation with the NEL ICB teams to discuss the best options for public engagement to continue.

Issues raised on behalf of residents

1. Neaman Practice Booking system

As raised in the last report the Neaman Practice have introduced a new appointment booking system. HWCoL were contacted by several concerned residents that the system was confusing and more importantly that they had not been informed of the change. HWCoL had a discussion with the Practice who explained the new system, and why it had been implemented. HWCoL held a Patient Panel with Dr Hillier (who has overseen the roll out) for concerned residents. To support residents HWCoL held a focus group to deep dive into the issues raised by residents which took place in Jan 2025. The team will also hold a focus group specifically for carers on 11th April.

Feedback from the patient panel, survey and focus groups will be co-ordinated and fed back to the Practice.

Planned activities for Q1

- Launch of Barts Enter and View Report
- Report on Falls Prevention Engagement
- Report of Neaman Practice Enter and View
- Report on engagement on Neaman Practice Booking System
- Healthwatch City of London Annual survey
- Production of Healthwatch City of London Annual Report
- Continued work with CoL to set up the Adult Social Care Advisory Group
- Production of three year work plan

- Increased engagement with the Portsoken Community through Court of Common Councillors
- Health in the City event

Conclusion

The team at Healthwatch City of London are proud to have produced three detailed reports in the past quarter. Engagement across all City communities is the main priority for the year ahead.

Appendices

1. Digital Apps: A help or hindrance? Understanding and accessing digital healthcare apps
2. Patient Advice and Liaison Service (PALS) A review of PALS services available to City of London residents
3. Barts Health NHS Trust Cardiology Department Enter and View Report

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

Rachel Cleave
General Manager, Healthwatch City of London
E. rachel@healthwatchcityoflondon.org.uk

healthwatch City of London

Digital Apps: A help or hindrance?

Understanding and accessing digital healthcare apps

Contents

A message from our chair, Gail Beer

We are pleased to be able to share our Digital Apps report with you and we hope you are able to relate to or gain an insight into the everchanging world of digital healthcare. We would like to thank those who worked on this project, including Matt James, and our volunteers, Saoirse Moriarty, Anna Louise Todsen and Najida Parveen, all who worked hard to make this piece of work happen.

As we started to undertake our research, we found that there are various different digital apps that you could access in relation to your healthcare within the City of London. These apps may vary depending on which GP surgery you are registered with, whether you have had to visit hospital for any appointments, and how many services are involved with your healthcare. We wanted to find out what NHS digital apps were on offer to patients in the local area, how they worked, and whether they were easy to use. Upon talking to local residents and gathering their feedback, we have found that accessing digital apps can prove difficult and confusing for many people.

Healthwatch City of London will be sharing this report with our stakeholders, who all have a role in your health services. These include, our local Integrated Care Board (ICB), Primary Care Network (PCN), Health and Wellbeing Board, the City of London Corporation and shared on our website to enable us to work collaboratively towards change. We will also be holding events/meetings to share the results we have found and enable our community to work collaboratively by sharing our findings.

The methodology used includes desktop research of the digital apps that local residents are most likely to use, what apps were available, what their functions were, and how accessible they were as well. Our team created a survey to capture the thoughts of patients, asking broad questions about their experience of using digital apps and how they had found it. We then also held three focus groups, holding one online and two in person, these were a great way to gain useful feedback, giving us a deeper insight into their experience of using digital apps. Via these methods we were able to access a sufficient number of users and insight to inform this report.

Our three key findings were:

- The number of apps/digital platforms that are now used is confusing.
- The different apps/platforms don't connect to each other; therefore, patients have to access several to get the information needed.
- There is a lack of language and disability access options.

In our report, we include our full list of recommendations. Our most critical recommendations include:

- Our Integrated Care Board and Local Authority should work together to facilitate digital access to all through support, advice and practical help, particularly with setting up and using the basic functions within the NHS app.
- Apps need to work together more effectively or be centralised into one app so that patients have fewer apps to access and are able to understand how to use them better.
- All digital apps to be compliant with the Accessible Information Standard and meet the requirements for those with any additional needs - NHS England Accessible Information Standard Specification.[i]
- Service providers to have adequate information accessible to those who can't access services digitally.

Gail Beer
Chair, Healthwatch City of London

i. england.nhs.uk/publication/accessible-information-standard-specification

Introduction

Did you know there are nine different digital apps you could be accessing in relation to your healthcare within the City of London? These may vary depending which GP surgery you are registered with, whether you have had to visit hospital for any appointments and how many services you have involved with your healthcare.

Healthwatch City of London wanted to find out what digital apps were on offer to patients in the local area, how they worked and whether they were easy to use. Upon talking to local residents and gathering their feedback, we have found that accessing digital apps can prove difficult and confusing for many people. We have also spoken to carers in the local area who have told us that navigating digital apps for themselves and family members has been complicated and tiring. We also asked patients to give feedback to us whether these digital apps were able to link together and whether they were offered any support in setting up or using a digital app.

By the time you have finished reading this report, we hope you will have a greater understanding of the digital apps available and what information/services you may be able to access for yourself and others. In addition to this, this report should enable you to access support and advice should you need further help setting up or using a digital app.

But what is a digital app?

For the purpose of this report, we have used the term "digital" throughout, this could be an app you have downloaded on a smart device such as the NHS app or a website you access through a web browser such as the Neaman Practice website. It could also be a portal that you can use by going through the NHS app such as Patients Know Best. There are many different digital apps, each with their own layout, features and operability which can become confusing for patients, particularly those who use more than one digital app.

Methodology

Our team conducted desktop research of nine digital apps local residents are most likely to use, to establish what apps were available, what their functions were and how accessible they were, particularly for those patients who may not have a high level of health or digital literacy. We focused on only apps that you can access your NHS health record through, rather than exploring all healthcare apps available such as prescription ordering services, health trackers and online GP consultation services. There are many more apps both for accessing your health record and other services available however we focused our research on a small, locally used portion of them.

We then created a survey to capture the thoughts of patients in a quick and concise way, asking broad questions about their experience of using digital apps and how they had found it. This survey was open for ten weeks online and we collected 51 responses digitally, we also collected another five via physical copies of the survey left in central areas such as libraries and community centres.

We also conducted three focus groups; one online and two in person. These proved very successful and we had a total of 15 attendees who gave useful feedback giving us a deeper insight into their experience of using digital apps.

The team also undertook several meetings with professionals who are assisting patients with these apps to get an understanding of their experience of them too. This enabled the team to get feedback on any common issues and what support they were directly offering patients who needed help accessing digital apps.

While conducting this research, the team were able to speak to many residents and professionals in the local community which has meant we now know what support is on offer for people wishing to access additional support with digital apps. This is included at the end of the report with contact information for each service.

Summary of desktop research

The team conducted desktop research through a variety of methods such as analysing websites, apps and portals, along with talking to professionals and those using digital apps themselves or on behalf of others.

The apps below are ones we found that residents of the City would be most likely to access if they seek treatment at a local GP or hospital, this is not a conclusive list of all apps available.

Name of app	Features	Accessibility	Support	Digital requirements
NHS app The Lawson Practice Barts Health Homerton Hospital Neaman Practice	▪ Request repeat prescription ▪ View GP health record ▪ Manage appointments ▪ View messages from GP ▪ Use 111 online	▪ Change contrast, colour and font ▪ Zoom up to 200% ▪ Screen reader compatible	▪ Dedicated support email[ii] ▪ Video ▪ How to guides ▪ AbilityNet[iii]	▪ Web browser ▪ iOS/Android app
Neaman Practice website	▪ Request repeat prescription ▪ Manage appointments ▪ Links to other platforms	▪ List of non compatible access features ▪ Change contrast, colour and font ▪ Screen reader compatible	▪ Support from GP ▪ Learn My Way[iv]	▪ Web browser only
Dr iQ Goodman's Fields	▪ Request repeat prescription ▪ View GP health record ▪ Monitor symptoms ▪ Online consultations ▪ Set medication reminders	▪ Limited accessibility features	▪ Dedicated support email[v] ▪ Live chat function[vi] ▪ Comprehensive FAQs ▪ Support from GP	▪ iOS/Android app only ▪ Camera enabled device (video appointments)

ii. help.login.nhs.uk
iii. mcmw.abilitynet.org.uk
iv. www.learnmyway.com
v. support@dr-iq.com
vi. support.dr-iq.com/hc/en-gb

Lifebox Homerton Hospital	▪ Online preoperative questionnaire	▪ Change contrast, colour and font ▪ Zoom up to 300%	▪ Live chat function[vii] ▪ How to guides ▪ Comprehensive FAQs ▪ Clear options on how to opt out	▪ Web browser only
Patients Know Best Barts Health Homerton Hospital	▪ Manage appointments ▪ View hospital record ▪ View test results ▪ View discharge summaries ▪ View care plans ▪ View clinic letters	▪ Simplified language ▪ List of non compatible access features ▪ Change contrast, colour and font ▪ Zoom up to 300%	▪ Dedicated support email[viii] ▪ Links to digital support ▪ Video ▪ How to guides ▪ Comprehensive FAQs	▪ Web browser only
My Care UCLH	▪ Manage appointments ▪ View test results ▪ View clinic letters ▪ Access video appointments	▪ Change contrast ▪ Limited accessibility features	▪ Dedicated support email ▪ How to guides ▪ Comprehensive FAQs	▪ Web browser ▪ iOS/Android app ▪ Camera enabled device (video appointments) ▪ Reliable internet connection
My Chart Guys and St Thomas'	▪ Manage appointments ▪ View test results ▪ Access video appointments ▪ Update staff before appointments	▪ Change contrast ▪ Limited accessibility features	▪ Dedicated support email[ix] ▪ Video ▪ How to guides ▪ Comprehensive FAQs	▪ Web browser ▪ iOS/Android app ▪ Camera enabled device (video appointments) ▪ Reliable internet connection
Attend Anywhere Barts Health Homerton Hospital	▪ Access video appointments	▪ Change contrast ▪ Limited accessibility features	▪ Video ▪ How to guides	▪ Web browser only ▪ Camera enabled device (video appointments) ▪ Reliable internet connection
Dr Doctor Chelsea and Westminster Hospital	▪ View hospital record ▪ Manage appointments ▪ View clinic letters	▪ List of non compatible access features ▪ Zoom up to 300% ▪ Screen reader compatible	▪ Dedicated support email[x] ▪ Comprehensive FAQs	▪ Web browser only

vii. help.lifeboxhealth.com/en
viii. support.patientsknowbest.com/support/tickets/new
ix. mycharthelpdesk@gstt.nhs.uk
x. support@drdoctor.co.uk

Data protection

All platforms had a comprehensive data protection policy/statement available to view with some offering more advice through their FAQ section. Some also offered more in depth answers to common data protection concerns when using digital apps.

Proxy access

All platforms researched offer proxy access which can be requested through the service e.g. directly with your GP or hospital which enables the patient to give access to someone else for them to view/manage their health records. The boundaries of what carers are able to access was unclear during this research stage.

Languages

On the majority of apps/websites, there was very limited information about being able to select another language or to even request this. Patient Knows Best offers up to 23 different languages but there doesn't appear to be this level of language support on other platforms.

Digital literacy

Using these apps/websites requires a certain level of digital literacy, particularly the ability to log in through the various apps, navigate online platforms, and understand health-related information presented in the apps. The registration process usually involves using an NHS login and creating a password, which indicates a baseline level of digital literacy is needed. However, the platforms are designed to be user-friendly and accessible.

Alternatives to digital access

All online services are offered as an addition, with the aim of improving the use and accessibility of the services they already offer. Patients are still able to call, email or visit in person and none of these digital services on offer are mandatory. Patients have the option of using them or sticking with traditional methods of contacting their healthcare providers. Patients who are unable to access their medical records, for example blood test results, repeat prescriptions, should have priority of access via their GP Practice or relevant healthcare setting.

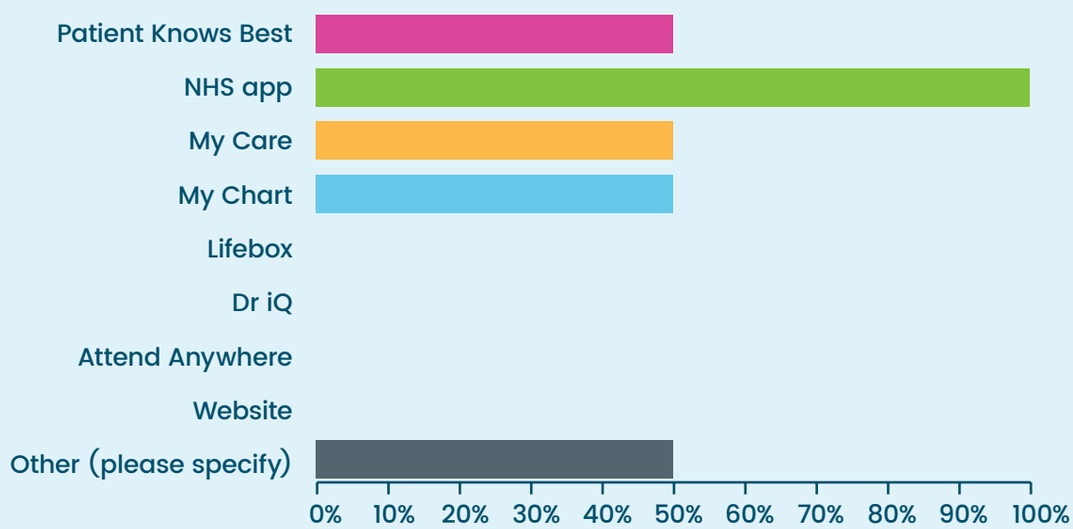
There is a range of support on offer from both the providers of the apps as well as the services themselves in various formats such as videos and face to face support.

Summary of survey results

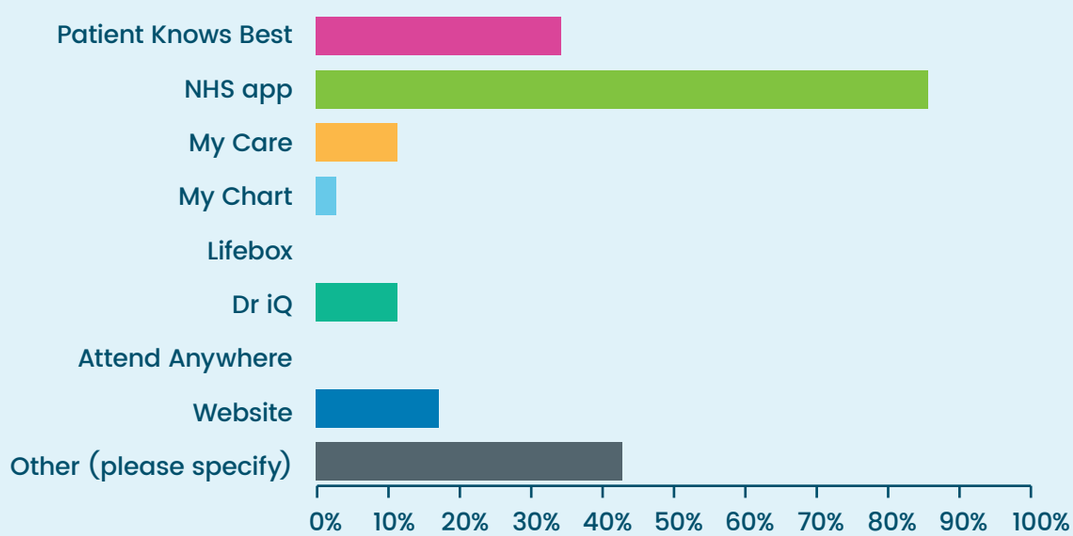
We collected the responses of local residents via an online and paper survey which generated 50 responses. This survey was open for several weeks to ensure there was enough time for people to complete it once it had been circulated both online and via posters in local areas.

We start at question 5 because this survey was formulated in a way that enabled us to identify if the responses were from carers or not and whether they used apps or didn't. The full questions and answers are included within the appendix. Below is a summary of the most relevant questions from the survey and the responses collated.

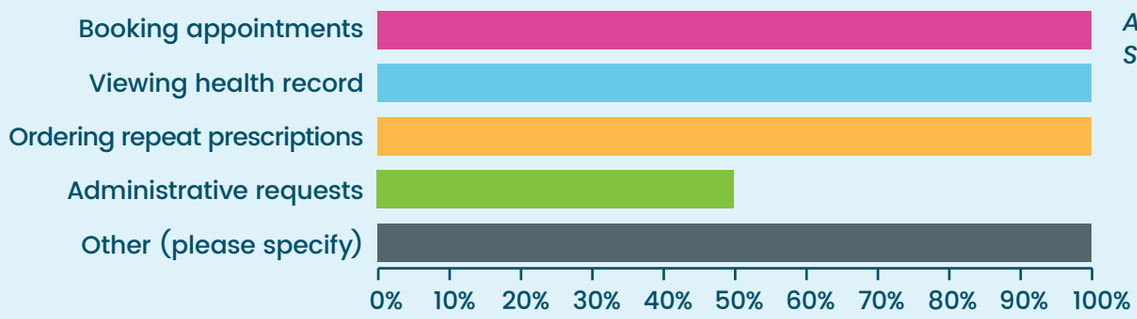
Q5. What apps/websites do you use? Please select all that apply or specify if not listed.



Q22. What apps/websites do you use? Please select all that apply or specify if not listed.

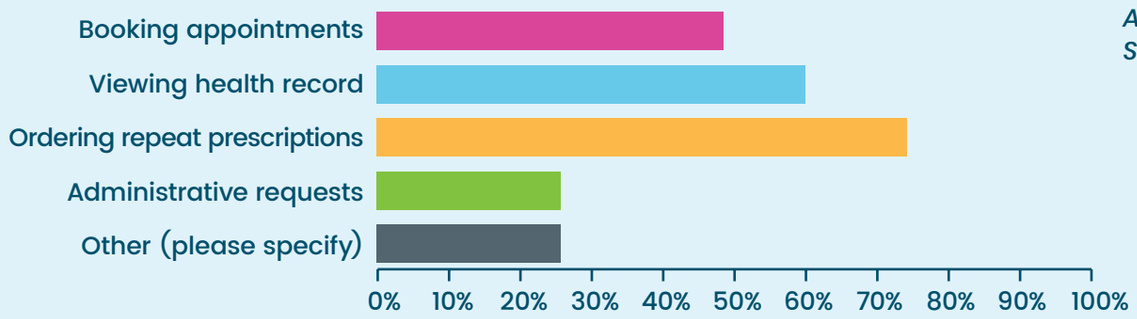


Q6. What do you use these apps/websites for? Please select all that apply.



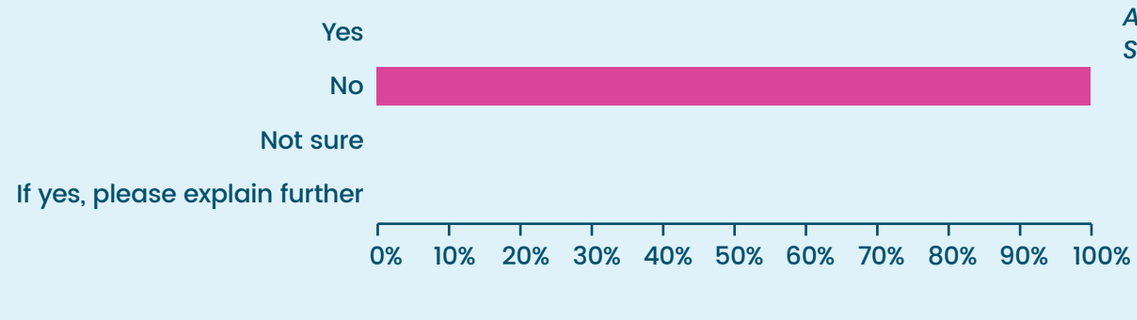
Answered: 2
Skipped: 54

Q23. What do you use these apps/websites for? Please select all that apply.



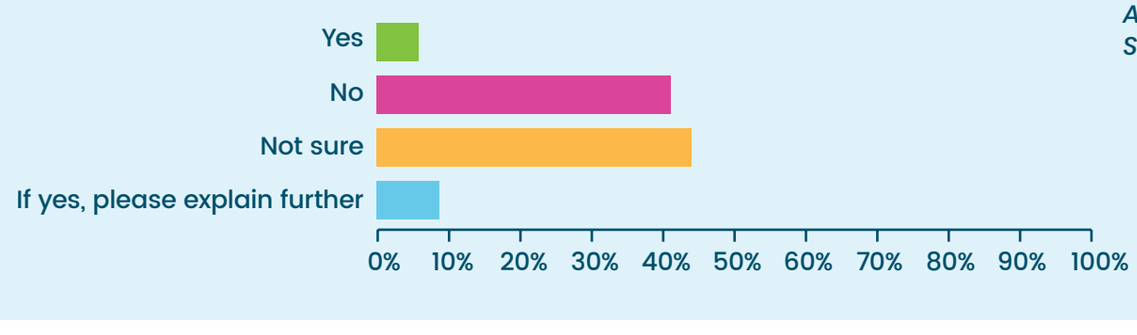
Answered: 35
Skipped: 21

Q12. Do the apps/websites you use link together?



Answered: 2
Skipped: 54

Q29. Do the apps/websites you use link together?



Answered: 34
Skipped: 22

Focus groups

We conducted a series of focus groups, aimed at giving residents the opportunity to share their experience of digital apps in more depth. We understand that an online survey may not be accessible to everyone and may not capture the entire story behind the feedback they would like to give.

We conducted three focus groups; one online and two in person. These proved very successful and we had a total of 15 attendees who gave useful feedback giving us a deeper insight into their experience of using digital apps. These ran for an hour each, with participants being asked some simple open questions about their experience with digital apps to promote conversation on the topic. For example, "How have you found using the NHS app?" and "Is there anything you would like to improve?". The conversation was then continued between the participants where they talked with each other about their struggles with accessing their information etc.

These sessions gave residents the opportunity to have a discussion with other like minded people and give the team the chance to capture valuable feedback. These gave us a good insight into the struggles faced by many local residents when it comes to accessing their health online, particularly from several local carers who shared their experiences with us of trying to juggle multiple online accounts across numerous apps/portals.

Overall from these focus groups, we have seen that many residents appear to be using the NHS app but seemingly for different reasons and are using different features within it. For example, some people are consistently using the NHS app to order their repeat prescriptions whereas others are only using it to access their health record and see any changes. Some residents are using other digital apps, such as Patient Knows Best, but with varying success and there is little or no option for their apps to be linked. For example, some patients are able to see their blood test results along with scans etc whereas others are only able to access their appointments that have been scheduled. This is down to individual services and what features they choose to have available for their patients; this causes consistency issues as details from some hospitals visited will show within a patient's digital app and others will not, which can become even more confusing. The focus groups also showed that many residents are still using traditional methods of communicating with their healthcare services e.g. calling or visiting in person which they have expressed is due to a number of reasons such as poor digital literacy or no desire to access online services.

Common themes

Within our survey and feedback collection, we have found some common themes which we will explore in more detail below.

Pros:

- Some residents have expressed that being able to order their medication online and see when it has been approved or sent to the pharmacy is helpful and erases the need for them to go back and forth between their GP and the pharmacy
- Residents have said that it is helpful to be able to book appointments online with their GP and see what time etc, whereas when you book over the phone there is rarely a follow up confirmation especially if it is the same day
- "It's good for being able to access documents that are uploaded as they are all in one place and they cannot be lost like a physical letter"
- Some residents have expressed that it's easier to use online features than contact their GP via phone and wait in a queue of people
- "It is helpful to see if and when referrals have been made on my behalf and what it is for"
- Residents have said that they like being able to see their test results however this can pose it's own issues which are discussed below
- Residents have expressed that they like the functionality of the NHS app and that it works more seamlessly than other digital apps
- Residents have told us that they find it helpful that they are able to access Patient Knows Best through the NHS app as they are not having to download and log in to a separate app
- Some find it convenient to have a video call rather than having to attend the service in person, especially if it is for something routine like a medication review
- "I can get my appointment reminders via text which I find helpful"
- "I can order my prescriptions whenever I want without having to wait for somewhere to open"
- Residents have said that it is easy to switch between profiles on the NHS app when using proxy access

Cons:

- Residents have reported that when ordering their prescriptions online, these are not always sent or fulfilled which leads to further time needed to chase this
- Some residents, particularly carers, have expressed a concern for the lack of paper copies of appointment letters, clinic summaries etc. as this can become confusing when organising the care for multiple people
- Residents have told us that it can be confusing when apps are updated and the look/interface of it is different, along with how to access previous features or where data is stored
- "There are multiple apps which can be overwhelming and confusing, some apps also send notifications via email/text when there is something to view which can cause additional confusion"
- Residents have told us that they are often confused by links sent in text messages via their GP or hospital as they are unsure if they are real or not
- Test results can be difficult for everyone to comprehend themselves without the assistance of their GP or a medical professional
- Residents have expressed that there are data concerns around the multitude of apps and how their data is being shared/stored which can lead to them not wanting to use it
- Many of the apps do not link up so it is difficult to access information online as this is having to be done through multiple apps/portals
- Proxy access is not always simple to obtain and when granted, it is not always possible to see the same information that the patient would be able to, which is needed in cases of carers etc
- Residents have told us that it's often difficult to contact someone in relation to these apps of they have an issue or something doesn't work as it should
- Some apps have complex verification systems which include sending text/email codes and downloading additional apps which can be inaccessible for those who struggle to use digital apps
- Residents feel that it can be more difficult now to book an appointment and see a GP face to face as the default is usually a phone call/video call
- Residents have told us that if there is an issue with their prescription or the GP needs to review their medication etc, this is not communicated through digital apps and this has to be chased by calling
- There is not always confirmation when sending messages to a clinician via an app or portal which is then frustrating when there is no response, leading to feelings of uncertainty on the part of the user

Key findings

- **The number of apps/digital platforms that are now used is confusing.**

  In the City, residents have nine different apps available to them to access their health information digitally. We researched and found a plethora of various apps, all stating that they offer a range of varying services and all having varying ways to access them etc. Residents have expressed to us that they feel they are constantly being offered a new app each time they have an appointment at another service which has become overwhelming for them. Our survey also showed us that there are more apps being used by respondents than we were able to research, with many people using the other section to tell us the app they use wasn't listed.

- **The different apps/platforms don't connect to each other, therefore patients have to access several to get the information needed.**

  Many residents have expressed that the apps they do use, don't link together at all which means they have to separately log on to each individual app/portal/website in order to access the different information that each one of these holds for them. Through our survey, this was also apparent with less than 10% of our survey respondents stating that the apps they used linked together.

- **There are issues with accessing information for the cared for by their carers and specific info not being given for appointments.**

  When speaking to carers in our focus groups, they have told us that it can become confusing when caring for multiple people and having different apps as well as different profiles for each person within each of them. There are also issues with the information shared as for example, one person cares for their mother and father but when they get an appointment through, it does not state who it is for. They have also expressed that without proxy access and communicating with the service multiple times, it is even harder to access the information they need which can add a lot of additional stress to their already busy day.

- **Proxy access is not always simple to obtain and when granted, it is not always possible to see the same information that the patient would be able to, which is needed in cases of carers etc.**

  During our focus groups, many carers expressed that they have had issues and faced a lot of barriers when trying to obtain and use proxy access for a person they care for. They have told us that it often takes several attempts to be granted proxy access and they aren't always supported through the process, often having to chase things themselves and follow up when things haven't been actioned for them. They have also told us that even once this access is granted, the individual services have the capacity to turn features on and off so the carer is then not always able to see the full information that the patient would. On some apps, you are able to see more than others but overall, carers are not able to see all the information that is on the patient's record which can cause additional stress and mean they then need to contact the service directly.

- **The level of information is different according to who is providing it and what service it is linked to.**

  Patients have told us during focus groups that even when their apps do link up or different services use the same app, what they can access varies drastically. For example, patients using PKB at one hospital can access their blood test results, discharge summaries and more, whereas when they access their records for another hospital using the app, they can only view appointments.

- **There is a lack of language and disability access options.**

  As you can see in the table above from our desktop research, there are very limited options for adapting the apps to be more accessible and they are very basic when they are available. Although it may seem like a lot of accessibility features are available, this very much varies between each app and we have been told that the functionality of these adaptations is often poor and difficult to access in the first place.

- **Multifactor authentication/complex verification processes are increasingly becoming a barrier to accessing digital services.**

  Lots of patients who completed our survey stated that the reason they aren't happy with using digital apps is because of the long processes that they have to go through to log in to each individual app. Carers that we spoke to also told us that it can become confusing for the people that they care for if they are having to input and receive multiple verification codes in order to access these digital apps. This can cause additional overwhelm as it's another layer of digital apps that become inaccessible to some as they face a barrier at the start of the process.

- **There are many worries about data storage and privacy with little information available regarding this.**

  During our focus groups, many patients expressed their concerns around data protection and the lack of available information about how their data is stored and used etc, in each of these apps. Patients have told us that there have been several apps before the ones currently used, for example, a patients GP practice has previously used two different platforms which now are invalid and not accessible to them however there is no information on what has happened to the data stored there.

- **Ordering medication/repeat prescriptions has become easier for patients**

  During our focus groups, the main feature that people were using on a digital app was ordering repeat prescriptions. This was also the case in our survey with over 70% of survey respondents telling us that they used a digital app to order their repeat prescriptions. Patients have also told us that it is helpful for them because they can order it whenever they are available rather than having to wait until their GP/pharmacy is open. They also like that it can be sent straight to the pharmacy and they are able to track the status of their prescription without having to contact the pharmacy multiple times.

- **Booking a GP appointment is usually easier than calling at 8am.**

  Patients have said that, when there are appointments available, booking online is a lot easier for them as opposed to calling their GP at 8am or visiting the surgery. Although in many cases, appointments are usually limited and sometimes difficult to get, patients have reported that the process of booking an appointment via a digital app is more convenient for them as they can do this in the comfort of their own home. We have heard that patients also find it useful that they are able to see past and current appointments via a digital app whereas when booking over the phone / in person, they are not always given confirmation of the day/time etc.

- **The text reminders for appointments is helpful.**

  Patients have told us that they like getting a text reminder before their appointment as they are able to check the date/time is correct and have it fresh in their memory for their upcoming appointment. Patients have also told us that it is helpful when they have multiple services involved as they can end up having a lot of appointments and having reminders means they don't have to find all the letters they have been sent. We have also been told that patients find it helpful as they can look back at their reminders to see what appointments they have had without going into a digital app as it is in their text messages.

Recommendations

As part of our findings and research, we feel able to offer some recommendations to improve the issues faced by many. These will be presented to our local Integrated Care Board, Primary Care Network, Health and Wellbeing board, the City of London Corporation and shared on our website to enable us to work collaboratively towards change.

We recommend that:

- Our Integrated Care Board and Local Authority should work together to facilitate digital access to all through support, advice and practical help, particularly with setting up and using the basic functions within the NHS app.
- Apps need to work together more effectively or be centralised into one app so that patients have less apps to access and are able to understand how to use them better.
- Our Integrated Care Board and Primary Care Network should provide adequate digital champions in multiple services e.g GP's, social care, to enable them to support those who need it.
- There is consistency of communications being broadcast to patients regarding digital apps and what is available for them to use to reduce confusion.
- Integrated Care Board and Primary Care Network to set up a monthly digital surgery at local GP surgeries to help set up and use digital apps.
- An increase in user friendly language/interfaces when using digital apps to make them more accessible.
- Digital teams working in each of the GP's/ Hospitals etc need to work collaboratively to ensure that their research and ongoing work is shared and utilised by those working in the same field who can benefit from it.
- Apps to have more accessibility and language features enabled so that more patients are able to access digital apps.
- All digital apps to be compliant with the Accessible Information Standard and meet the requirements for those with any additional needs - NHS England Accessible Information Standard Specification.[xi]
- Service providers to have adequate information accessible to those who can't access services digitally, without needing to go through lots of complicated steps.

xi. england.nhs.uk/publication/accessible-information-standard-specification

Digital support

From our findings, we were able to get an idea of what support is out there for those residents wishing to learn how to use technology or further the skills they already have. Below is a summary of the support available locally and how to access this, created by the Digital Inclusion Team at Homerton Hospital.

Digital inclusion support in City and Hackney

Name / Link	Open to	Support offer
Homerton Digital Inclusion Team homerton.nhs.uk/digital-inclusion-team	City and Hackney residents	One-to-one support and drop-in sessions, helping people to build their confidence using digital health services, including NHS App. Leave a voicemail on 07721 737918 or email huh-tr.digitalinclusion@nhs.net
Age UK East London ageuk.org.uk/eastlondon/our-services/digital-inclusion	East London residents aged 50+	Telephone digital buddy scheme. Drop-in digital support at Marie Lloyd Centre on Tuesdays from 10am Contact Linessa on 020 8981 7124 or linessa.oliveierre@ageukeastlondon.org.uk
Age UK City of London ageuk.org.uk/cityoflondon/services/digital-inclusion-and-technology-support	City of London residents aged 55+	Drop-in support on Tuesday at Barbican Library, 5.30pm-7.30pm One-to-one support available, call 020 3488 6884
Fifty-Plus Digital 50pd.uk	Anyone aged 50+	Drop-in digital support. Wednesdays 1pm-4pm at Mildmay Community Centre
Hackney Council digital skills opportunities.hackney.gov.uk/find-a-course	All Hackney residents	Free digital skills and IT courses, taking place across Hackney.
AbilityNet abilitynet.org.uk	Older and disabled people	Free IT support in the home or over the phone, call 0800 048 7642.
Digital helpline lloydsbank.com/help-guidance/get-skills-and-support-near-you.html	Everyone	Free one-to-one training sessions over the phone. Call 0345 222 0333. If you have a hearing or speech impairment you can book a session using Relay UK or BSL SignVideo.
Citizens Online citizensonline.org.uk/what-we-do/help-for-individuals	Everyone	Free Digital Skills Helpline: 0808 196 5883.

Appendix

Other services we worked with:

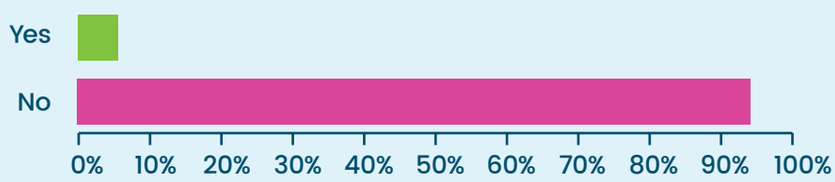
Barts Health NHS Trust • Homerton Healthcare NHS Foundation Trust
Shoreditch Park and City Primacy Care Network • Carers Connections

Survey results

Through Survey Monkey, we were able to create a survey tailored to those who use digital apps, those who don't and those with caring responsibilities, to get specific insight into a variety of experiences. This means that the below survey results reflect the different survey pathways created for this.

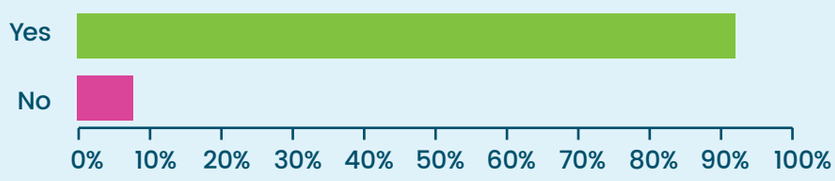
Survey results - Carers

Q2. Are you completing this survey as a carer? For the purpose of this survey, this needs to involve managing or helping someone to manage their healthcare e.g. booking appointments, viewing test results etc.



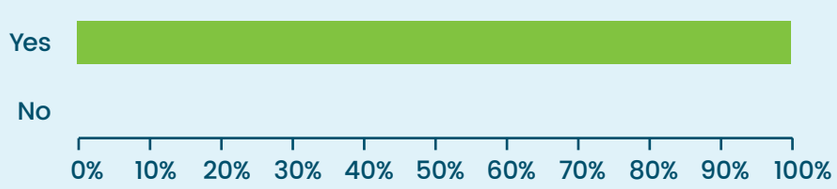
Answered: 53
Skipped: 3

Q3. Do you use apps/websites in relation to your healthcare?



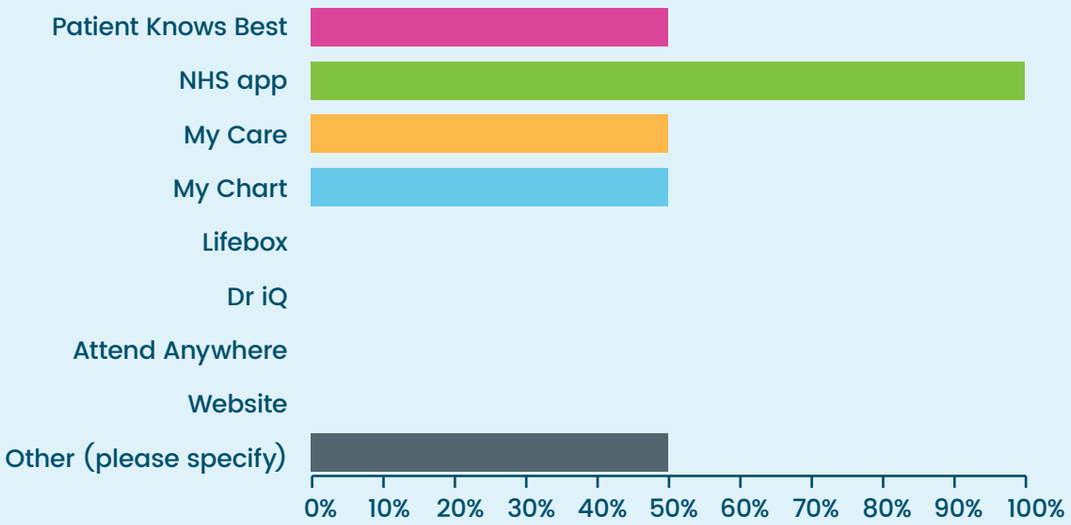
Answered: 51
Skipped: 5

Q4. Do you use healthcare apps/websites on behalf of the person you're caring for?



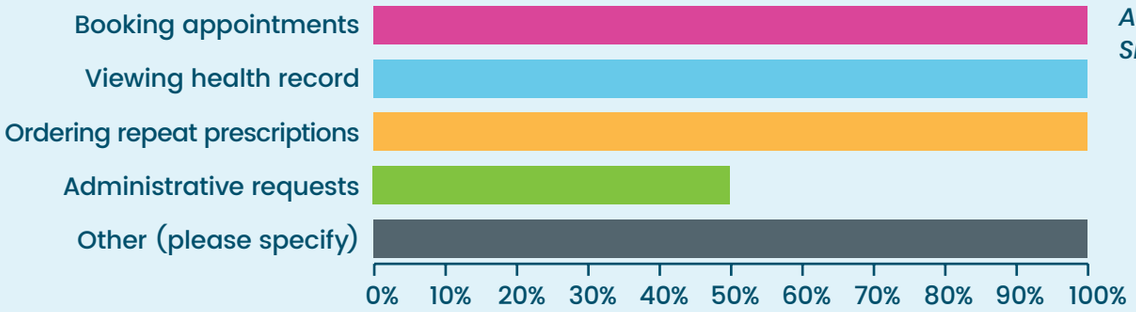
Answered: 2
Skipped: 54

Q5. What apps/websites do you use? Please select all that apply or specify if not listed.



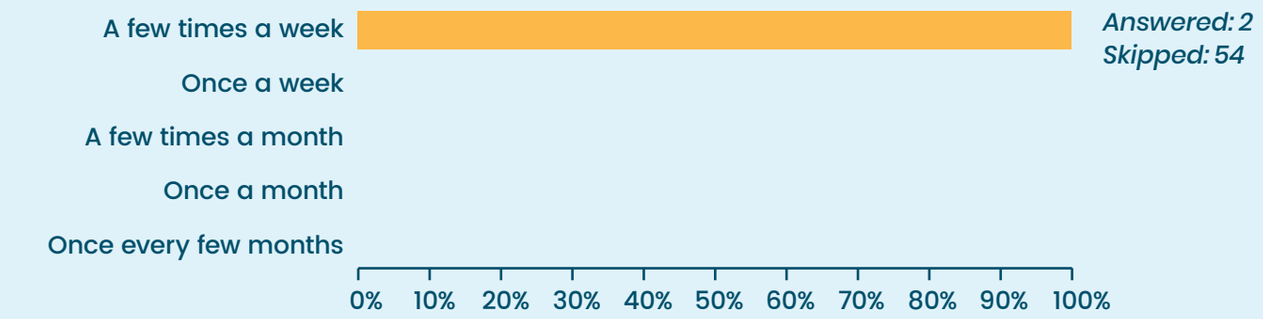
Answered: 2
Skipped: 54

Q6. What do you use these apps/websites for? Please select all that apply.



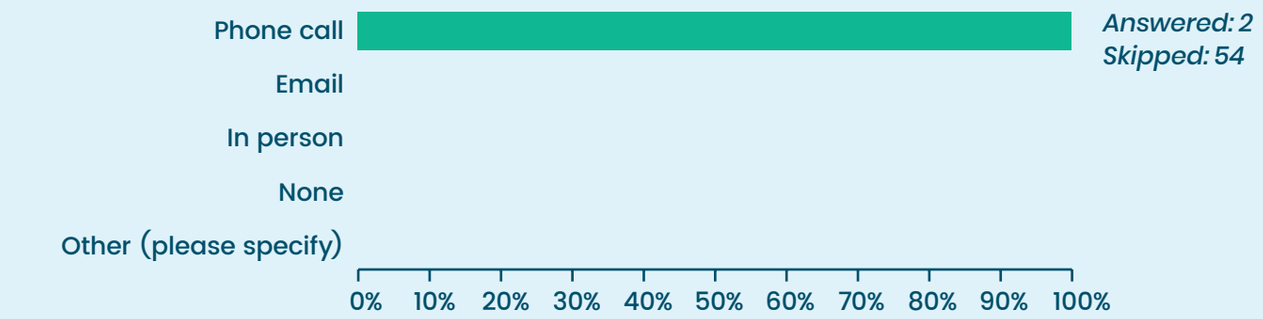
Answered: 2
Skipped: 54

Q7. How often do you use these apps/websites?



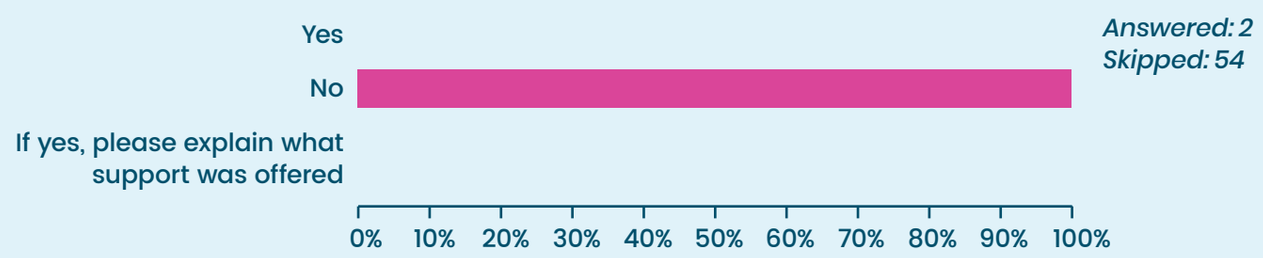
Answered: 2
Skipped: 54

Q10. What other methods do you use to communicate with healthcare providers?



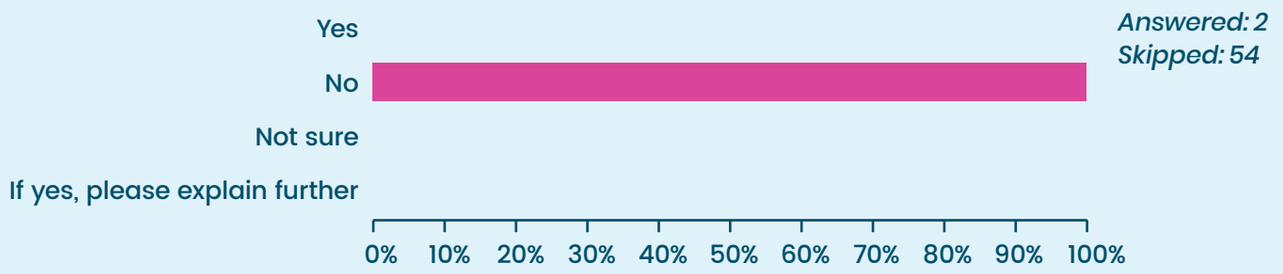
Answered: 2
Skipped: 54

Q11. Were you or the patient offered any support from your healthcare providers to access the apps/websites available?

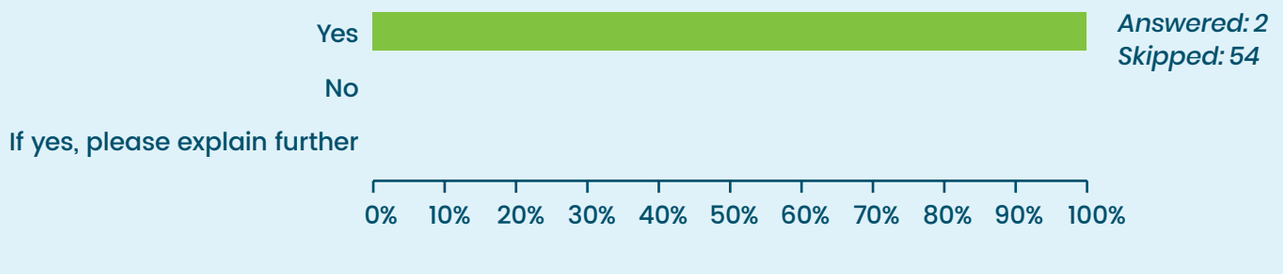


Answered: 2
Skipped: 54

Q12. Do the apps/websites you use link together?



Q13. Do you or the patient have any concerns about how your personal data is handled/processed?



Not answered questions

Q15. How do you contact healthcare providers?

Q16. Is there a reason the person you care for doesn't use digital apps/websites?

Q17. Does the person you care for struggle to access any services as a result of not using the digital apps/websites offered?

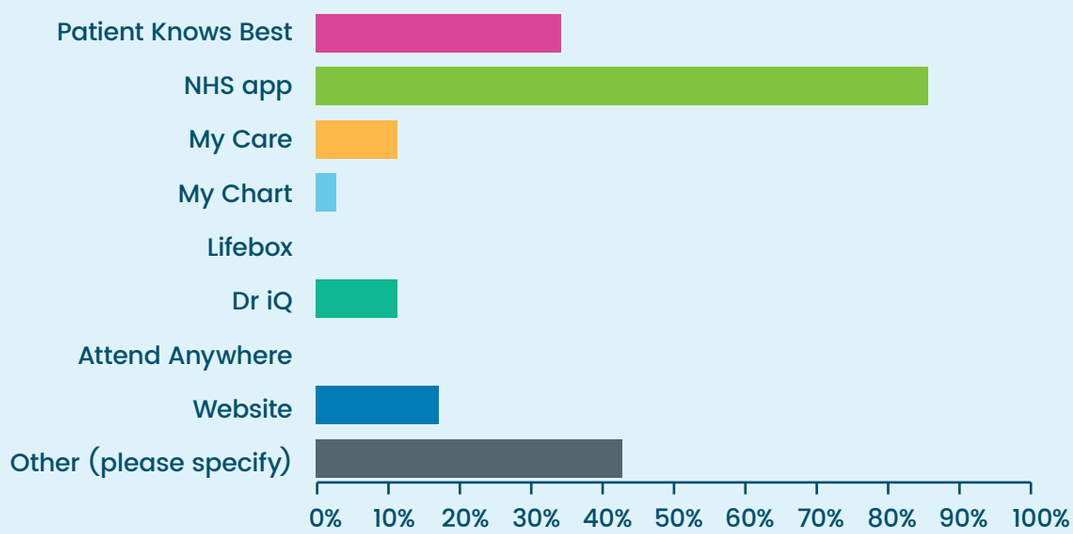
Q18. Does the person you care for have access to a web-enabled device and wifi?

Q19. Would you be interested in using an app/website on behalf of the person you care for or assisting them to use one?

Q20. Does the person you care for use apps/websites for other aspects of their life? e.g banking, food shopping

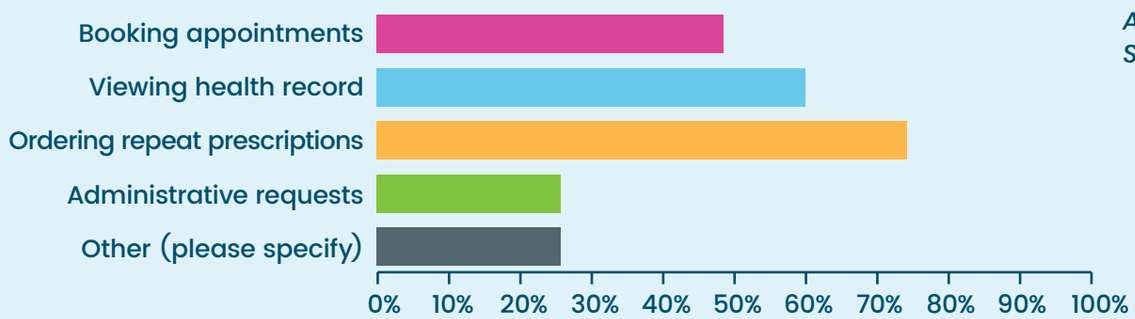
Survey results - Non carers

Q22. What apps/websites do you use? Please select all that apply or specify if not listed.



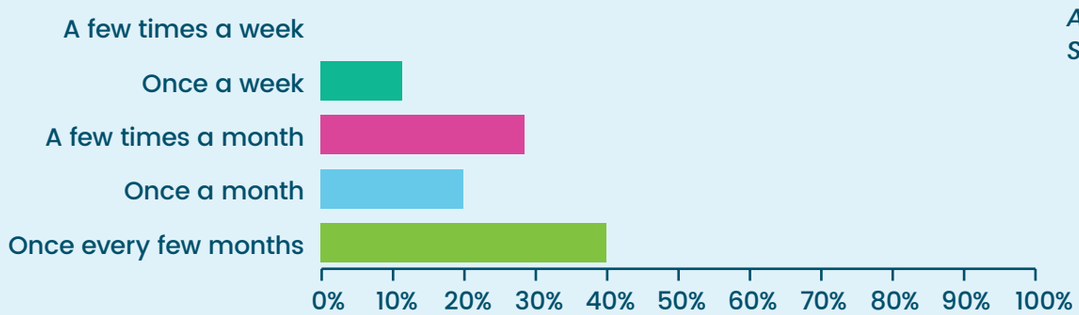
Answered: 35
Skipped: 21

Q23. What do you use these apps/websites for? Please select all that apply.



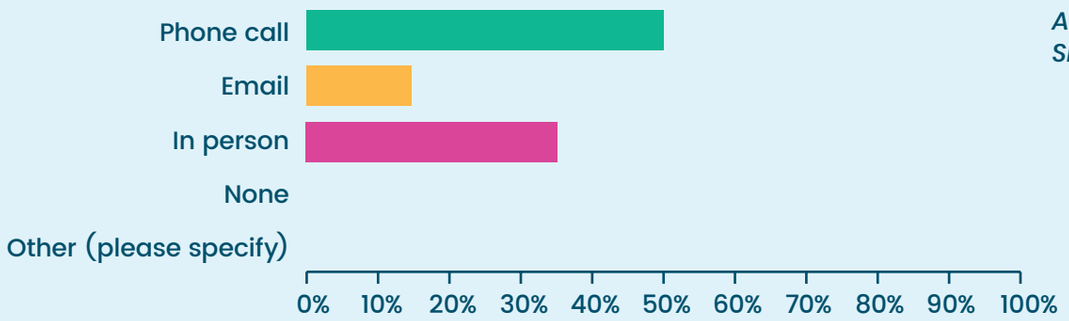
Answered: 35
Skipped: 21

Q24. How often do you use these apps/websites?



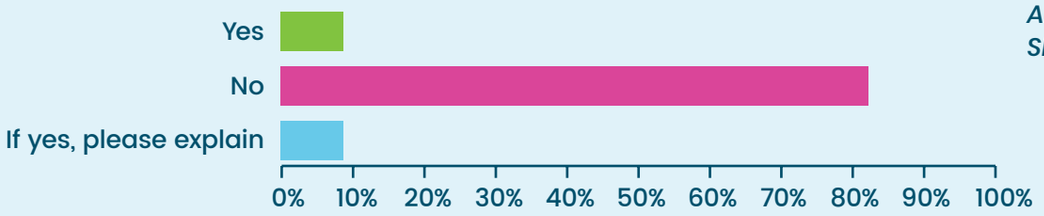
Answered: 35
Skipped: 21

Q27. What other methods do you use to communicate with healthcare providers?



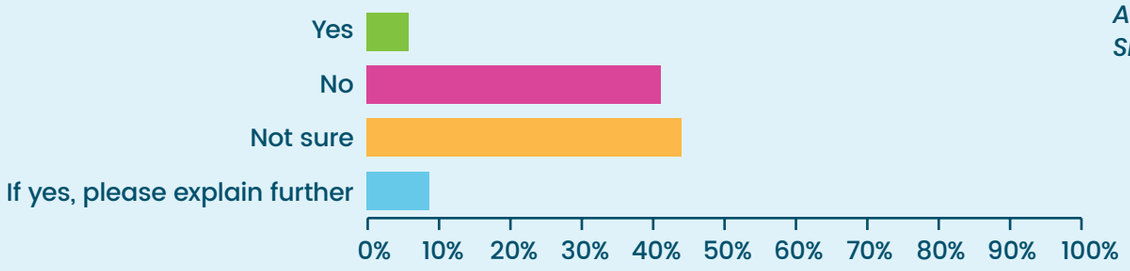
Answered: 34
Skipped: 22

Q28. Did you receive any support from your healthcare providers to access the apps/websites available?



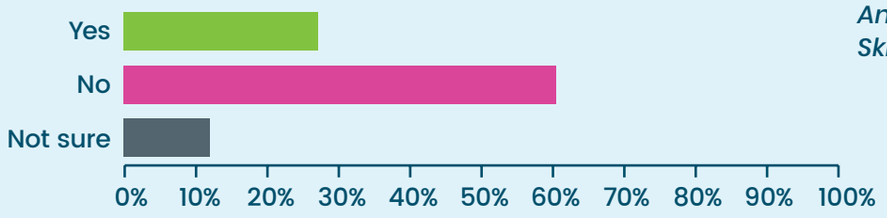
Answered: 34
Skipped: 22

Q29. Do the apps/websites you use link together?



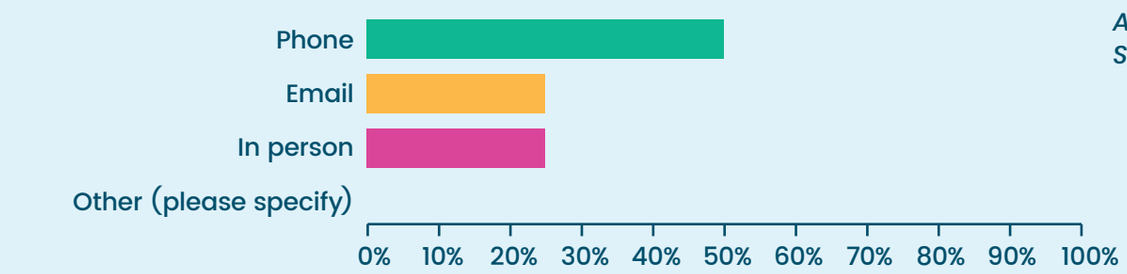
Answered: 34
Skipped: 22

Q30. Do you have any concerns about how your personal data is handled and/or processed?



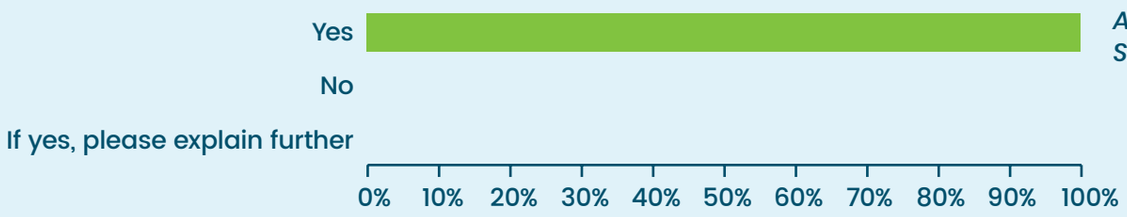
Answered: 33
Skipped: 23

Q32. How do you contact healthcare providers?



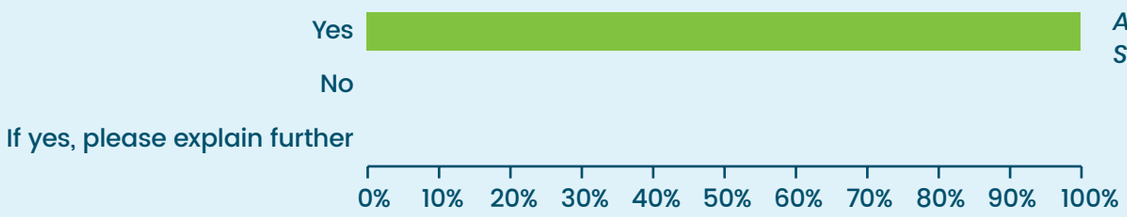
Answered: 4
Skipped: 52

Q33. Is there a reason you don't use digital apps/websites?



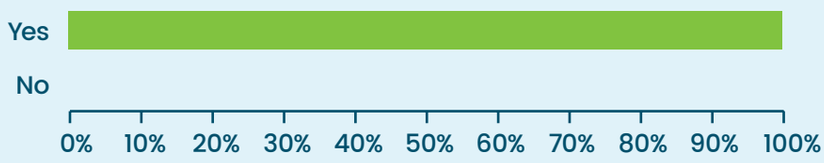
Answered: 4
Skipped: 52

Q34. Do you struggle to access any services as a result of not using the digital apps/websites offered?



Answered: 4
Skipped: 52

Q35. Do you have access to a web enabled device and wifi?



Answered: 4
Skipped: 52

healthwatch
City of London

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

020 3745 9563

info@healthwatchcityoflondon.org.uk

www.healthwatchcityoflondon.org.uk

CoLHealthwatch @Healthwatchcity @Healthwatchcity

Design and layout: www.causeffectdesign.co.uk Cover photo: Freepik

healthwatch City of London

Patient Advice and Liaison Service (PALS)

A review of PALS services available to City of London residents

Authors: Generoso Roberto and Caitlan Barrow
Contributors: Rachel Cleave, Gail Beer and Liesa Sandt

Contents

Introduction

The Patient Advice and Liaison Service (PALS) is a service that is mandated within the National Health Service (NHS). Each trust is required to have PALS that provides the following services based on the NHS website:

- Help with health-related questions
- Help to resolve concerns or problems when using the NHS
- Provide information on how to get more involved in one's own healthcare
- Provide information on:
  - The NHS
  - The NHS complaints procedure
  - Support groups outside the NHS

This report investigates the functionality and accessibility of the PALS of ten NHS trusts that provide healthcare services to residents of the City of London as listed below:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Barts Health NHS Trust
- East London NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Homerton Healthcare NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Royal Free London NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- Whittington Health NHS Trust

This piece of research was conducted as a result of a number of queries about access to PALS and visibility of the service. HWCoL set out to better understand how PALS can be located, contacted, and accessed and to give residents more confidence in the service. HWCoL therefore set about trying to understand the issues faced and endeavor to provide information to potential users and give providers some insight into the user's experience. We hope that this report will enable more residents to be able to contact PALS should they need to in the future. We did not assess the performance or patient satisfaction in relation to PALS and researched purely what was on offer and whether this information was easily accessible both online and in person.

Methodology

Online desktop research was conducted to establish what PALS were available at each trust and how patients can contact them. We established how to reach each PALS page on the trust's website, methods of contact and what accessibility features were available. This was conducted by visiting each trust's website, as well as contacting the PALS directly to ask what services they offered via email/phone.

In-person research was then undertaken through visiting a selection of hospitals and completing a short checklist of the available PALS at each. We established whether there was a physical PALS office, opening times and accessibility as well as further questions detailed at the end of the report. These visits were greatly beneficial and enabled us to identify any potential gaps in patients being able to access the PALS at their local hospital.

Summary of local PALS services

Figure 1 is a summary of the PALS services and what they offer. The local hospitals were assessed online to find out the opening hours, contact details and what methods of contact they offer.

* Those who offer an answering machine service. Services that don't offer an answering machine service are only contactable via phone during opening hours.

Barking, Havering and Redbridge University Hospitals NHS Trust	
PALS office location and hours	King George Hospital: Barley Lane, Goodmayes, Greater London IG3 8YB Queen's Hospital: Rom Valley Way, Romford, Greater London RM7 0AG No specific opening times mentioned
Email	bhrut.pals@nhs.net
Phone	01708 435454 Monday-Friday, 9am-5pm
Online form	https://www.bhrhospitals.nhs.uk/askpals
Post	King George Hospital: Barley Lane, Goodmayes, Greater London IG3 8YB Queen's Hospital: Rom Valley Way, Romford, Greater London RM7 0AG

Barts Health NHS Trust	
PALS office location and hours	Newham Hospital: Zone 1, St Andrews Wing, Newham Hospital, Glen Road Plaistow, London E13 8SL. Monday-Friday 9:30am-4:30pm St Bartholomew's Hospital: Next to Imaging Reception, KGV Building, Ground Floor, St Bartholomew's Hospital, West Smithfield, City of London, EC1A 7BE. Monday-Friday 9:30am-4:30pm The Royal London and Mile End Hospital: Patient and Family Contact Centre, 2nd Floor, Central Tower, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1FR. Monday-Friday 10am-4:30pm Whipps Cross Hospital: Junction 4, Main Building, Whipps Cross Hospital, Whipps Cross Road, London, E11 1NR. Monday-Friday 9:30am-4:30pm
Email	Newham Hospital: nuhpals.bartshealth@nhs.net St Bartholomew's Hospital: SBHpals@bartshealth.nhs.uk The Royal London and Mile End Hospital: RLHpals@bartshealth.nhs.uk Whipps Cross Hospital: WXpals@bartshealth.nhs.uk
Phone	Newham Hospital: 0207 363 9292 Monday-Friday 9:30am-4:30pm St Bartholomew's Hospital: 0203 465 5919 Monday-Friday 9:30am-4:30pm The Royal London and Mile End Hospital: 0203 594 2040 Monday-Friday 10am-4:30pm Whipps Cross Hospital: 0208 535 6438 Monday-Friday 9:30am-4:30pm
Online form	No online form
Post	No postal address

East London NHS Foundation Trust	
PALS office location and hours	East London NHS Foundation Trust, 1st Floor, Health E19 - 11 Brick Lane, London E1 6PU. Monday-Friday 9am-5pm
Email	elft.pals@nhs.net
Phone	0800 783 4839 Monday-Friday 9pm-5pm
Online form	No online form
Post	FREEPOST RTXT-HJLG-XEBE, The Complaints Manager, Complaints Department, Governance and Risk Management, East London NHS Foundation Trust, 1st Floor, Health E19-11 Brick Lane, London, E1 6PU

Guy's and St Thomas' NHS Foundation Trust	
PALS office location and hours	Guy's Hospital: Ground floor, Guy's Hospital, Great Maze Pond, London SE1 9RT St Thomas' Hospital: Main entrance, St Thomas' Hospital, Westminster Bridge Road, London SE1 7EH. Monday-Tuesday, Thursday-Friday 9am-5pm, Wednesday 10am-5pm Harefield Hospital: Main reception, Hill End Road, Harefield, Middlesex UB9 6JH Royal Brompton Hospital: Near reception, Royal Brompton Hospital, Sydney Street, London SW3 6NP. Monday-Friday 9am-4pm
Email	Guy's and St Thomas Hospitals: pals@gstt.nhs.uk Harefield and Royal Brompton Hospitals: pals@rbht.nhs.uk
Phone	Guy's and St Thomas Hospitals: 020 7188 8801. Monday-Friday 9am-5pm Harefield Hospital: 01895 826 572.* Monday-Friday 9am-4pm Royal Brompton Hospital: 020 7349 7715*. Monday-Friday 9am-4pm
Online form	Guy's and St Thomas Hospitals: https://www.guysandstthomas.nhs.uk/pals-feedback Harefield and Royal Brompton Hospitals: https://www.rbht.nhs.uk/patients-visitors/for-patients/patient-support-services/patient-advice-and-liaison-service-pals/contact-pals
Post	Guy's and St Thomas Hospitals: PALS, St Thomas' Hospital, Westminster Bridge Road, London SE1 7EH Harefield and Royal Brompton Hospitals: No postal address

Homerton Healthcare NHS Foundation Trust	
PALS office location and hours	Main entrance, Homerton University Hospital, Homerton Row, London, Greater London, E9 6SR. Monday-Friday 9:30am-4pm
Email	huh-tr.pals.service@nhs.net
Phone	020 8510 7315* Monday-Friday 9:30am-4pm
Online form	https://www.homerton.nhs.uk/patient-advice-liaison-service-pals
Post	Homerton Healthcare NHS Foundation Trust, Homerton Row, London E9 6SR

Imperial College Healthcare NHS Trust	
PALS office location and hours	Charing Cross Hospital: Charing Cross Hospital, Fulham Palace Road, London W6 8RF Hammersmith Hospital: Hammersmith Hospital, Du Cane Road, London W12 0HS Queen Charlotte's & Chelsea Hospital: Queen Charlotte's & Chelsea Hospital, Du Cane Road, London W12 0HS St Mary's Hospital: St Mary's Hospital, Praed Street, London W2 1NY Western Eye Hospital: Western Eye Hospital, Marylebone Road, London NW1 5QH Monday-Friday 10am-4pm
Email	imperial.PALS@nhs.net
Phone	020 3312 7777 Monday-Friday, 10am-4pm
Online form	https://www.imperial.nhs.uk/patients-and-visitors/help-support-and-feedback/feedback/pals/pals-form
Post	PALS Manager, Ground floor, Clarence building, St Mary's Hospital, Praed Street, London W2 1NY

Moorfields Eye Hospital NHS Foundation Trust	
PALS office location and hours	Ground floor, Moorfields Eye Hospital, 162 City Road, London EC1V 2PD Monday-Friday 9am-5pm. Clinic/Ward appointments can be arranged
Email	moorfields.pals@nhs.net
Phone	020 7566 2324 Monday-Friday 9am-5pm
Online form	No online form
Post	No postal address

Royal Free London NHS Foundation Trust	
PALS office location and hours	Barnet Hospital: Ground floor near the main entrance, Barnet Hospital, Wellhouse Lane, Barnet EN5 3DJ. Monday-Friday, 10am-4pm Chase Farm Hospital: Chase Farm Hospital, The Ridgeway, Enfield, Middlesex EN2 8JL. Monday-Friday 10am-4pm. Clinic/Ward appointments can be arranged Royal Free Hospital: Ground floor, opposite the main reception, Royal Free Hospital, Pond Street, London NW3 2QG. Monday-Friday, 9am-5pm
Email	Barnet Hospital: bcfpals@nhs.net Chase Farm Hospital: rf.cfhpeg@nhs.net Royal Free Hospital: rf.pals@nhs.net
Phone	Barnet Hospital: 020 8216 4924 Monday-Friday, 9am-5pm Chase Farm Hospital: 020 8375 1328 Monday-Friday, 10am-4pm Royal Free Hospital: 020 7472 6446 Monday-Friday, 9am-5pm
Online form	https://www.royalfree.nhs.uk/contact-us/patient-advice-and-liaison-service-pals/compliments-suggestions-and-complaints/make-suggestion-or-raise-concern
Post	Barnet Hospital: Patient Advice and Liaison Service (PALS), Barnet Hospital, Wellhouse Lane, Barnet EN5 3DJ Chase Farm Hospital: No postal address. Royal Free Hospital: Patient Advice and Liaison Service (PALS), Royal Free Hospital, Pond Street, London NW3 2QG

University College London Hospitals NHS Foundation Trust	
PALS office location and hours	University College Hospital, 235 Euston Road, London NW1 2BU Monday-Friday, 9am-4pm
Email	uclh.pals@nhs.net
Phone	0203 447 3042 Monday-Friday, 9am-4pm
Online form	No online form
Post	No postal address

Whittington Health NHS Trust	
PALS office location and hours	On the left in the main entrance, Whittington Hospital, Magdala Avenue, London N19 5NF. Monday-Friday, 9.30am-4.30pm
Email	whh-tr.pals@nhs.net
Phone	020 7288 5551* Monday-Friday, 9.30am-4.30pm
Online form	No online form
Post	PALS & Complaints, Whittington Health NHS Trust, Magdala Avenue, London N19 5NF

PALS web page accessibility

Direction to the PALS webpage

Starting from the homepage, each of hospital has several ways to navigate towards their PALS webpage. These can be grouped into five:

- through the website's search bar
- through navigating to the 'patient and visitors' section
- through the site map
- through the 'contact us' section
- through a link on the homepage

Figure 1.1 shows the different methods to reach the PALS webpage and how many NHS trusts use them. All of them have a search function in their site that users could utilise to find the PALS webpage.

The following sections show the different methods and complexity for patients to access PALS information online.

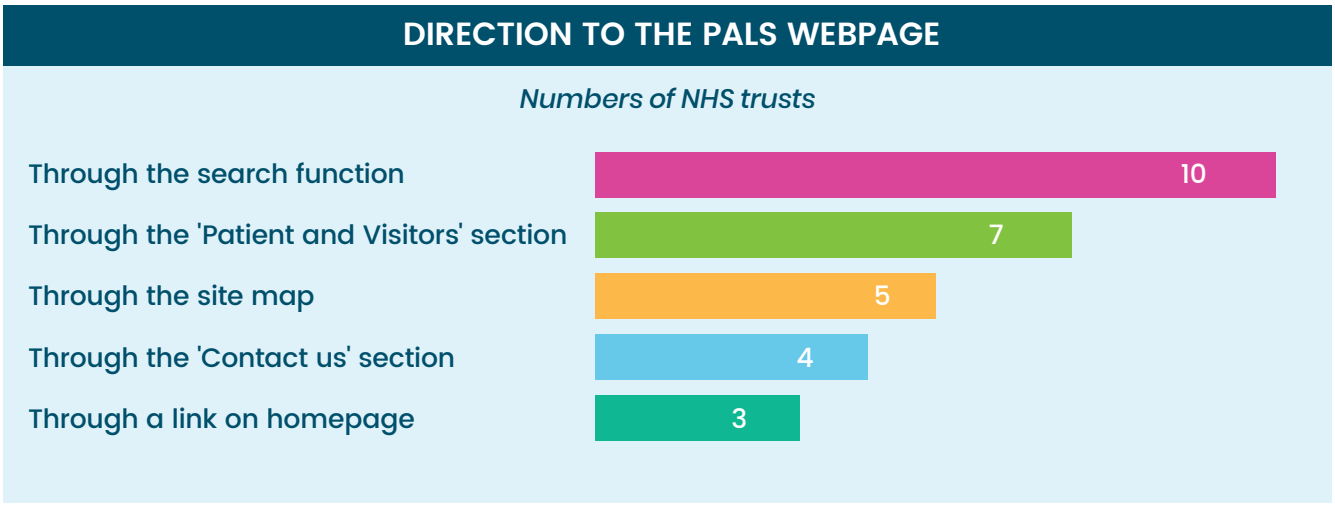


Figure 1.1 Navigation methods to PALS webpage from the homepage of NHS Trusts

Search bar

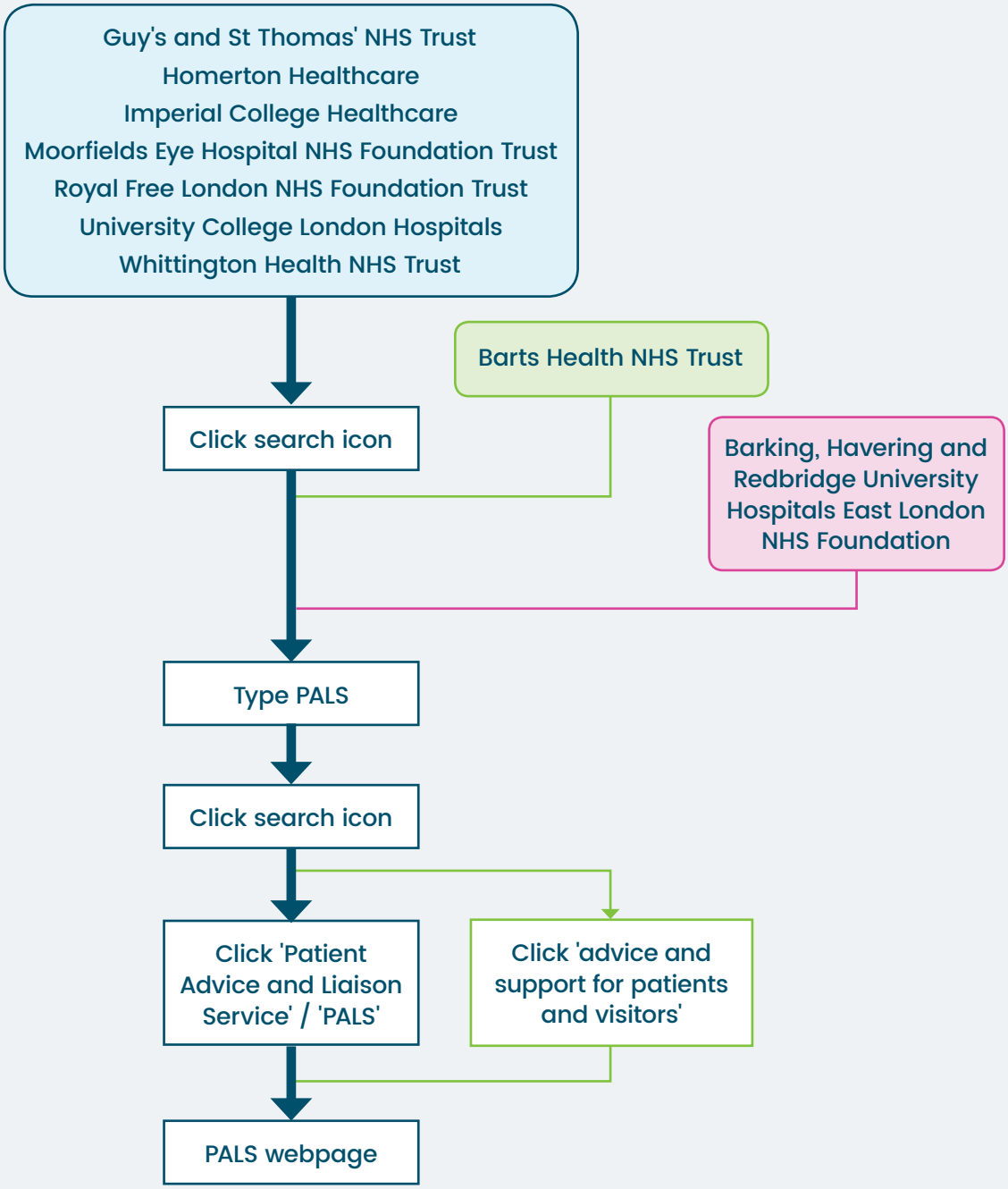


Figure 2. Navigational flowchart to Patient Advice and Liaison Service (PALS) webpages via search function

Using the search bar in the ten NHS trusts is straightforward, just typing PALS in the search bar of the site and clicking the necessary link. For most of the sites, the link to the PALS webpage is easily seen as they are titled as "Patient Advice and Liaison Service" or "PALS". The one exception is that for Barts Health NHS trust it is titled as "Advice and support for patients and visitors".

This might confuse some patients if they have used PALS on previous websites, although Barts in the description of the link had mentioned the Patient Advice and Liaison Service.

Patient and visitor section

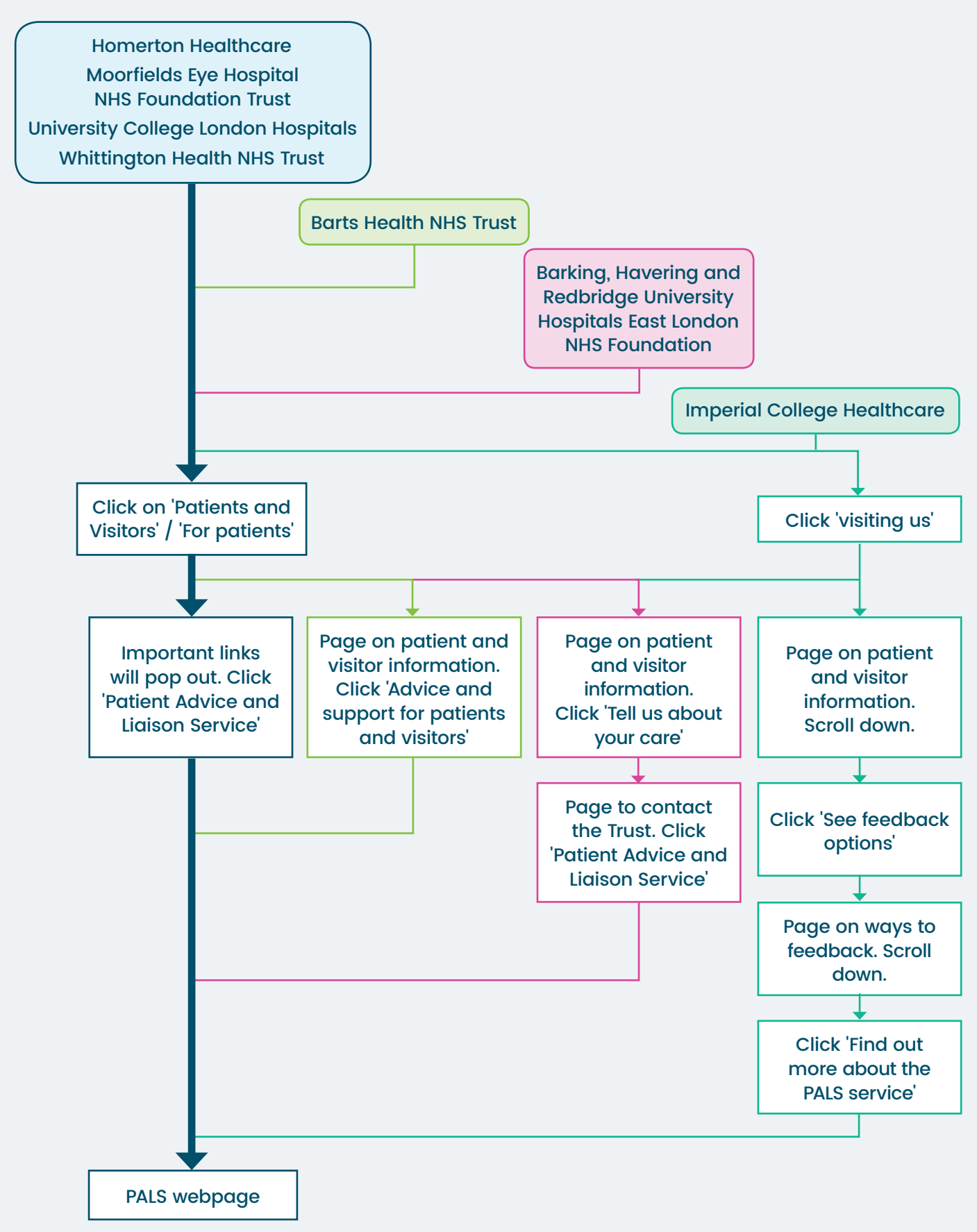


Figure 3. Navigational flowchart to Patient Advice and Liaison Service (PALS) webpages via the patient and visitor section on National Health Service (NHS) Trusts website

Seven of NHS trusts have their PALS webpage in their "Patient and Visitor" section and more than half of these have a straightforward path where you just need to click on the "Patients and Visitors" or "For patients" and important links would pop up which would include a link for PALS. For the other three NHS trusts, the way to reach the PALS webpage is varied and with various levels of complexity.

Barts Health NHS Trust differs slightly in that patients are opening another webpage including a pop-up; "Advice and support for patients and visitors" instead of "Patient Advice and Liaison Service" which could be confusing for patients. The Barking, Havering and Redbridge University Hospitals and Imperial College Healthcare trusts are like each other as both require users to pass through two web pages to reach PALS, but Imperial is more complex as it means scrolling down the page to reach the required link.

Contact us section

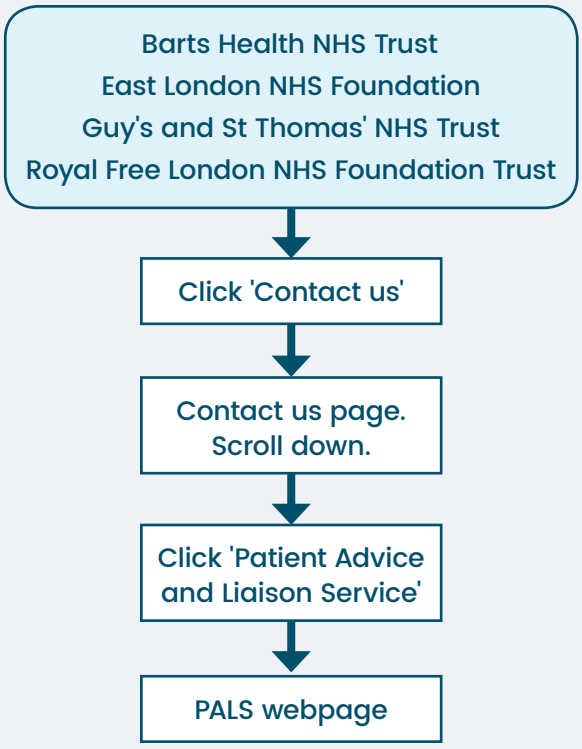


Figure 4. Navigational flowchart to Patient and Liaison Service (PALS) webpages via the contact us section on National Health Service (NHS) Trusts websites

Figure four shows the navigation process to the PALS webpage on various NHS Trusts' websites through the 'Contact Us' section. Users typically click on 'Contact Us,' scroll down the contact page, and then click on 'Patient Advice and Liaison Service' to reach the PALS webpage. This standardised approach is used by multiple trusts, including Barts Health NHS Trust, East London NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust. Barts Health NHS Trust is unique in that its PALS webpage can be navigated to by both its 'Contact us' and 'Patient and visitor' section.

Site map

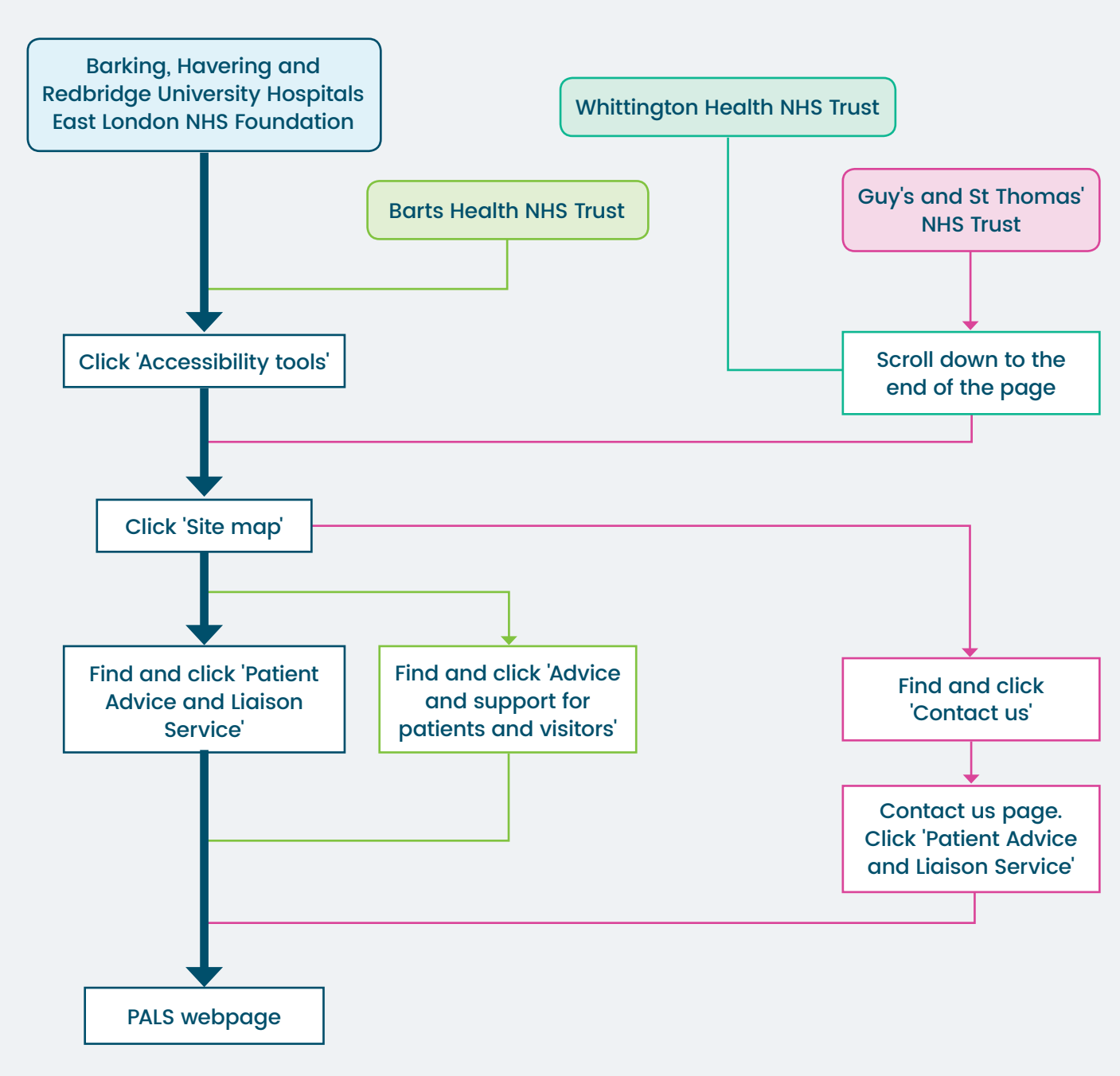


Figure 5. Navigational flowchart to Patient and Liaison Service (PALS) web pages via site map on National Health Service (NHS) Trusts websites

Five of the NHS trusts have sitemaps to help with navigation. Three of them, namely Barking, Havering and Redbridge University Hospitals, Homerton University Hospital and Barts Health NHS Trust have sitemaps as part of their site's accessibility tools. Meanwhile, for Whittington Health and Guy's and St Thomas' NHS trust's sites, the site map could be accessed at the end of the webpage. In the site map, you just need to click "Patient Advice and Liaison Services'. For Barts, this is replaced by 'Advice and Support for Patients and Visitors' while for Guy's and St Thomas' you must first pass through their "contact us" page.

Homepage link

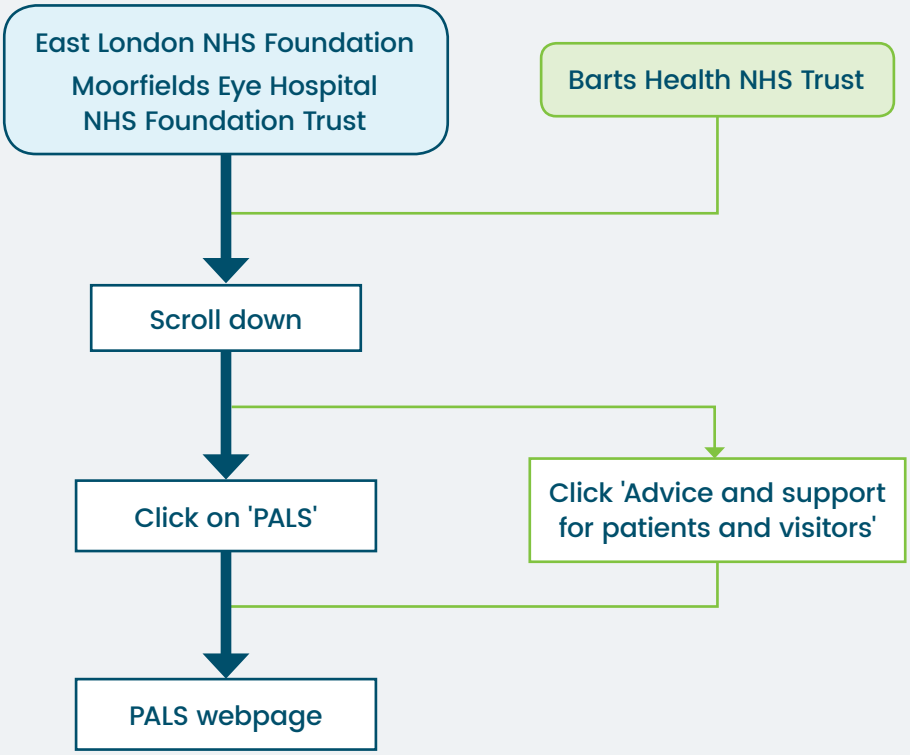


Figure 6. Navigational flowchart to Patient and Liaison Service (PALS) web pages via homepage link on National Health Service (NHS) Trusts websites.

Lastly, one of the methods to reach the PALS web page is a direct link from the site's home page. Three trusts use this: East London, Moorfield's Eye Hospital and Barts Health NHS Trust. With these, you just need to scroll down the home page to find the direct link. Again, for Barts the link is titled 'Advice and support for patients and visitors.'

Accessibility tools

Accessibility tools are designed to help individuals interact with digital content more effectively e.g. zoom features, colour contrast, screen reading. The website of Moorfield's Eye Hospital and Guy's and St Thomas' have no accessibility tools available. Below is a summary of the accessibility tools available on those websites that had them.

Languages

Focusing on the page translator tool, we can see a significant difference in language support among these trusts. The majority provide services in over 200 different languages, demonstrating extensive multilingual capabilities. In contrast, some only support over 100 languages, and another supports over 50 languages.

Conclusions

- The method of accessing the PALS page used most by the hospitals we researched is the search bar on the homepage of each website.
- There are many different methods of reaching the PALS page on each website such as through the search bar, site map or via a direct link.
- There is a lack of consistency between hospitals in regard to the language used when talking about PALS.
- The language translation options are limited at some hospitals in comparison to others.
- There are accessibility tools being used at some hospitals but not consistently.

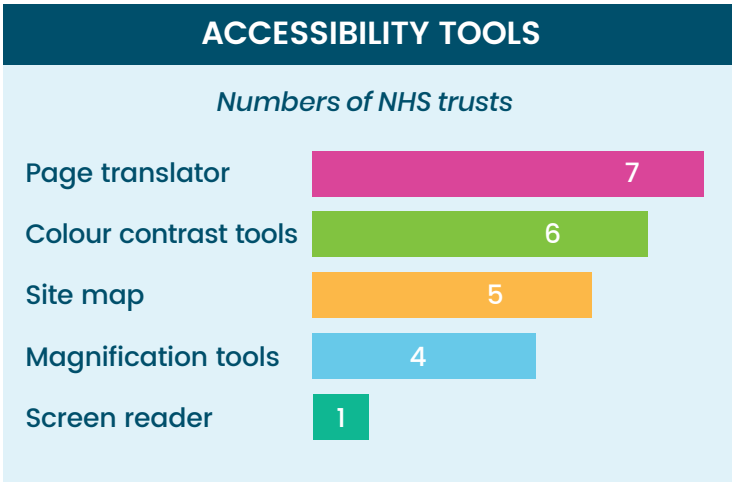


Figure 7. Availability of accessibility tools in NHS Trusts

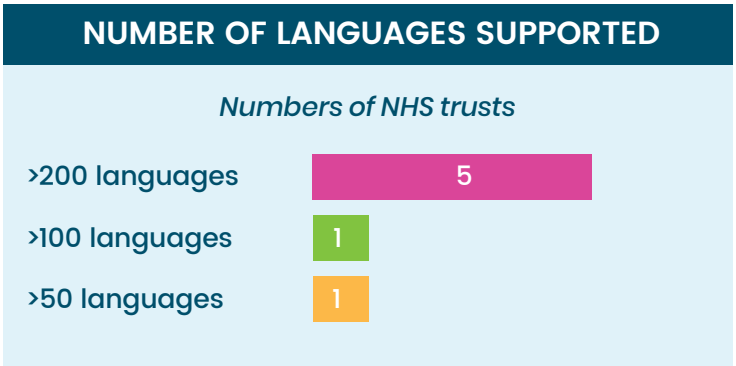


Figure 8. Range of supported languages by different NHS Trust

Ways to contact PALS

This information found as a result of this research has been summarised in the table of contact details at the start of this report.

Each of the NHS trusts has at least one hospital under their management and the ten NHS trusts oversee a total of 23 hospitals altogether. Each trust has several methods to contact their PALS. Based on the webpages, all hospitals' PALS could be reached through telephone and email.

Walk-ins are the next most common way to contact PALS with 91% saying on their websites that they offer walk-ins. On further inquiry, this value is at 100% as the remaining 9% confirmed that they have walk-in services. However, they don't advertise them. At the other end of the spectrum, the methods that are least used are the video and clinic/ward appointments.

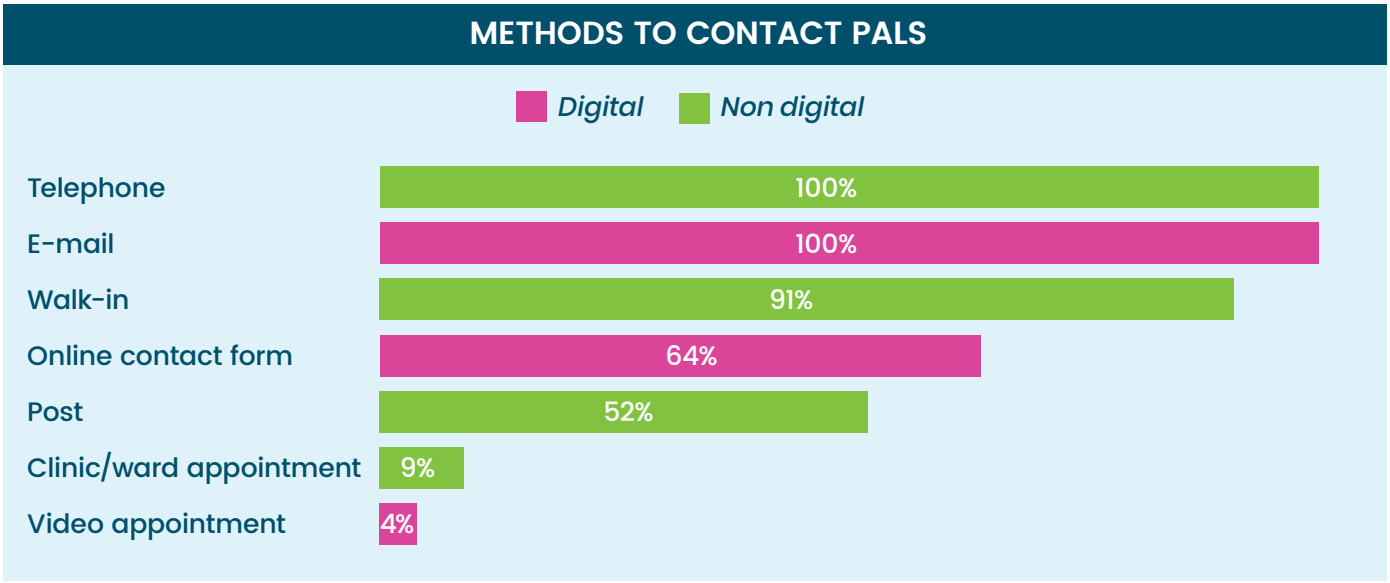


Figure 9. Percentage of hospitals by methods to contact PALS based on their PALS' webpage

Telephone

PALS of the 23 hospitals can be contacted by telephone but there are only 17 unique numbers. Some hospitals share one PALS telephone number among them, these are all detailed in the table at the beginning of the report. There are also variations with regards to the use of answering machines by the different hospitals with some using it so that clients could leave a message, while others prefer to be called during the PALS office hours. This is also detailed in the table at the start of this report.

E-mail

There are also 17 unique email addresses for the PALS of the different hospitals across the ten NHS trusts. Among the 17, nine utilised an automatic response system on an email requesting additional information. Eventually only four provided answers to the query but one of the four only replied with links back to their PALS webpage.

Walk-in

All PALS in the ten NHS trusts, when inquired, had said that they cater to walk-in clients but not all had specifically indicated this on their website. There are also differences in how they state the location of their office so that clients could drop in, with some providing specific instructions on how to find it while others just gave the general location of the hospital.

Online contact form

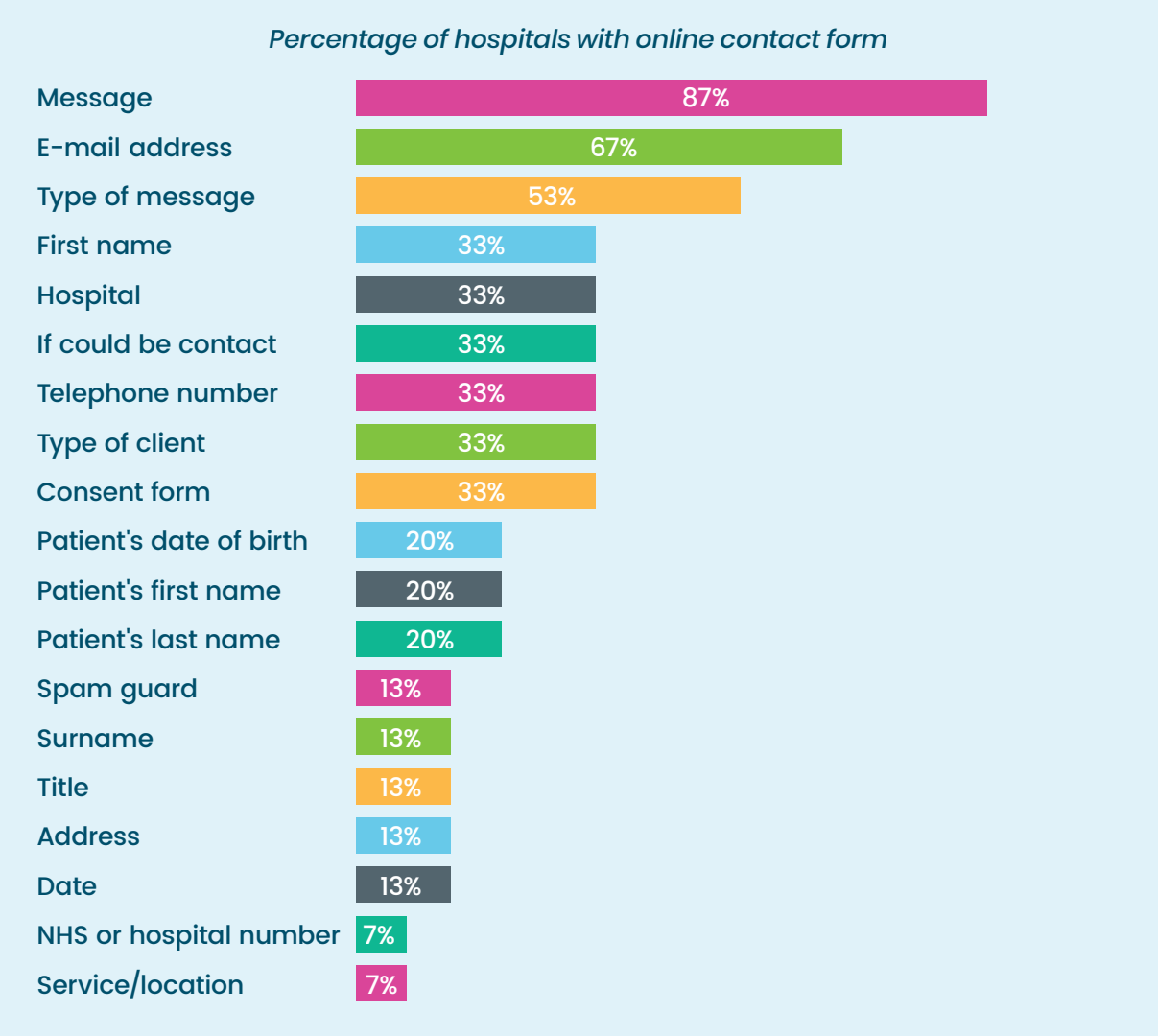


Figure 10. Percentage of hospitals with online contact form and the required fields in it

There is quite a variation to the required data to be given among the forms available. An email address is required by 67%, while 53% ask the type of message and 33% require a first name, the hospital to which the message is addressed, telephone number, type of client, if one could be contacted and if one would agree to the consent form.

By post

Only half of the hospitals had indicated in their PALS websites that they accept messages via post. In practice this could be higher but only twelve explained how to address the post to their respective PALS.

Clinic/ward appointment and video appointment

Clinic/ward and video appointments are the more niche methods to contact PALS. Only Chase Farm and Royal Free Hospitals state on their websites that they offer clinic/ward appointments and only University College London Hospital for video appointments.

Conclusions

- There are various different ways to contact each PALS services such as phone, email and walk in.
- Not all hospitals utilise the contact methods they could, such as video or ward appointments.
- The information required by those who offer online forms varies drastically.

Walk in service summary

Staff and volunteers conducted some in-person observations of PALS services at the following hospitals and below is a summary of the observations made.

St Bartholomew's Hospital

There were no signs for PALS at this hospital and it was unclear how to find PALS from the main entrance. Reception staff were able to advise where to find the PALS office when asked, it's located on the ground floor, next to the imaging reception. The opening times were available on the door, but they were handwritten, small and unclear. There were no PALS leaflets or resources available. When asked, two staff members were unaware of where to find PALS and one wasn't sure if there was a walk-in service available at all.

Mile End Hospital

Walking into reception, there were no signage for PALS. A receptionist asked if we needed help, and despite knowing what PALS was, he was unsure of where it was located – also asking two other receptionists. He directed us to the other side of the hospital, however, there was still no signage available. A staff member asked if we needed help, and he said that there was no PALS on site, but reception have an email which we can use to contact the PALS reception. Upon going back to reception, there was a small A4 poster on the inside of reception (not accessible for patients to see) which had information of PALS on site at the Royal London Hospital. The receptionists were unsure if the information on the poster was correct.

The Royal London Hospital

There are no signs for PALS in the main entrance to the hospital, or on any hospital maps. We asked at reception where the PALS office was and was directed to the second floor via lift one. On exiting the lift, there again, was no signage for the service. We asked a consultant who was waiting by a lift, who didn't know where it was located but assumed it would be near the 'Bereavement Centre' to which he directed us.

Near the Bereavement Centre we found the PALS office which is called the 'Patient and Family Contact Centre'. On the door there was a sign advertising the drop-in service available between 10am - 4.30pm and an email address. We were unable to access the room as we visited outside of these hours. There were no leaflets available. The only directional sign for the service was on the 'Cashiers and Fares' office window.

Guy's Hospital

No signposts outside the hospital. Reception knew where it was and what it was and directed us to a large hospital plan on the wall, which wasn't helpful, but we caught sight of a small notice sticking out off the wall which is grey and uninformative. PALS is squashed in a corner of a busy area. Signposting on doors is misleading as we thought it was an information place as did many people asking for directions. It was not welcoming as it is small with no room for a confidential discussion, and we had to ask for leaflets as these were behind the door. The door was split in two like a stable door and the member of staff had the bottom half closed. We asked for a leaflet and was asked what we wanted to know, we were handed two leaflets on making a complaint and that was the end of the interaction.

We asked three staff where PALS was, two nurses and a porter, two didn't know what PALS was. The second nurse said there wasn't one on site and we would need to go to St Thomas' Hospital. Limited opening notices are cold and impersonal regarding opening hours.

St Thomas' Hospital

The PALS office was easy to find, located right by the main entrance and reception area, although signs were not available from other entrances. Good opening hours but limited for visitors out of hours but a notice was helpful on how to make contact when closed. Staff were very welcoming and there is room to have a confidential private discussion that also has a good display of excellent leaflets.

Upon arrival three members of staff were asked about PALs, one knew what and where it was, but two others didn't know what it was although one did try and help us find it. There were a variety of leaflets available detailing what PALS is, what they can offer and how to contact them.

Homerton Hospital

The PALS Service at the Homerton Hospital is advertised on the hospital site map. Upon entering the main entrance of the hospital, the PALS office is clearly visible on the left-hand side. When we visited the hospital the PALS office was not open. However, there was a very useful sign displayed which gave both a telephone number and an email address to allow patients to contact them. It also displays their opening hours.

University College London Hospital

There were no signs directing patients to the PALS office and it was unclear how to find this out. Upon talking to reception staff, they were able to provide a leaflet detailing what PALS is, what they can help with and how to contact them. We were advised that there are no PALS staff on site and to contact them via phone/email to gain more information. We have attempted to contact PALS but have not yet received a response.

Turnaround time for PALS inquiry

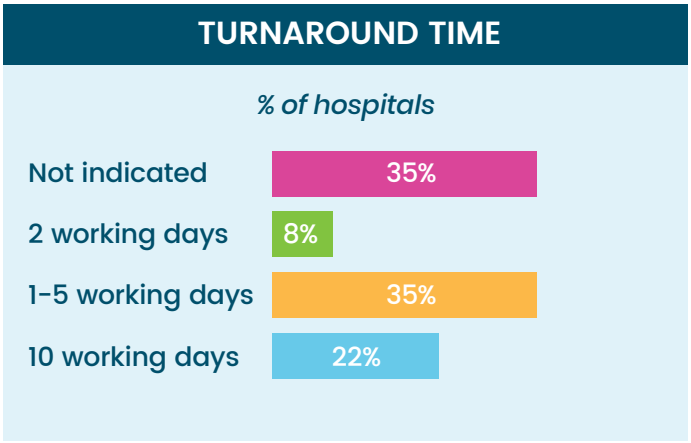


Figure 11. Percentage of hospitals and the turnaround time of their PALS

We examined the turnaround time for PALS to respond to messages, inquiries, or complaints and 35% of hospitals say they will respond within one to five working days, 22% say up to 10 working days and the minority is 8% which say two working days. A large portion at 35% had not indicated in their website what their turnaround time was.

Information about PALS

PALS webpage

The PALS web page provides an overview to those that use the website about the Patient Advice and Liaison Services of the Trust. The content of each web page is different from one Trust to another, but this section will look into the general themes that could be seen on the pages.

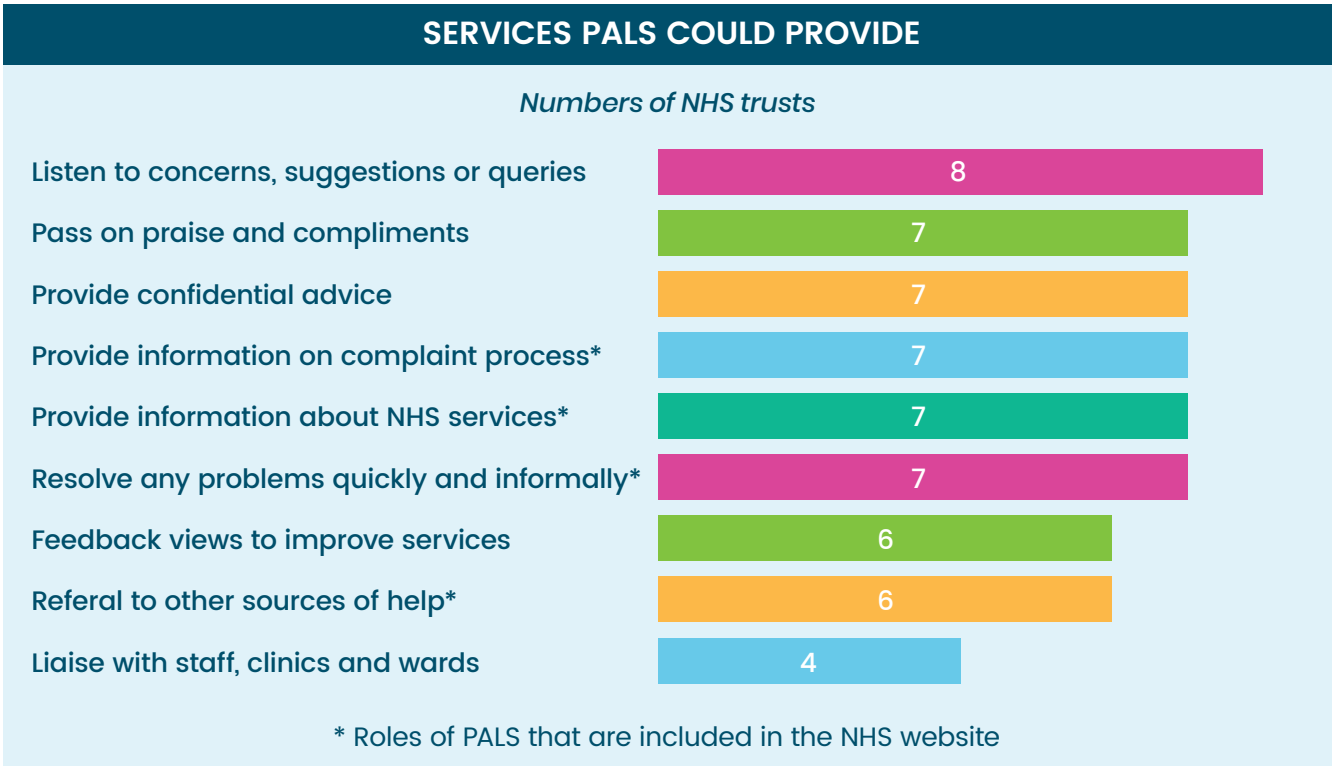


Figure 12. Distribution of services provided by PALS according to the Trust's webpage

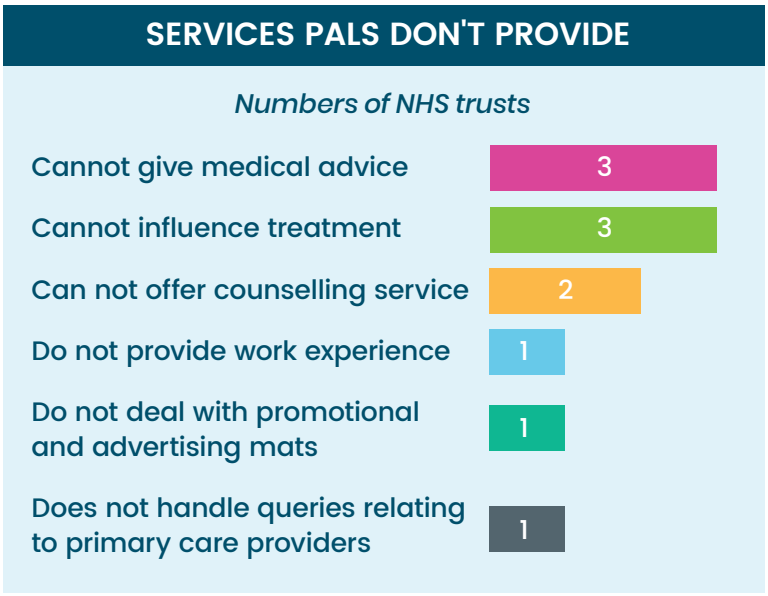


Figure 13. Distribution of services not provided by PALS according to the Trust's webpage

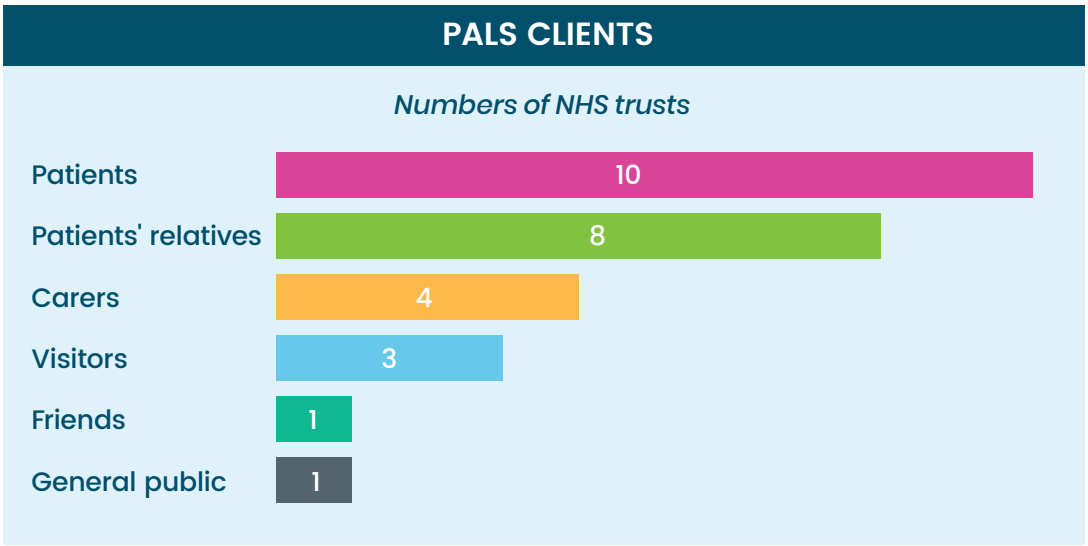


Figure 14. Who PALS class as their clients according to the Trust's webpage

Additional information

Apart from the PALS website, three of the NHS trusts have downloadable leaflets that talk more about PALS. These leaflets detail more about the services that the PALS of the trusts provide. The following trusts have such leaflets:

- East London NHS Foundation Trust
- Homerton University Hospital NHS Foundation Trust
  - Apart from English, the leaflet is translated to Vietnamese, Polish, Bengali and Turkish
  - Also has an easy-to-read version
- Whittington Health NHS Trust
  - Has easy-to-read version

Conclusion

This report has provided a comprehensive overview of the Patient Advice and Liaison Service (PALS) across ten NHS trusts. The analysis revealed that while PALS offers a valuable resource for patients, there are areas where consistency and accessibility could be improved.

Overall, the most consistently used method to reach PALS was via the search bar on the homepage of each website. This is a well-known and accessible method of being able to find the information needed on the PALS services. However, methods such as through a direct link on the homepage or via a site map, should still be available. People accessing this information may have various levels of both digital and health literacy, so we should be providing as many options as possible to be able to find and access the information that is required.

There is a lack of consistency between hospitals with regard to the language used when talking about PALS, but also in terms of where the information about PALS is located. This could be confusing for some, particularly if they are not familiar with PALS or what technical language means.

There are a number of accessibility tools that services could be utilising - however, most are not. Tools such as screen readers and magnification are used the least, which makes the PALS information on a website inaccessible to a large number of people. This is also the case with translation tools as there is a vast difference in the number of languages offered as well as the functionality.

There are many ways to contact PALS - however this is another area of inconsistency as there are differing options of contact depending on which hospital you are visiting. All hospitals offer phone, email, and walk-in options for contacting their PALS service, but online, postal and other methods aren't always used and vary in availability. Hospitals should be offering a range of diverse ways to contact their PALS and utilise alternative methods in order to be more accessible. There is an opportunity to expand with the ever-growing digital world and make use of video appointments if appropriate for the patient as this could reduce the turnaround time as well.

Of hospitals researched, 35% didn't specify a turnaround time for PALS enquiries. This should be listed on every PALS website to ensure the service is transparent and patients are aware of the time frame they should expect. This would enable patients to be in control of their PALS experience and means they know what to expect from their enquiry.

From our in-person visits, we were able to establish that PALS services within each hospital are not always well signposted and not all staff are aware of the services on offer/how to access them. There was a variety of responses when we asked staff where to find PALS at each hospital, some were able to tell us where it was and were helpful in their directions on how to find the office however some were not aware there was a PALS office on site or didn't know how to find it. We will be addressing these issues with the hospitals in the aim to rectify these issues and ensure PALS is accessible for all.

Recommendations

- Standardising the navigation process to get to the PALS webpage, eg, having all PALS pages in the same place or having a link on the home page.
- All websites should utilise a site map for ease of navigation and accessibility.
- Language should be user-friendly and consistent across the websites to ensure PALS advice is as accessible as possible.
- Implement screen readers and other assistive technologies to accommodate users with accessibility requirements.
- Ensure all methods to reach PALS are up-to-date and on their website.
- Turnaround time should be clearly indicated so that patients and other clients are aware of the time frame and are able to follow up if needed.
- Include a section addressing frequently asked questions or misunderstanding about PALS as many patients and staff aren't aware of the services provided.
- Developing downloadable leaflets that provide detailed information about PALS services, including translations and easy-to-read versions.
- Staff to be refreshed regarding the PALS services their hospital offers so they are able to advise patients correctly.
- Signposting within hospitals should be assessed to ensure that patients are able to access PALS services easily.
- Leaflets about PALS should be accessible near the PALS office at each hospital so that patients can still find information even when they are not open.

APPENDIX: PALS of different hospitals

Barking, Havering and Redbridge University Hospitals NHS Trust	
Homepage	https://www.bhrhospitals.nhs.uk
Direction to web page from homepage	▪ Through the search bar ▪ Through the Patients and Visitors Section ▪ Through the Site map
Accessibility tools	▪ Change contrast ▪ Site map ▪ Language translation (104 languages supported)
PALS web page link	https://www.bhrhospitals.nhs.uk/patient-advice-and-liaison-services
PALS location	King George Hospital: Barley Lane, Goodmayes, Greater London IG3 8YB Queen's Hospital: Rom Valley Way, Romford, Greater London RM7 0AG
E-mail	bhrut.pals@nhs.net
Telephone	01708 435 454 Monday-Friday, 9am-5pm
Online form	https://www.bhrhospitals.nhs.uk/askpals
Turnaround time for PALS enquiry	10 days

Barts Health NHS Trust		
Homepage	https://www.bartshealth.nhs.uk	
Direction to web page from homepage	▪ Through the search bar ▪ Through the Patients and Visitors Section ▪ Through the Contact us section ▪ Through the Site map ▪ Through the link on the front page	
Accessibility tools	▪ Change contrast ▪ Site map ▪ Language translation (243 languages supported)	
PALS web page link	https://www.bartshealth.nhs.uk/pals	
	Newham Hospital	**St Bartholomew's Hospital**
PALS location and walk-in schedule	Zone 1, St Andrews Wing, Newham Hospital, Glen Road Plaistow, London E13 8SL Monday-Friday 9:30am-4:30pm	Next to Imaging Reception, KGV Building, Ground Floor, St Bartholomew's Hospital, West Smithfield, City of London, EC1A 7BE Monday-Friday 9:30am-4:30pm
Telephone	0207 363 9292 Monday-Friday 9:30am-4:30pm	0203 465 5919 Monday-Friday 9:30am-4:30pm
E-mail	nuhpals.bartshealth@nhs.net	SBHpals@bartshealth.nhs.uk
Turnaround time for PALS enquiry		1-5 working days
	The Royal London and Mile End Hospital	**Whipps Cross Hospital**
PALS location and walk-in schedule	Patient and Family Contact Centre, 2nd Floor, Central Tower, Royal London Hospital, Whitechapel Road, Whitechapel, London E1 1FR Monday-Friday 10am-4:30pm	Junction 4, Main Building, Whipps Cross Hospital, Whipps Cross Road, London E11 1NR Monday-Friday 9:30am-4:30pm
Telephone	0203 594 2040 Monday-Friday 10am-4:30pm	0208 535 6438 Monday-Friday 9:30am-4:30pm
E-mail	RLHpals@bartshealth.nhs.uk	WXpals@bartshealth.nhs.uk

East London NHS Foundation Trust	
Homepage	https://www.elft.nhs.uk
Direction to web page from homepage	▪ Through the search bar ▪ Through the Contact us section ▪ Through the link on the front page
Accessibility tools	▪ Language translation (82 languages supported)
PALS web page link	https://www.elft.nhs.uk/contact-us/pals-here-help
PALS leaflet download link	https://www.elft.nhs.uk/sites/default/files/2023-03/PALS-Leaflet-A5-ELFT%20updated.pdf
PALS location and walk-in schedule	East London NHS Foundation Trust, 1st Floor, Health E19 - 11 Brick Lane, London E1 6PU Monday-Friday 9am-5pm
Postal address	FREEPOST RTXT-HJLG-XEBE, The Complaints Manager, Complaints Department, Governance and Risk Management, East London NHS Foundation Trust, 1st Floor, Health E19-11 Brick Lane, London, E1 6PU
E-mail	elft.pals@nhs.net
Telephone	0800 783 4839 Monday-Friday 9pm-5pm

Guy's and St Thomas' NHS Foundation Trust		
Homepage	https://www.guysandstthomas.nhs.uk	
Direction to web page from homepage	▪ Through the search bar ▪ Through the Patients and Visitors Section ▪ Through the Site map	
Accessibility tools	▪ Site map	
PALS web page link	https://www.guysandstthomas.nhs.uk/contact-us/your-feedback/contact-pals	
	Guy's and St Thomas Hospitals	**Harefield and Royal Brompton Hospitals**
PALS location and walk-in schedule	*Guy's Hospital*: Ground floor, Guy's Hospital, Great Maze Pond, London SE1 9RT *St Thomas' Hospital:* Main entrance, St Thomas' Hospital, Westminster Bridge Road, London SE1 7EH. Monday-Tuesday, Thursday-Friday 9am-5pm, Wednesday 10am-5pm Closed 1-1.30pm	*Harefield Hospital:* Main reception, Hill End Road, Harefield, Middlesex UB9 6JH *Royal Brompton Hospital:* Near reception, Royal Brompton Hospital, Sydney Street, London SW3 6NP. Monday-Friday 9am-4pm
Postal address	PALS, St Thomas' Hospital, Westminster Bridge Road London SE1 7EH	
Telephone	020 7188 8801 Monday-Friday 9am-5pm	*Harefield Hospital:* 01895 826 572 Monday-Friday 9am-4pm (have answering machine) *Royal Brompton Hospital:* 020 7349 7715 Monday-Friday 9am-4pm (have answering machine)
E-mail	pals@gstt.nhs.uk	pals@rbht.nhs.uk
Online form	https://www.guysandstthomas.nhs.uk/pals-feedback	https://www.rbht.nhs.uk/patients-visitors/for-patients/patient-support-services/patient-advice-and-liaison-service-pals/contact-pals
Turnaround time for PALS enquiry	Urgent: 1-2 working days Non-urgent: 4-5 working days	

Homerton Healthcare NHS Foundation Trust	
Homepage	https://www.homerton.nhs.uk
Direction to web page from homepage	▪ Through the search bar ▪ Through the Patients and Visitors Section ▪ Through the Site map
Accessibility tools	▪ Change contrast ▪ Site map ▪ Change font size
PALS web page link	https://www.homerton.nhs.uk/patient-advice-liaison-service-pals
PALS leaflet download link	https://www.homerton.nhs.uk/download/doc/docm93jijm4n12894.pdf?amp;ver=29206 (Bengali, Polish, Turkish and Vietnamese translation) https://www.homerton.nhs.uk/download/doc/docm93jijm4n1161.pdf?amp;ver=1748 (easy read version)
PALS location and walk-in schedule	Main entrance, Homerton University Hospital, Homerton Row, London, Greater London, E9 6SR. Monday-Friday 9:30am-4pm
E-mail	huh-tr.pals.service@nhs.net
Telephone	020 8510 7315 Monday-Friday 9:30am-4pm (have answering machine)
Online form	https://www.homerton.nhs.uk/patient-advice-liaison-service-pals
Turnaround time for PALS enquiry	2 working days

Imperial College Healthcare NHS Trust	
Homepage	https://www.imperial.nhs.uk
Direction to web page from homepage	▪ Through the search bar ▪ Through the Patients and Visitors Section
Accessibility tools	▪ Change contrast ▪ Change font size ▪ Language translation (242 languages supported)
PALS web page link	https://www.imperial.nhs.uk/patients-and-visitors/help-support-and-feedback/feedback/pals
Online form	https://www.imperial.nhs.uk/patients-and-visitors/help-support-and-feedback/feedback/pals/pals-form
PALS location and walk-in schedule	Charing Cross Hospital, Fulham Palace Road, London W6 8RF Hammersmith Hospital, Du Cane Road, London W12 0HS Queen Charlotte's & Chelsea Hospital, Du Cane Road, London W12 0HS St Mary's Hospital, Praed Street, London W2 1NY Western Eye Hospital, Marylebone Road, London NW1 5QH Monday-Friday 10am-4pm
E-mail	imperial.PALS@nhs.net
Telephone	020 3312 7777 Monday-Friday, 10am-4pm (Must call within these hours)
Postal address	PALS Manager, Ground floor, Clarence building, St Mary's Hospital, Praed Street, London W2 1NY
Turnaround time for PALS enquiry	E-mail, online contact form: 2-5 working days; Telephone, walk-in: 1 working day

Moorfields Eye Hospital NHS Foundation Trust	
Homepage	https://www.moorfields.nhs.uk
Direction to web page from homepage	▪ Through the search bar ▪ Through the Patients and Visitors Section ▪ Through the link on the front page
PALS web page link	https://www.moorfields.nhs.uk/about-us/our-support-network/pals
PALS location and walk-in schedule	Ground floor, Moorfields Eye Hospital, 162 City Road, London EC1V 2PD Monday-Friday 9am-5pm. Clinic/Ward appointments can be arranged
E-mail	moorfields.pals@nhs.net
Telephone	020 7566 2324 Monday-Friday 9am-5pm

Royal Free London NHS Foundation Trust			
Homepage	https://www.royalfree.nhs.uk		
Direction to web page from homepage	▪ Through the search bar ▪ Through the Contact us section		
Accessibility tools	▪ Change contrast ▪ Change font size ▪ Language translation (281 languages supported)		
PALS web page link	https://www.royalfree.nhs.uk/contact-us/patient-advice-and-liaison-service-pals		
Online form	https://www.royalfree.nhs.uk/contact-us/patient-advice-and-liaison-service-pals/compliments-suggestions-and-complaints/make-suggestion-or-raise-concern		
Turnaround time for PALS enquiry	10 working days		
	Barnet Hospital	**Chase Farm Hospital**	**Royal Free Hospital**
PALS location and walk-in schedule	Ground floor near the main entrance, Barnet Hospital, Wellhouse Lane, Barnet EN5 3DJ Monday-Friday 10am-4pm (closed 1-2pm)	Chase Farm Hospital, The Ridgeway, Enfield, Middlesex EN2 8JL Monday-Friday 10am-4pm Clinic/Ward appointments can be arranged	Ground floor, opposite the main reception, Royal Free Hospital, Pond Street, London NW3 2QG Monday-Friday 9am-5pm
Postal address	Patient Advice and Liaison Service (PALS), Barnet Hospital, Wellhouse Lane, Barnet EN5 3DJ	No postal address	Patient Advice and Liaison Service (PALS), Royal Free Hospital, Pond Street, London NW3 2QG
Telephone	020 8216 4924 Monday-Friday 9am-5pm	020 8375 1328 Monday-Friday 10am-4pm	020 7472 6446 Monday-Friday 9am-5pm
E-mail	bcfpals@nhs.net	rf.cfhpeg@nhs.net	rf.pals@nhs.net

University College London Hospitals NHS Foundation Trust	
Homepage	https://www.uclh.nhs.uk
Direction to web page from homepage	▪ Through the search bar ▪ Through the Patients and Visitors Section
Accessibility tools	▪ Change contrast ▪ Change font size ▪ Language translation (243 languages supported)
PALS web page link	https://www.uclh.nhs.uk/patients-and-visitors/help-and-support/patient-advice-and-liaison-service-pals
PALS location and walk-in schedule	University College Hospital, 235 Euston Road, London NW1 2BU Monday-Friday, 9am-4pm Video appointment can be arranged.
E-mail	uclh.pals@nhs.net
Telephone	0203 447 3042 Monday-Friday, 9am-4pm

Whittington Health NHS Trust	
Homepage	https://www.whittington.nhs.uk
Direction to web page from homepage	▪ Through the search bar ▪ Through the Patients and Visitors Section ▪ Through the Site map
Accessibility tools	▪ Site map ▪ Read aloud ▪ Language translation (242 languages supported)
PALS web page link	https://www.whittington.nhs.uk/default.asp?c=1341
PALS leaflet download link	https://www.whittington.nhs.uk/document.ashx?id=6222 PALS easy read leaflet download link: https://www.whittington.nhs.uk/document.ashx?id=15428
PALS location and walk-in schedule	On the left in the main entrance, Whittington Hospital, Magdala Avenue, London N19 5NF Monday-Friday, 9.30am-4.30pm (closed 1-2pm)
E-mail	whh-tr.pals@nhs.net
Telephone	020 7288 5551 Monday-Friday, 9.30am-4.30pm (closed 1-2pm) (have answering machine)
Postal address	PALS & Complaints, Whittington Health NHS Trust, Magdala Avenue, London N19 5NF
Turnaround time for PALS enquiry	2 working days

healthwatch
City of London

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

020 3745 9563

info@healthwatchcityoflondon.org.uk

www.healthwatchcityoflondon.org.uk

CoLHealthwatch @Healthwatchcity @Healthwatchcity

Design and layout: www.causeffectdesign.co.uk Cover photo: © Healthwatch England

Barts Health NHS Trust Cardiology Department Enter and View Report

healthwatch City of London

Contents

Visit Details

Visit Details	
Service visited	Barts Health NHS Trust Cardiology department
Address	St Bartholomew's Hospital West Smithfield London EC1A 7BE
Service Manager	Matthew Young, General Manager for Electro Physiology, Intervention and Networked Cardiology (13th June 2024) Alison Digney, Outpatient Service Manager (25th July 2024)
Dates and Times of Visits	13th June 2024 10am – 1pm 25th July 2024 10am – 12pm
Status of visit	Announced
Authorised representatives (staff)	Rachel Cleave, Liesa Sandt, Caitlan Barrow
Authorised representatives (volunteers)	Lynn Strother, Judy Guy Brisco, Janet Porter, Stuart MacKenzie, Bee Lim

What is Healthwatch?

Healthwatch City of London is an independent organisation which relies on feedback from the local community regarding their experience using health and social care services across the borough. It is part of a nationwide network of local Healthwatch and a national body, Healthwatch England. As the local Health and Social Care Champion, Healthwatch City of London ensures that your voice is heard by National Health Service (NHS) leaders and local authorities when decisions are made on how services will be delivered and further improved.

What is Enter and View?

One of Healthwatch City of London's statutory functions is to carry out Enter and View visits to health and social care service providers in the borough. The Health and Social Care Act 2012 allows local Healthwatch Authorised Representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies.

During visits, we observe service delivery and talk with service users, their families, and carers. We also interview management and staff regarding their views of the service provided. The aim is to get an impartial view of how the service is operated and being experienced.

Following the visits, our official 'Enter and View Report', will be shared with the service provider, local commissioners and regulators outlining what has worked well, and give recommendations on what could have worked better. All reports are available to view on our website.

> "The aim is to get an impartial view of how the service is operated and being experienced."

Disclaimer

Please note, this report relates to findings observed on the specific dates set out. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Acknowledgements

Healthwatch City of London would like to thank the service provider, service users and staff for their contribution and hospitality in enabling this Enter and View visit to take place. We would also like to thank the Healthwatch City of London volunteers who assisted in conducting the visit.

Why Barts Cardiology?

The rationale for conducting an Enter and View visit to the cardiology department is based on feedback given to Healthwatch City of London by patients concerning their experience of the communication and information given prior to and after appointments.

The level of satisfaction with the care received is not subject to this project.

Pre visit research

Prior to the visit Healthwatch City of London undertook desktop research to understand the published information already available on the service. It also undertook an online survey for service users to complete to give feedback on their experiences of the service.

Information on Barts Cardiology Department

Barts Cardiology department is based at St Bartholomew's hospital. Cardiology is a medical specialty to diagnose, assess and treat diseases and defects of the heart and blood vessels (the cardiovascular system).

You would visit the cardiology department at Barts Health to receive investigation and treatment for heart conditions such as arrhythmias (irregular heartbeat), cardiomyopathy (disease of the heart muscle) and myocardial infarction (heart attack).

Waiting Times

According to My Planned Care the average waiting time for first outpatient appointment at this hospital for this specialty is 12 weeks with the average waiting time for treatment being 16 weeks.

CQC Rating

The Care Quality Commission (CQC) are the independent regulator of health and adult social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

The most recent CQC inspection at Barts Hospitals NHS Trust took place in February 2019 with an overall rating of 'Needs Improvement', however St Bartholomew's hospital was not included in this inspection.

The previous CQC inspection at St Bartholomew's Hospital was in 2017 when it was rated good.

Patient Reviews

Of the three reviews left on the NHS Review site, two rated the service as 5 out of 5, with one reviewer giving the service 1 out of 5.

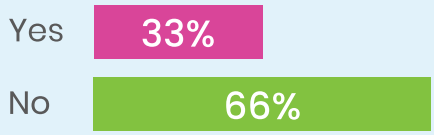
Survey Feedback

Healthwatch City of London carried out an online survey for service users of the of the cardiology department to complete. The survey was designed to further explore the issues that service users had expressed to Healthwatch City of London. The online survey was open from February 2024 and closed in June 2024 following the first enter and view visit to the hospital.

Survey Results

Healthwatch City of London carried out an online survey for service users of the of the cardiology department to complete. The survey was designed to further explore the issues that service users had expressed to Healthwatch City of London. The online survey was open from February 2024 and closed in June 2024 following the first enter and view visit to the hospital.

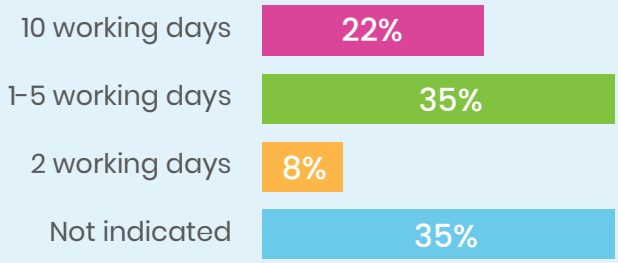
Q1 Have you received an appointment letter from the Barts cardiology department that contained incorrect information?



Comments:

- Bart's failed to keep a confirmed telephone consultation appointment.
- Out of date or no phone numbers, often no email address

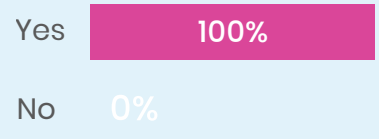
Q2 Have you received an appointment letter that was missing or had insufficient contact information in it? (no phone number for the department, no email address for the department)



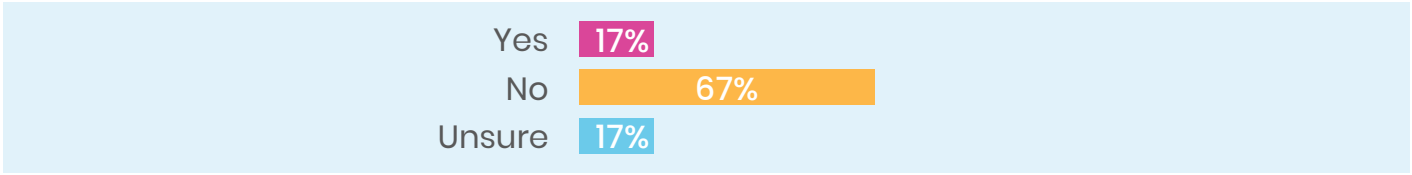
Comments:

- I have received many appointment letters like this. The clinic letter does have email address, and phone numbers which are different to the number on the appointment letters, but no department opening hour details are on any letter.

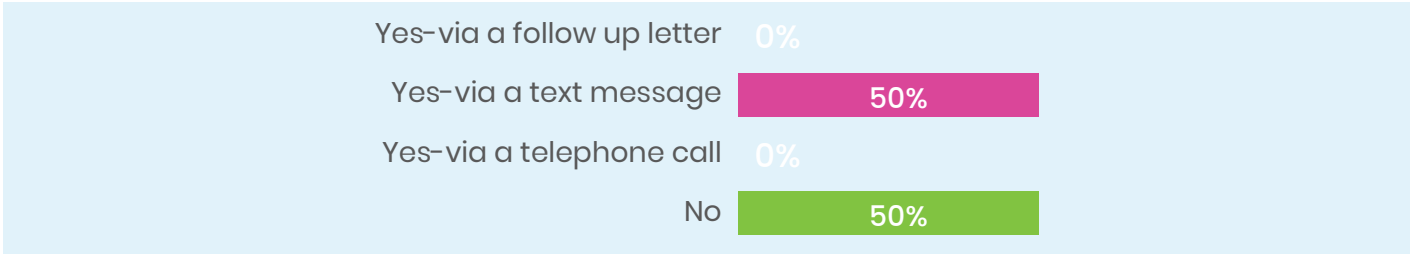
Q3 Did the letter you received stipulate if the appointment was in person or virtual (telephone or video call)?



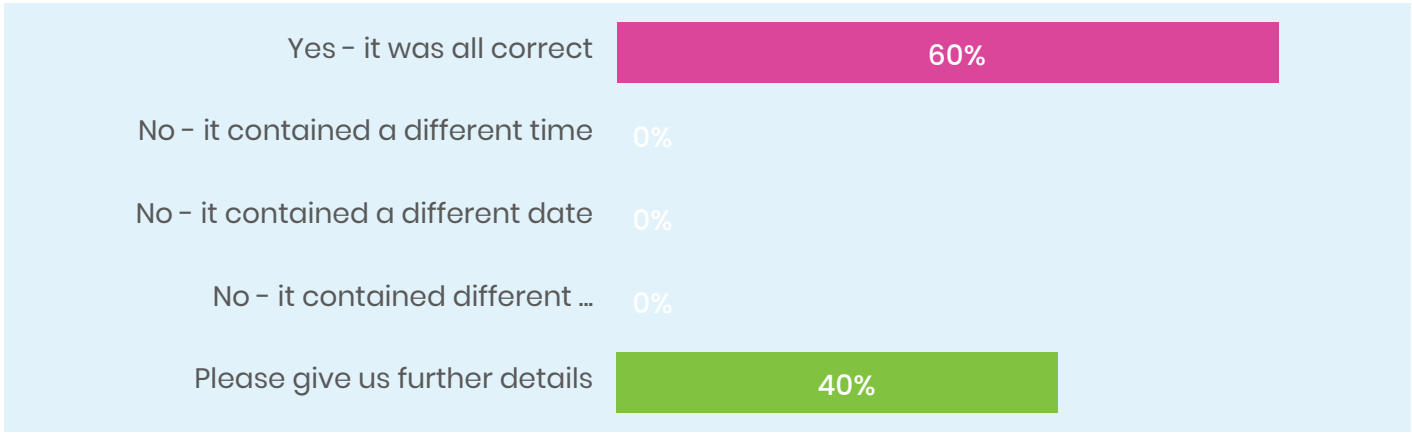
Q4 Did the letter give you the option to obtain the details in your preferred language?



Q5 Before your appointment did you receive a timely reminder?



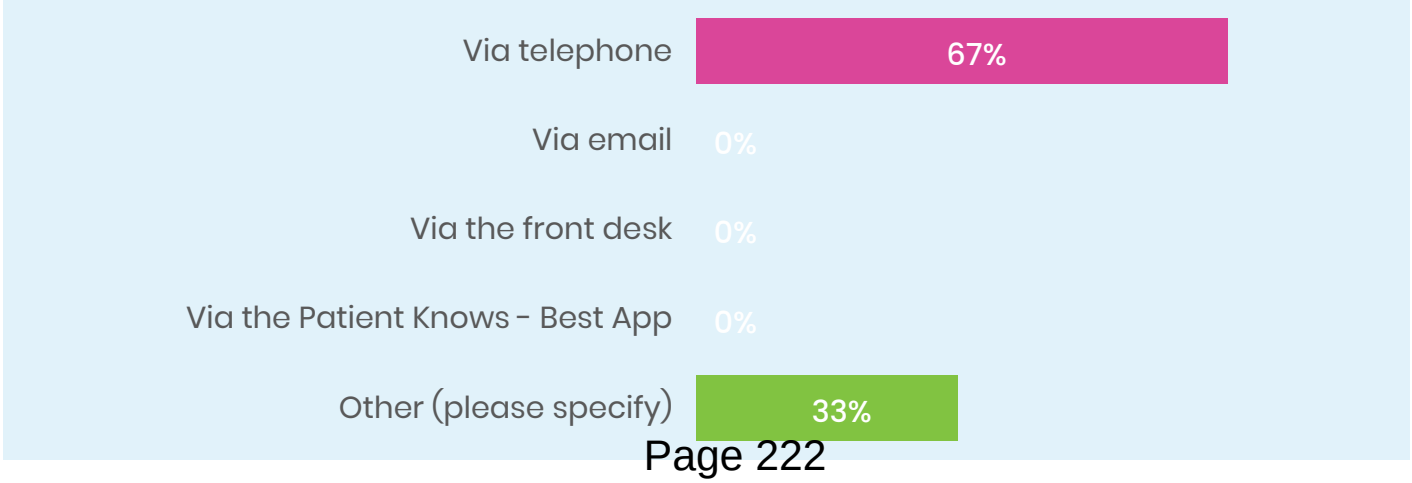
Q6 Did the reminder information contain the same information as the original appointment



Comments:

- N/A - no reminder received.
- For last appointment, no reminder for an appointment made six months earlier.

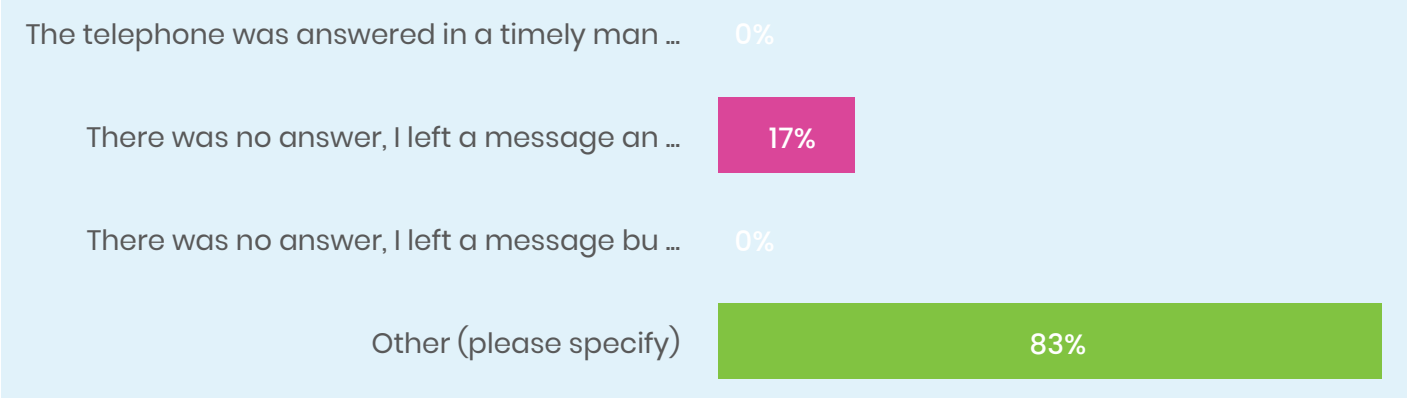
Q7 If you tried to contact the department, how did you do this?



Comments:

- I have contacted by phone but usually no one answers. I generally contact by email and sometimes receive a reply and other times not.
- I've made contact with the department on a few different occasions via telephone, email and via the front desk.

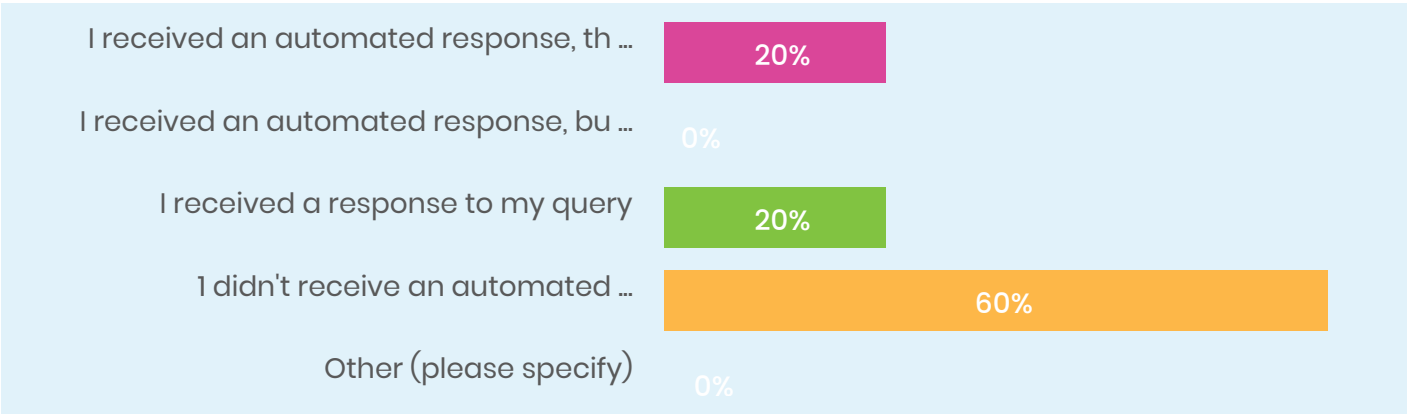
Q8 If you contacted the department via telephone, please let us know of your experience.



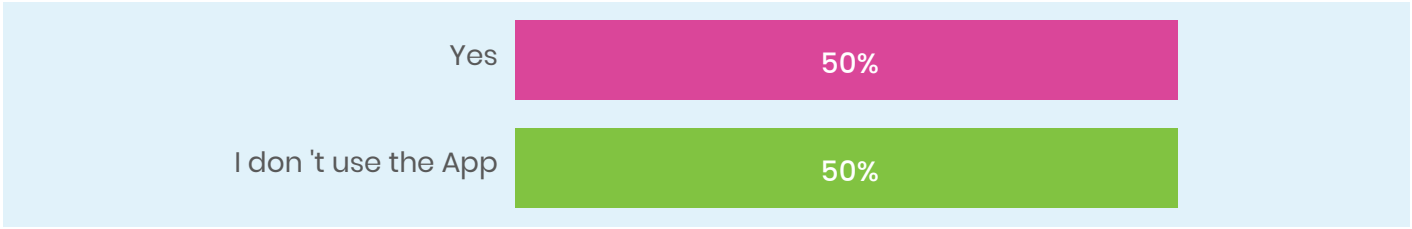
Comments:

- I tried many times but always received the message "nobody is available to take your call, please try later".
- There is usually no answer, and it is not always possible to leave a message. This is not the only service where it is not possible to leave a message - in fact it is quite common with the NHS. I have occasionally been able to speak with someone who does answer the phone.
- If the phone is not answered, as happens sometimes, I ring off. I do not want a call back that might be during an inconvenient time - I often turn my phone off when I'm busy.
- Nobody answered, and no voicemail, so could not leave message.
- No answer and not possible to leave a message as no facility to do so. No voicemail, and phones just left to ring endlessly.

Q9 If you contacted the department via email, please let us know of your experience.



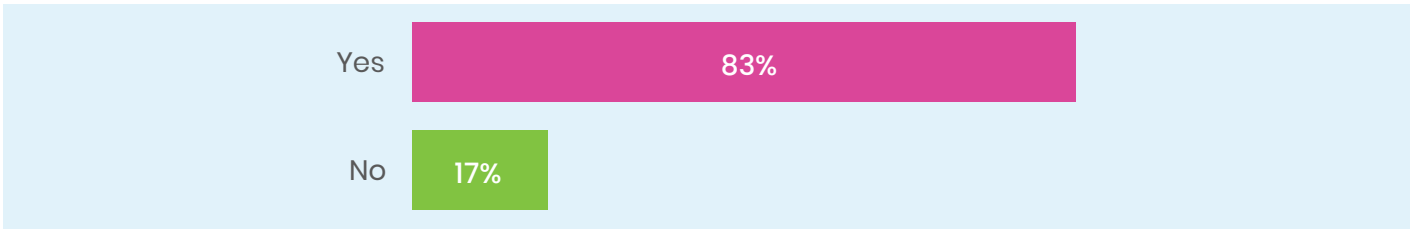
Q10 If you use the Patient Knows Best App, was your appointment information correct within it?



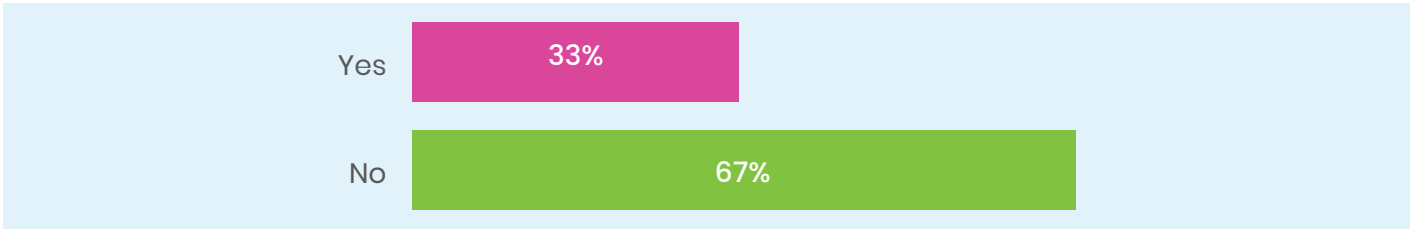
Comments:

- I only occasionally use this App as initially I found it unfit for purpose, but it has now improved.
- Appointment was not kept by Bart's.

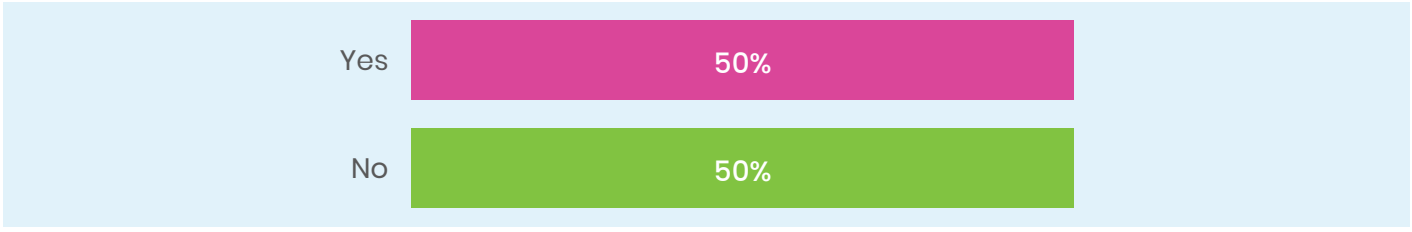
Q11 Did you receive information on how to get to your appointment and where to report to with your appointment letter?



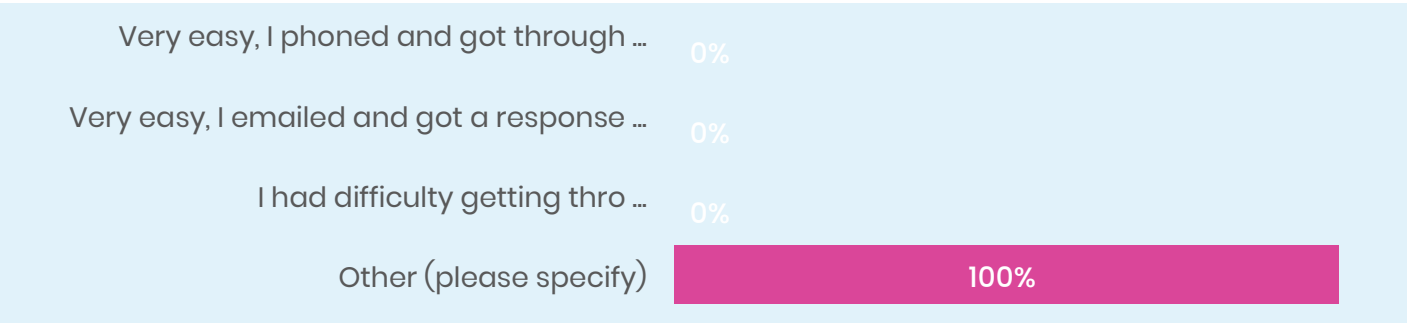
Q12 Did you receive further information with your appointment letter? Such as an information leaflet on your condition.



Q13 Did your appointment get changed or cancelled?



Q14 If yes, please let us know if it was easy to get a new appointment



Comments:

- My father has been a patient here for many years. We went through a phase when the appointments kept on being changed and then for some reason always had to be on a Saturday which my father cannot do. It was extremely difficult to change this - in fact we were told we had no choice but to have the appointments by phone at the weekend, so I did then on my own. Now all of a sudden, we can have them Monday to Friday, so not sure what to make of the "they can only be on the weekends" conversation.
- The appointment was automatically rebooked.
- They cancelled and sent a reschedule letter, a number of times.
- My scheduled appointment was not kept by Bart's and the hospital made a new appointment for five months' time without any explanation.

Q15 Please let us know of any further information or comments you'd like to make about Barts Cardiology department.

- There have not been secretaries to the department at times, so they then have enormous backlogs, no one to answer the phone or emails, etc, I don't know why.
- My experience of the Barts cardiology department has been excellent - good communication, excellent nursing and specialist medical skills. My experience at Barts is by far the best in comparison with that at Homerton (ghastly) and even the London at Whitechapel. Both Barts and Moorfields have excellent services from all points of view
- Staff are kind and polite. - Email replies can be multiple e.g. one staff member replies followed by the same day or next another staff member replying to the same email. - The leaflets, video cartoon links and information need to be updated to explain a "box change" pacemaker battery change. The information currently is for new pacemakers. - The steps needed before surgery need to be clarified e.g. MRSA swab needs to be taken. Unfortunately, we had to delay the procedure, which meant were aware a swab had to be taken. After a device check we went straight over for swabs. 10 or more days later we received a call the pre assessment could not go ahead as swabs as not be sent. We had to state this was already done; we walked in 10 days ago. Perhaps all of the information needs to be kept on one file. After staff checked the pre assessment date was kept. - The letter for the day of procedure needs to be updated, e.g. the number of people you can bring, one other family had 4 other members which meant the waiting area did not have enough seats, patients and other people were standing. The letter also needs to be made aware the check in desk and procedure floors are different. - The staff are very good at listen to and adjusting times with unpaid carers. - The languages of cardiac videos need to state which dialectic, not just the general language name as not all people can understand different dialects. - A process flow would be helpful of what happens at what stage from either GP or hospital internal referral. - The staff on the day of the procedure are very good in explaining what will happen and how - There needs to be more information on the holistic aftercare of the patients on the best way to sleep, changes to diet, how to heal effectively - The aftercare leaflets needs to state timeframes, e.g. in one of the stages it

states to phone the arrhythmia nurse if certain symptoms. However, on calling the number it goes to voicemail and won't be replied to for (I think 48 hours or more) at the end of the voicemail gives further contact number which take you back to the device clinic. - Aftercare advice from device technicians is good, prompt with the use of email and photos to manage from home. - In general, the first appointment after a procedure feels as if too long, online it can be 10 days, in reality over 6 weeks. We are very fortunate to have a wonderful facility within walking distance. If all heart related items could be covered at Barts for City patients would be great instead of sending to Royal London or UCLH and only if serious or an op needed at Barts then back to the other hospitals which are far away for us.

- I have had bad communication experiences in the past. The most recent experience has been by far the worst.
- Letters have contained inaccurate content which demonstrated very clearly that there is no oversight or supervision before they are sent out. The results of tests have gone missing.
- The remaining questions were demographic, GDPR reasons, these will not feature in this report.

Conclusions from the survey

From the survey results we can surmise that the majority of service users received letters with either incorrect or missing contact details, and when attempts were made to contact the department from which they received the letter, there was no answer or instructions on how to leave a message.

The letters contain no option to receive the information in an alternative language or accessible format.

Only 50% of recipients received a follow-up reminder of their appointment.

Another issue that is strongly highlighted is the rescheduling of appointments, service users receive information of the new appointment details, but some have experienced many rescheduled dates and times, which has led to confusion and frustration.

The issues raised in the survey results informed the questions used when interviewing the teams at St Bartholomew's Hospital.

Personal stories: One of the survey participants

"My experience of the Barts cardiology department has been excellent - good communication, excellent nursing and specialist medical skills. My experience at Barts is by far the best in comparison with that at Homerton (ghastly) and even the London at Whitechapel. Both Barts and Moorfields have excellent services from all points of view"

About the visits

On 13th June 2024 the Healthwatch City of London team carried out the first visit to St Bartholomew's hospital. The team were made up of eight staff and volunteers, all had completed the required training to undertake Enter and View visits, and therefore were 'Authorised Representatives'

The focus of this visit was the Electro Physiology, Intervention and Networked Cardiology administration team. The administration teams are based in St Martin's Le Grand office site.

The Healthwatch team were split into three sub teams.

One Healthwatch team focused on the administration systems and staff members responsible for carrying out administrative duties. The second Healthwatch team interviewed the team managers. Four managers were interviewed and six team members.

The third Healthwatch team went across to St Bartholomew's Hospital site to interview cardiology outpatients and reception staff. 11 patients were interviewed in total and one member of the reception staff.

After the initial visit to the outpatient's department, it was felt that there was an insufficient number of patients interviewed, therefore a subsequent visit was arranged to the main cardiology outpatient's department on 25th July 2024. Four Healthwatch representatives carried out this visit, all of whom were present at the initial visit. 15 patients were interviewed in total.

At each visit the authorised representatives followed an interview script with predesigned questions, however they were told to use their initiative to explore other issues if they came up in the discussion. Techniques for this was covered in the training for the authorised representatives.

The authorised representatives were also asked to make general observations of the site.

General observations

Observations made of the external side of St Bartholomew's Hospital

St Bartholomew's Hospital is located in the City of London, with three entrances, on King Edward Street/Little Britain, Giltspur Street, and West Smithfield. All three are fairly close to bus stops and underground stations. There is heavy traffic past the main entrance on King Edward Street and there is no visitor parking apart from some Blue Badge spaces, but there is a public car park close by.

External street signage to the hospital is not well marked. The hospital name is prominent above and beside the main entrance on King Edward St, however, the entrance off Giltspur Street (close to the 56, 59 and 46 bus stop) leading to Clinic 3 and on to the central atrium, is poorly marked. A sign showing the pedestrian route to the hospital, which should be on a post, is in fact on the ground and Healthwatch City of London volunteers were informed it had been like that for several years.

The entrance to the Nuffield wing, a private clinic on the Barts campus, has Nuffield Health St Bartholomew's Hospital above the door. The receptionist told us she gets up to 50 people a day asking her the way to the main NHS hospital. The third entrance, through King Henry V111 Gate in West Smithfield, has a sign stating there are no A&E services in large type, but the hospital name at the top is in very small print.

Signage within the hospital

Once into the square, signs to the various wings and departments are good. The main reception area and atrium are very pleasant and welcoming; bright, clean, and spacious. There are interesting displays and photographs telling the history of the hospital, a fruit and vegetable stall, shop, and piano for anyone to play. The outside courtyard is lovely, with plenty of trees and shrubs, and covered seating, for patients, staff, and visitors to enjoy. St Bartholomew's the Less Church is also in the hospital grounds, providing a quiet and tranquil space.

Signage in the hospital is generally clear and easy to read, however, it is confusing for patients wanting to reach Clinics 1 and 2, or other wards and departments, from the Giltspur St entrance and via the area where patients wait for transport.

The route from Clinic 3 to the rest of the hospital is not well marked, and heavy doors are an added difficulty for anyone with mobility issues. There were plenty of hand sanitisers, but none of the water dispensers we checked were working on the day of our visit. There are several self-check-in machines but there did not seem to be anyone using them.

There is a sign indicating the treatments undertaken at Clinic 3 has a rogue apostrophe on Holter Monitor's. It should be Monitors.

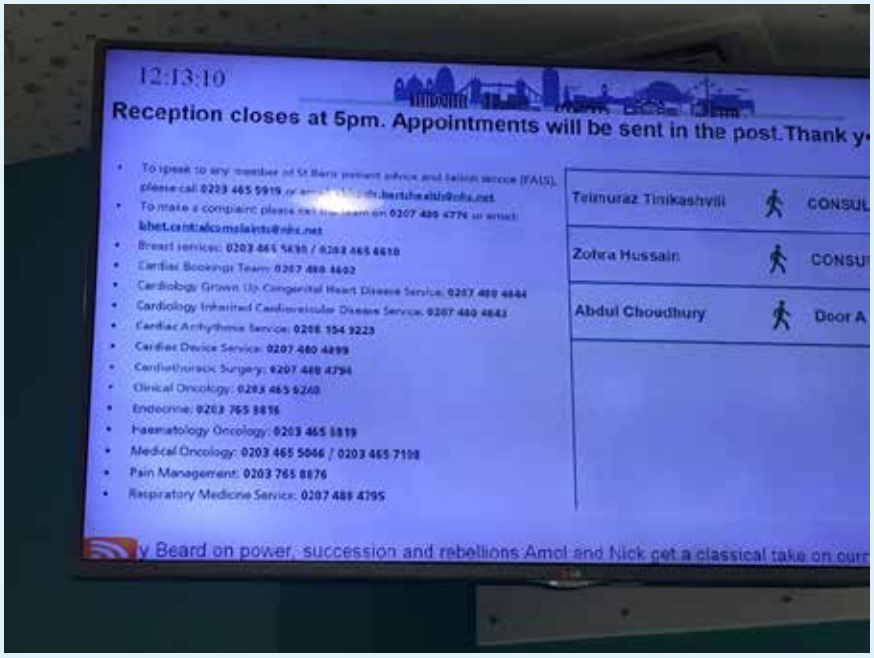


Figure 1. The screen at reception

Patient Experience

The screens in waiting areas, shown in Figure 1, are used to both call patients for their appointments, and display other information about hospital services. While the font size used for patient names is large and easy to read, that is not the case for other information (department names and telephone numbers) which would be impossible to see from more than a few feet away. More importantly, the monitors are not always visible from seats in the waiting areas because of the way seating is arranged, and the hospital is designed.

On the ground floor, some of the waiting areas (such as for Clinic 2) are very cramped and uncomfortable. The same is true for the pharmacy with not enough room for those waiting to collect prescriptions. The hand-written notices at the pharmacy looked very unprofessional. Also on the ground floor, seats are arranged in rows at angles that make it difficult for many patients to see the monitors without straining. This is particularly true for Clinic 1B. For the same reason, some patients find it hard to hear their names being called out.

Signage was generally good, although there is no information in the lifts detailing what wards/clinics are on which floor. The signs outside the lifts were to one side, with only limited information about clinic/ward locations. They could be more prominently positioned adjacent to the lift doors themselves.

The main sign opposite the lift was on the small side, and although it described the 3A clinic, the 3B and 3C clinics, which were arrowed, did not have a description. The 3A waiting area had two long lines of seating opposite each other, some quite far from the reception desk. The whole area was clean, but somewhat impersonal. There was a unisex toilet right by the reception desk, and two more nearby off the main corridor. They were clean and adequately stocked with washing and drying materials.

The Cardiac Catheterisation Suite is on the first floor, accessible via a Lift. The entrance of the suite is next to the lift with good signage. The waiting area immediately to the left of the lift consists of a dimly lighted long corridor with long rows of chairs on both sides of the corridor, A two-seater sofa available near the entrance is opposite the reception counter which was manned by a receptionist.

In Figure 3, there is a poster that was in the waiting area, the QR code leads to an invalid page, despite the poster still providing those details.

Figure 2. Information poster

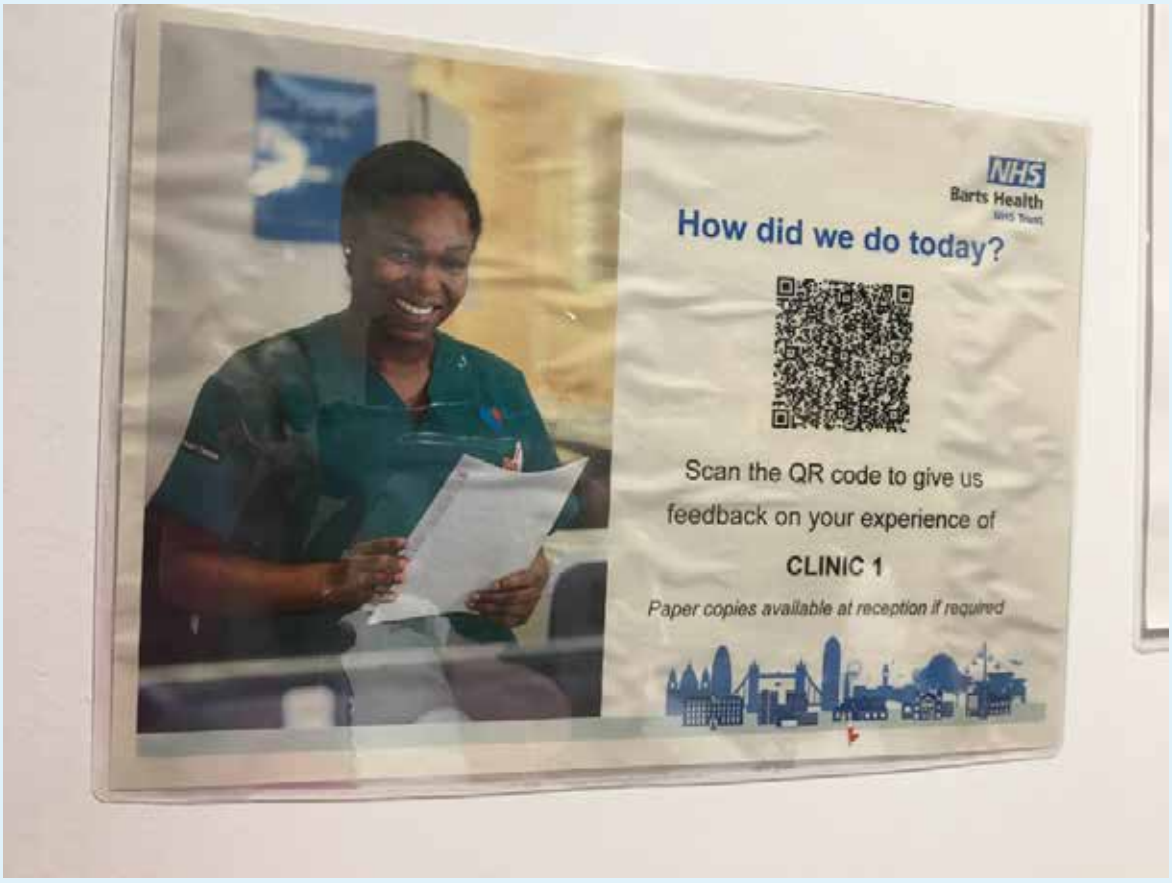


Figure 3. Barts Trust questionnaire poster with misleading QR code

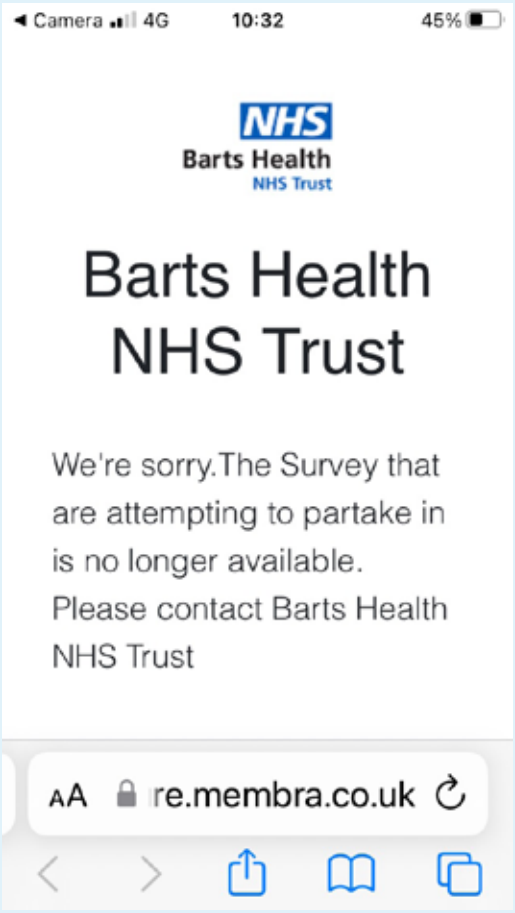


Figure 4. Screenshot of the unavailable survey when we tried to access it

Figure 5. Have your say poster

Interviews with the Management Team

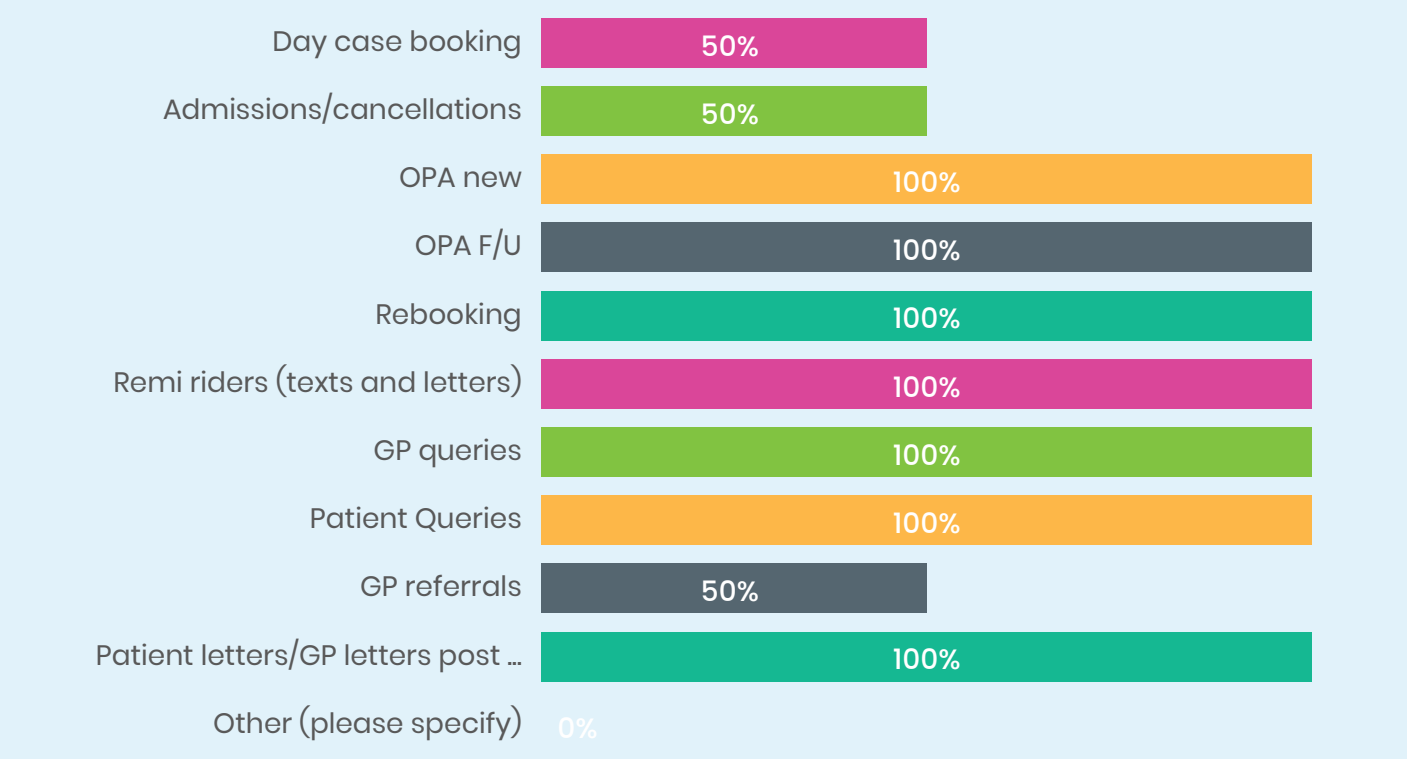
During the visit the team interviewed four managers including the General Manager for Electro Physiology, Intervention and Networked Cardiology, the Service Manager and the Delivery Manager and the Deputy Delivery Manager for that department.

Upon arrival for the second visit an informal discussion was held with Alison Digney the outpatient service manager, who gave a valuable overview of the hospital outpatients department.

The next section will cover the questions and responses from the management team.

Questionnaire for managers

Question 1. How many different areas are covered by the administrative services of the cardiology department?



Areas that are covered by the administrative services include, day case booking, admissions/ cancellations, Outpatients Appointment (OPA) new, OPA Follow up, Rebooking, Reminders (texts and letters), GP queries, Patient queries, GP referrals, Patient letters/GP letters post Outpatients Department/admission.

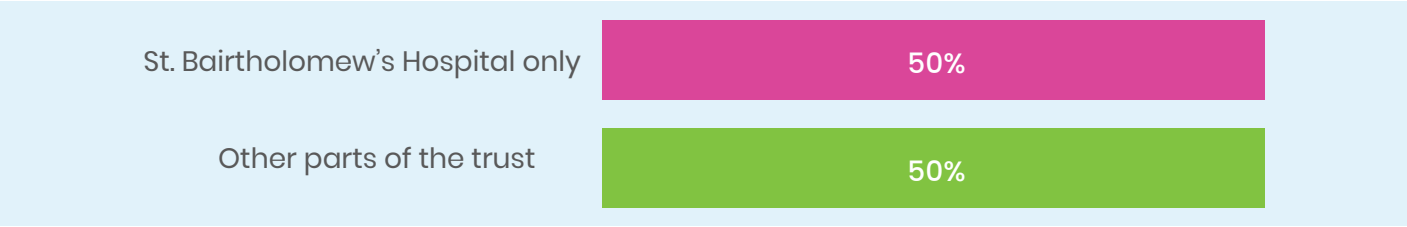
Question 2. How many patients do you see or contact a year?

Depending on the area it ranged from 500 per year up to 8,000 per year.

Question 3. Where are your teams located?

Managers and the administrative teams are located in St Martins LeGrand, King George Building and the East Wing of the hospital. The outpatient's department are in the main hospital site.

Question 4. Do the team only deal with St Bartholomew's Hospital or other parts of the Trust?



The team deals with St Bartholomew's Hospital and all other hospitals of the Trust. All the procedures are carried out at St Bartholomew's Hospital.

Note: Barts Health NHS Trust consists of St Bartholomew's Hospital, Whipps Cross Hospital, The Royal London Hospital, Mile End Hospital and Newham Hospital.

Question 5. How long is the wait time for:

An Outpatients Appointments (within the department) (new and follow up)	Between 3-6 weeks, there is currently some backlog and delays due to strikes.
Investigation	Wait times vary depending on the investigation required.
Day case	Between 6 weeks to 6 months based on clinical priority.
Admission	6 weeks to 6 months

Observation: the wait times varies greatly from 3 weeks to 6 months. The appointment waiting times should be available for patients to view.

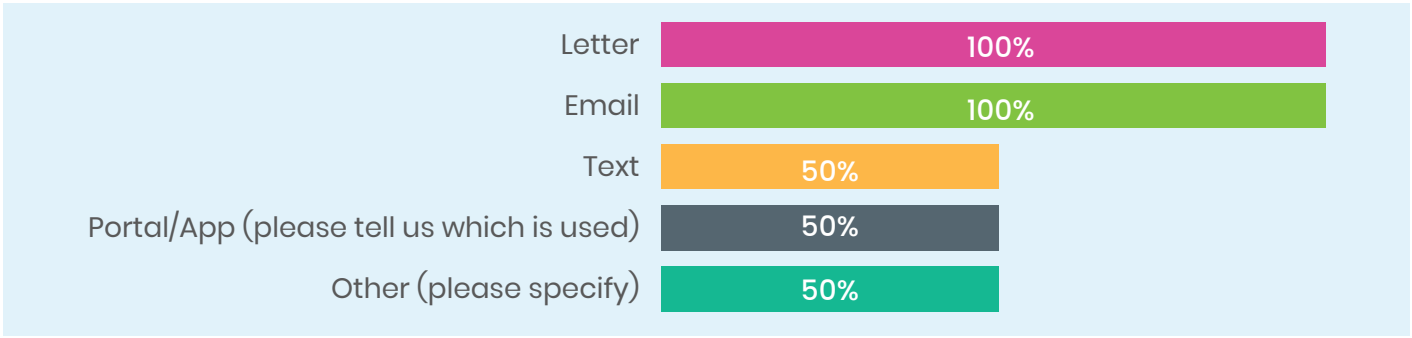
Question 6. How are patients informed of these waiting times?

This varies within the team. Some patients are told when they are called to book the appointment and are offered the next available date.

Another manager said that expectations of wait times would be handled by the consultant at the outpatient's appointment.

Observation: As per the previous point, the waiting times information should be available and accessible to all patients.

Question 7. How do you contact patients?



The majority of patients are contacted through letter, email, text and portal. The admin team also make phone calls to book pre-assessment appointments.

Question 8. What arrangements are made for those who require translation of written material (either text, portal access or letter)?

One manager explained that "there is an advocacy service where an interpreter can be arranged for a patient for a particular appointment. There is a booking form that staff can fill out to request this in advance, and this can be put in place for a variety of appointments. There is also a service used called Language Live where a live interpreter can be added to a call whether that's for booking an appointment or for a telephone appointment and they can translate for the patient in real time. This can be requested at the time and has proved useful. There is also the option to make notes on the system for a specific patient with any translation or communication needs they have".

Another manager spoke on how, "there is a QR code on appointment letters where you can translate the letter into several main languages, there are also videos available in different languages on explainmyprocedure.com which are animated videos that explain how the procedure they are having done will work. We also have access to Language Live which is a live translator service that can be added onto a call for a live interpretation of the call. The team are familiar with accessibility aids and those who have a hearing impairment".

Observation: the accessibility of information in alternative formats should be standard procedure and readily available. Knowledge of how to access the advocacy service for a translator was only acknowledges by one team manager.

Question 9. What arrangements are made for those with disabilities, such as poor sight or learning disabilities?

When arrangements need to be made, "notes can be made on the system and patients are asked of any accessibility requirements they may require for their appointment". One manager highlighted that, "patients with a disability are tracked on the system and notes are made so that staff are aware of their disability and what adjustments they may need. You would expect to see this from the service sending the referral".

Observation: This once again is dependent on the patient or the administrator being vigilant and knowing how to access the information.

Question 10. How much notice of appointments are patients given?

The manager explained that "appointments are booked by staff calling patients to offer them an appointment and book them in, this is usually several weeks in advance, so patients have a chance to arrange things. Patients are sometimes offered short notice appointments if there are cancellations etc so this could be for the following day". Another manager stated that, "minimum 2 weeks however we may call patients if there are cancellations to offer an appointment sooner than the one, they already have".

Observation: There appears to be no standard notice period for appointments.

Question 11. What is the turnaround time for letters out to: Patients, GPs

Patients	Same day, post goes out daily Same day, posted within 24 – 48 hours
GPs	Same day, post goes out daily

Question 12. Are hospital telephone numbers and contact details included in all correspondence?

All managers stated yes to hospital telephone numbers and contact details being included in all correspondence. However, the administrator has to manually input the correct consultant details and contact information.

Observation: Although the details are included in the letters, there is now system to check that the contact information is correct. We know from our survey that letters are received with the incorrect contact information.

Question 13. What is your response time for emails from patients?

A manager explained that, "the main inbox is monitored by all staff throughout the day so all emails are answered within the working day or picked up the following day" and another manager spoke on how, "there is a communal inbox that is manned during the working day, it's checked every morning and throughout the day by staff. There is usually a maximum 24-hour response time".

Observation: A consistent answer from the managers on this point. However, is there an automated response to emails received stating the timelines for a reply?

Question 14. What is your response time for voice messages left by patients?

A manager spoke on how, "a new phone system has been installed so there are no voice messages able to be left anymore for this team. During working hours calls are forwarded to available staff members and passed on if they don't answer so there will likely be staff available to answer most calls throughout the day. The phone system is turned off over the weekend, so patients aren't able to contact or leave a message until Monday morning".

Observation: A new system is now in place which should minimise the number if unanswered calls. However, patients are unable to leave messages outside of working hours or over the weekend. Patients need to be informed of opening time when reaching voicemail and given a standard timeline for a response to their message.

Question 15. Describe your cancellation policy

One manager explained that "patients can cancel anytime, and it's still noted as a cancellation as long as they let us know. If we need to cancel a patient's appointment, we will aim to give them at least 24 hours' notice". A second manager explained, how "if a patient cancels then they can cancel up to the appointment time and it does not affect their treatment or other appointments being offered. Patients are given 2 reasonable appointment offers via phone call and then a letter would be sent to the patient and the referring service. They wouldn't be automatically discharged for missing an appointment as they have been referred for important treatment so this would be followed up with the referrer. If we need to cancel a patient appointment, we will aim to give them as much notice as possible however depending on the circumstances it can be short notice. We will aim to rebook this appointment for within the next 28 days however this isn't always currently met".

Question 16. How do you monitor performance in your areas?

The team use the Patient Tracking List (PTL) to monitor patient waiting times

One manager is, "able to view PTL which manages patient wait times so I can see how well my team are performing and whether they are achieving their targets. There are also weekly reports available to monitor performance as well as meetings every 2-3 weeks which review different patients depending on how long they've been waiting for an appointment. We have good communication as a team and I keep them updated on wait times, issues and anything they need to know". Another manager, spoke on how they "supervise 3 full time and 2 part time staff, 1 full time post vacant currently. Regular meetings with team, both together and 1:1 to discuss workload and any issues and that staff have targets that are monitored regularly".

Observation: Performance monitoring across the teams varies. A standardised approach would be beneficial.

Question 17. How many complaints do you receive a year regarding: late correspondence, no correspondence, no response to letters, emails, voice messages, incorrect appointment information, failure to call back.

Late correspondence	
No correspondence	Unsure of amount 10 – 15
No response to letters, emails, voice messages	Unsure of amount 40
Incorrect appointment information e.g. face to face instead of call	
Failure to call back	

One manager was unsure of the amount, with a second manager stating there being 10 – 15 complaints for no correspondence and 40 complaints for no response to letters, emails and voice messages.

Observations: The number of complaints received should be logged with issues raised monitored and addressed.

Question 18. What, in your opinion, is the biggest cause of failure in patient communication?

One manager highlighted, that in their opinion, the biggest cause of failure in communication is, “contact with patients who have a language barrier can be an issue as it can be a struggle to get them in for an appointment and communicate with them clearly. There is also a backlog of work/appointments so that has contributed to staff not being able to contact patients in the preferred time frame”.

Observation: Patient records should identify if communication with that patient should be in an alternative language. A standard procedure needs to be put in place to allow non-English speakers to be contacted in a timely manner.

Question 19. What do you think can be actioned to remedy this?

A manager stated that, “consultants not managing patients’ expectations about wait times realistically which then means we are doing damage control when patients are then upset with how long they’re having to wait”.

Observation: Waiting times for appointments should be available on the website.

Interviews with the Staff Team

During the visit the team interviewed six team members from the administration team and one receptionist from the outpatient's department. Below is a summary of the responses from the Staff team.

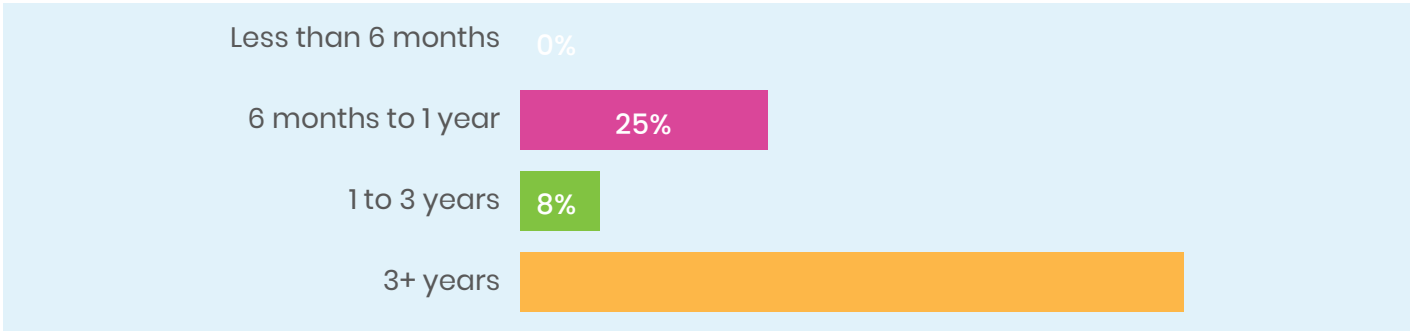
Questionnaire for staff and team members

Question 1. Which department do you work in?

Electro Physiology	2
Cardiology	2
Cardiology Arrythmia EP	1
Arrhythmia	2
Intervention	2
3A East CCU Ward	1
Ward 3AW	1

There was a diverse range of areas of departments, including electro physiology, cardiology, arrhythmia, intervention and two wards.

Question 2. How long have you worked in this department?



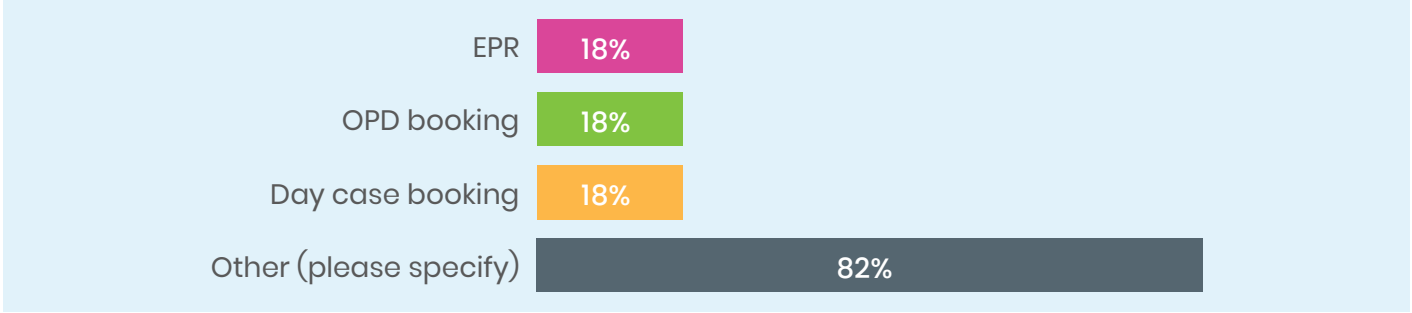
Most members of staff have worked in this department for over three years at 66 percent, whilst 25 percent have worked in this department from 6 months and 8 percent have worked in this department for 1 to 3 years.

Observation: The workforce in the department is stable with the majority having worked in this department for over three years

Question 3. How many people work in this department?

Departments had a range of people working in them, including there being 8 team members, 15 team members and 4 team members.

Question 4. Which administrative systems do you use?



There was a range of administrative systems in use, including CRS millennium for patient details and scheduling, Spine for contact numbers, ERS for GP referrals. CRS, Powerchart, PM office and G2 schedulers are also in use.

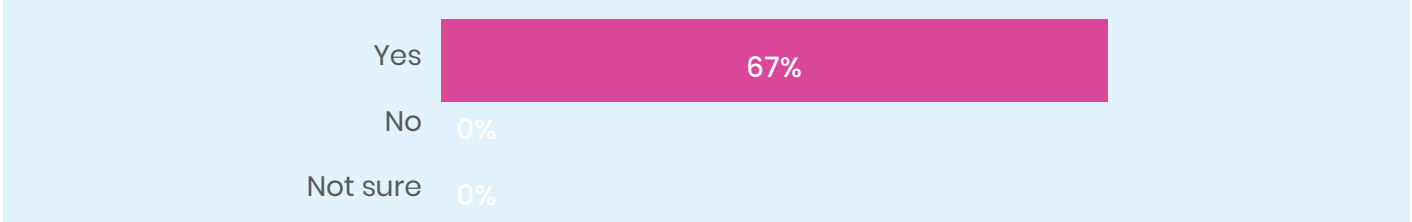
Observation: There is a high number of systems used; each system is used for different tasks. However, a reduction in the number used would streamline the process of patient communication and patient records. The fewer systems used the chances of incorrect information entered also lessens.

Question 5. How much and what training did you receive for this role?

The training seemed to be primarily online, with all 12 members of staff speaking on their online training. Although the specific training varied amongst staff members, with one member of staff stating that there is "always new training coming in, mandatory and statutory training". Another member of staff stated that there was "some online software training, mainly shadowing from previous staff member before they left. Another floating staff member also assisted in training and showing me how to do things" and one staff member stated that, "minimal formal training, mainly just shadowing and picking things up as I went along."

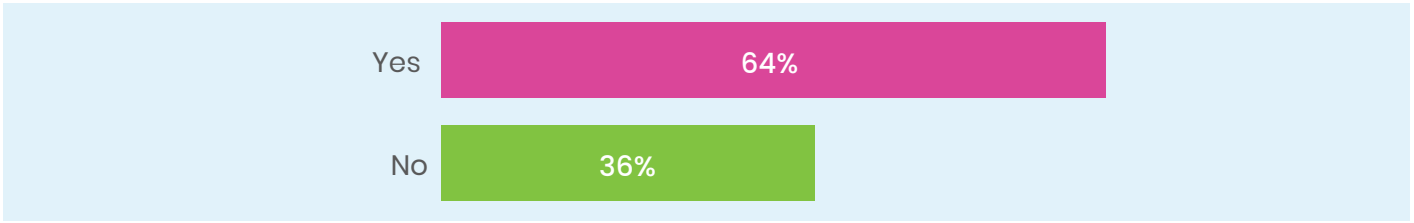
One member of staff had previously worked in Newham Hospital, so had an understanding and knowledge of the role. At Barts, they received 2 days of online training and were shown the appointment bookings and discharges which is a similar procedure to Newham Hospital.

Question 6. Do you think the training was adequate for you to carry out the role?



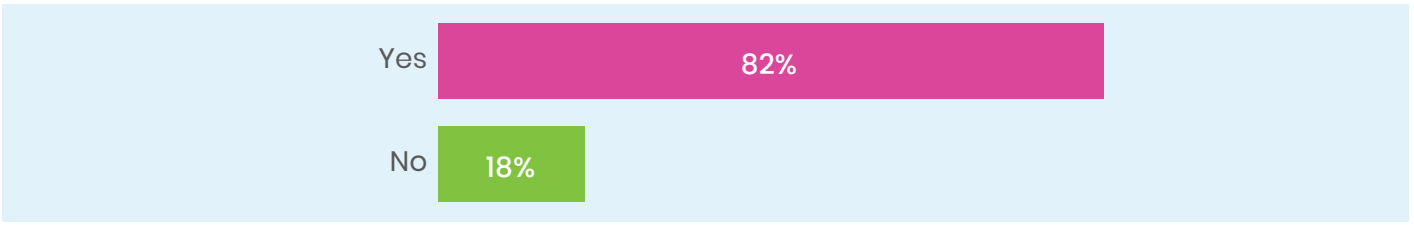
Over 60 percent of staff believe that the training was adequate for them to carry out their role, with one staff member speaking on "there has recently been an improvement in training", she went on to explain that there are new training courses available, and they have now attended more. Although not all members of staff agree, with one stating, "online training needs to be more in depth as I didn't find it helpful" and another member of staff stating that "more training in general needed."

Question 7. Do you receive regular refresher training?



75 percent of staff members receive regular refresher training whilst 25 percent do not receive regular refresher training.

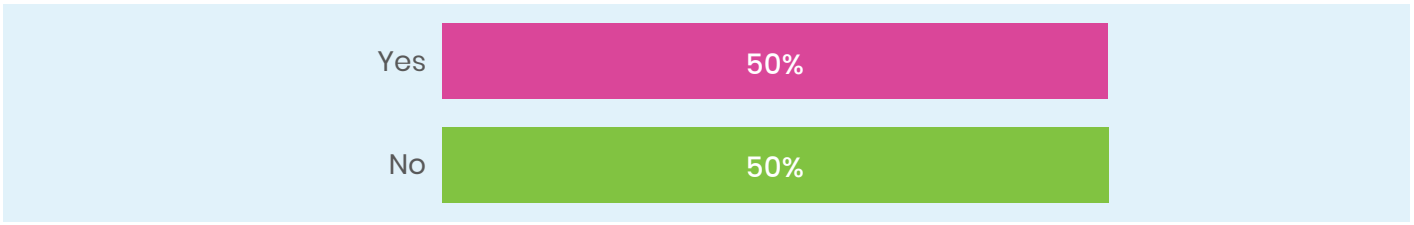
Question 8. Do you feel this is adequate?



Over 80 percent of staff members believe it is adequate, with one member of staff stating that she feels fully supported and supports her team 100%. 25 percent of staff members don't feel that this is adequate, including one member of staff who believes there needs to be "more regular training needed to update staff on the current way to do things and any updates about communication".

Observation: From the previous four questions we can see that training varied from one team to the next. A structured and standardised approach would be beneficial.

Question 9. Do you supervise or train other staff?



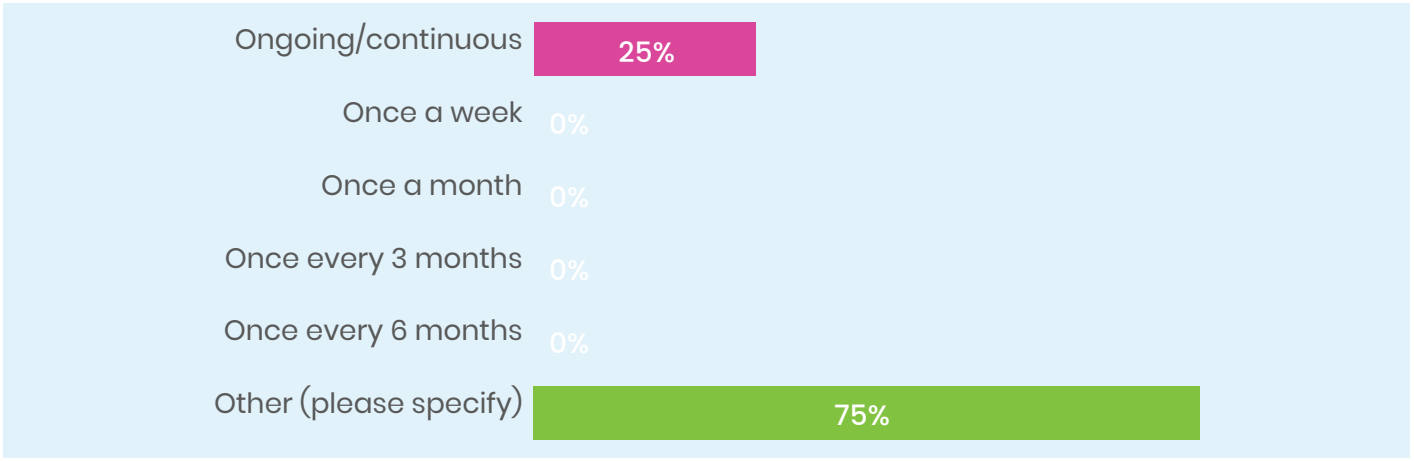
Half of the members of staff interviewed were responsible for supervising or training other members of staff, one member of staff stated that for new members of staff, they, "check what they have and what they need and encourage them to take training opportunities" whilst another experienced member of staff stated, "yes, I am one of the most experienced on the team so I support all new-comers".

Question 10. How is your work supervised?

Most staff members have annual appraisals, team meetings and regular check ins with their line managers.

One member of staff spoke on how their supervisor checks in with them in the afternoon and that they are able to easily ask their supervisor for any advice, by calling or going directly to their office. They also have a catch up with their supervisor every month, to see how they are finding the work.

Question 11. How often is your work assessed and monitored by your line manager?



Many staff members work was not checked on a regular basis, however, if there were issues in their work, it would be flagged in the system, such as the staff member who said, "if something goes wrong then they may look at my work but it's not monitored regularly" and another stating, my work isn't constantly monitored by my manager but if something goes wrong or there is an issue, it would be flagged on the system to her".

Although this does vary, as one member of staff stated that they have a meeting once a fortnight with their supervisor and is "constantly monitored".

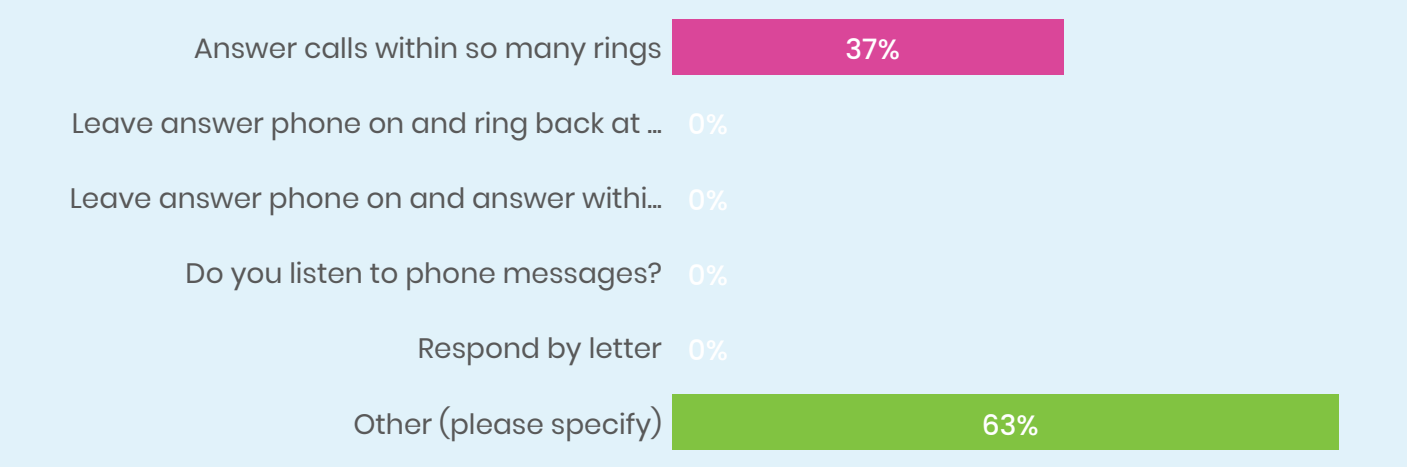
Observation: as with the responses by the team managers, a standardised approach to supervision and performance management is needed.

Question 12. How much time do you spend answering patient queries?

The answers to this question varied, with one member of staff stating, "all the time" and "all day" whilst another member stating, "minimal, my main queries are from family members calling to ask how the patient is" and another member of staff stating, "not much time at all".

Members of staff, also spoke on answering questions in person, "as a receptionist, there are more queries in person, mostly from family members of patients."

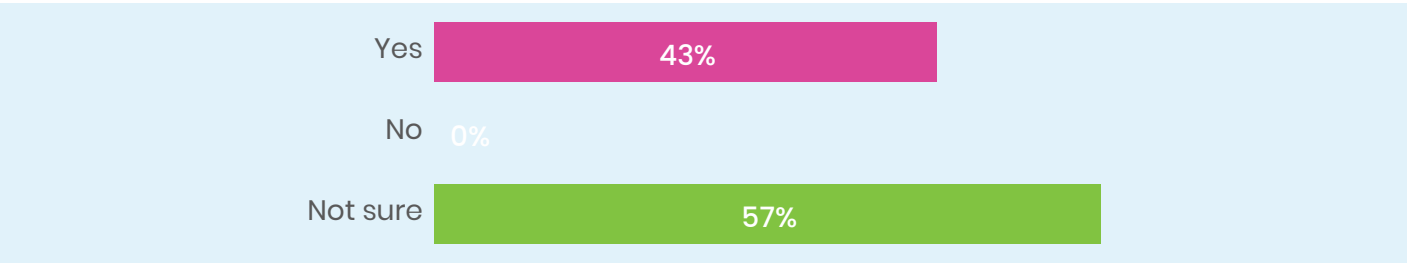
Question 13. What's the telephone policy in your department?



For 36 percent of members of staff, the telephone policy is to answer the calls within so many rings. For 64 percent of members of staff, it varied, with many members of staff speaking on the implementation of Netcall and new systems currently in place, "now using Net call 15 to 20 calls a day spread over the team of nine" and another member of staff stating, "all departments have their own policy. New system installed last week so will now be monitored more closely."

Netcall, a new telephone system was installed the week prior to the visit. The system will enable to closer monitoring of the timely answering of calls.

Question 14. Are these systems clear to patients on both letters and answer machine telephone messages?



Most staff members were unsure of whether these systems are clear to patients on both letters and answer machine with 57 percent of members being unsure, and 42 percent of staff members stating that they are clear.

Observation: The newly installed telephone system should reduce the number of unanswered calls, therefore the need for patients to leave a message should be reduced. The staff team need to be made aware of the standards for response.

Question 15. How much notice do patients receive of appointment date and times?

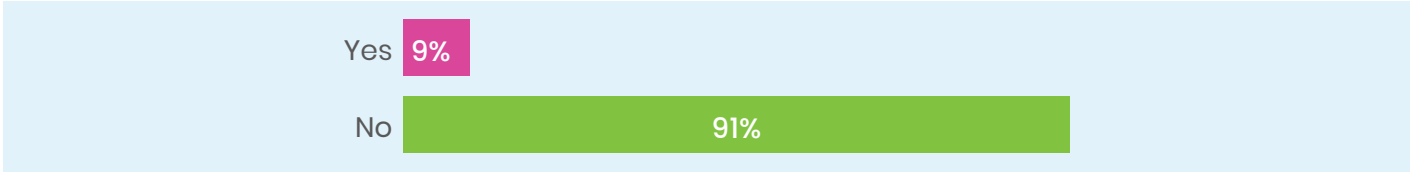
This information varied, with 2 members of staff stating, 6 to 8 weeks, 2 members of staff stating 4 to 6 weeks and one member of staff stating 5 to 6 weeks or longer. If an appointment is in two weeks or less patients will be phoned otherwise, they receive a letter. One member of staff, stating, "usually a few weeks, the letter is printed as soon as the booking is made and we will call the patient if it's a short notice appointment" and another member stating, "patients receive 1 week notice for a telephone appointment, 2-3 months' notice via letter for an in person appointment".

Observation: Staff seem unsure of the policy regarding notice period for appointments.

Question 16. How does the text system work for patients?

The majority of staff members were unaware of the system, one member stated, "certain appointments get an automatic text message from the system, I don't send them. If they are on the AMI/ATLAS pathway then they will get a text reminder, but all other appointments go through another system which doesn't send texts".

Question 17. Are you responsible for sending texts?



The majority of staff members are not responsible for sending texts at 90 percent.

Observation: The text system needs clarification to team members, the majority did not know how the system worked or who was responsible for sending the appointment information/reminder texts.

Question 18. How does the letter system work for patients?

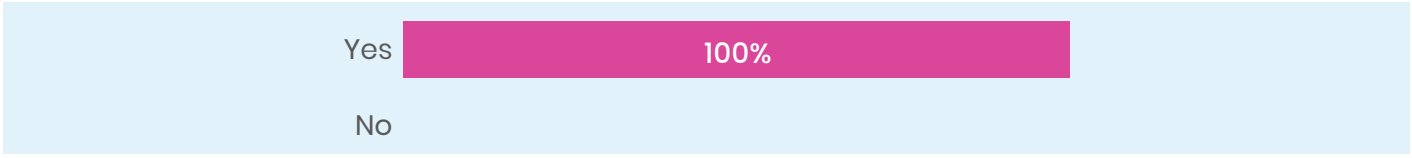
Staff members told us how they are responsible for printing and putting the letters in envelopes, then the letters are sent down to the post room, "the day after a patient leaves the ward, I will generate all the letters and add in any leaflets then send it off to be posted. This is all done within the same day, it's all done in one go and all sent together, we use scheduling book to make the appointment then it's printed and put in the post the same day".

Another staff member said" there is a 7-day turnaround for letters to be sent following a clinic or GP referral. Emails are checked daily. All contact details are on the letters but have to be put in manually" and "a letter is sent, text message and ring the patient. Confirm the details when referred from consultant. Schedule appointment when there are clinics. Patient not given a choice".

Observation: Patient choice should always be available. There is disparity between the managers response to this and the team members. Managers told us patient choice is available, with the team members stating that they are just booked an appointment.

Question 19. Are you responsible for sending letters?

All members of staff are responsible for sending letters.

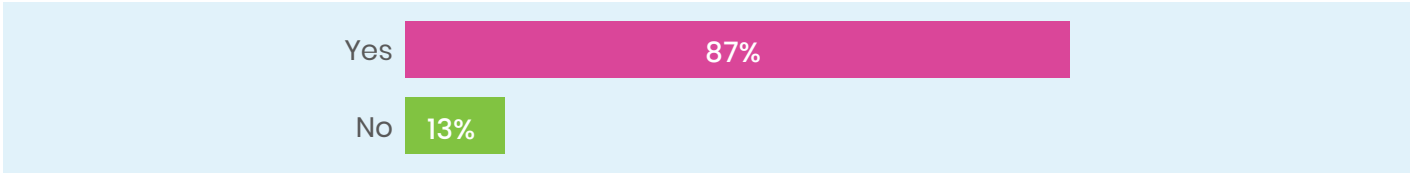


Question 20. How do you know if patient is F2F or a call?

It is listed on the discharge summary whether a patient is F2F or a call, there is also a specific F2F list, and two members of staff said the information is in the patient's letter.

Observation: This is clearly marked on the discharge summary.

Question 21. Are you aware that some patients receive conflicting information or inaccurate information?



The majority of staff members were aware that some patients had received conflicting or inaccurate information, with only 12 percent of staff members being unaware.

Question 22. What checks are in place to ensure that the correct information is included in all correspondence?

Staff members told us that all appointment letters are double checked by us before being posted, the same for clinic letters and we may get someone to proofread before it gets sent out and when the correspondence is generated, they check to see if the information is correct. If it isn't, they have to call IT to change it as all correspondence is automatically generated.

One team member said that if something does go wrong, they phone to apologise and talk to the patient and agrees with them the next appointment.

Observation: Appointment letters, we are told, are double checked before they are sent out, however the team are unable to amend some of the information within the letters if it is inaccurate.

Question 23. What improvements would you like to see?

The improvements that staff members would like to see varied, one member of staff spoke on needing more central bookings and a central booking team. Another member of staff spoke on needing faster generation of letters, as it can take up to 30 minutes.

Others would like the search facility on their systems to be improved by using the patient's condition to identify them. At present they have to manually search for patients, which can be time consuming.

Two members of staff told us they would benefit from better training on dealing with patients to defuse any problematic situations.

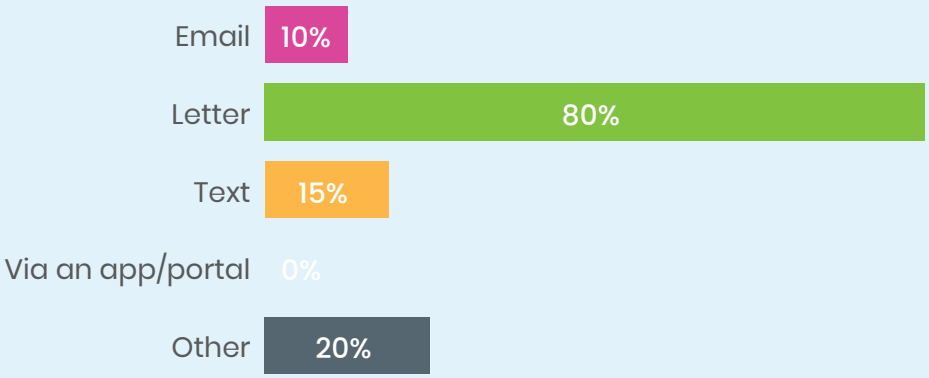
Interviews with Patients

The patients were interviewed across both visits, 11 patients were interviewed on the first visit in the Cardiac Catheterisation Suite and 15 in the cardiology outpatient's department.

Below is a summary of the feedback received.

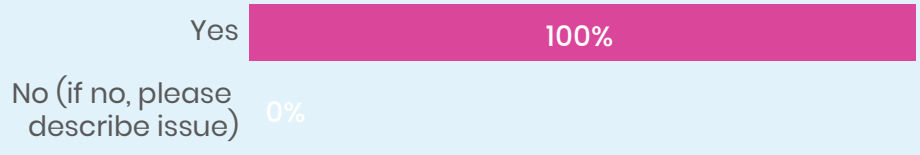
Questionnaire for patients

Question 1. How did you receive your appointment?



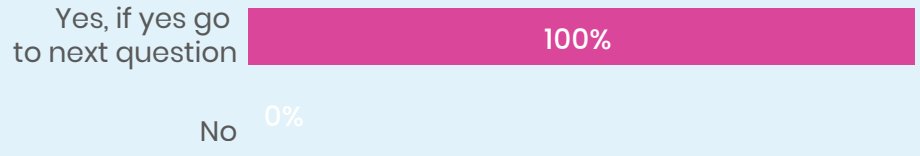
Most patients received their appointment information by letter at 80 percent, with 15 percent of patients received a text message and 10 percent receiving an email. There were three patients who received referrals, from Newham Hospital and Kings, and two patients who received phone calls.

Question 2. Did you find the information easy to understand?



All patients found the information easy to understand.

Question 3. Did you have to cancel your appointment?



There were no patients who had to cancel their appointments.

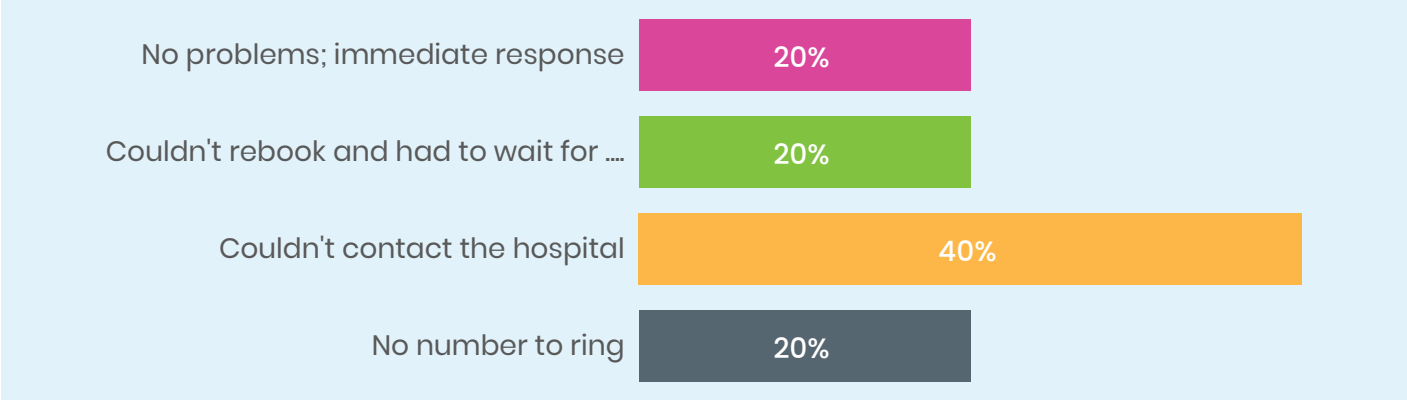
Question 4. How did you cancel your appointment?

None of the patients we interviewed had to cancel their appointment.

Question 5. How easy was it to cancel and rebook appointment?

None of the patients we interviewed had to cancel their appointment.

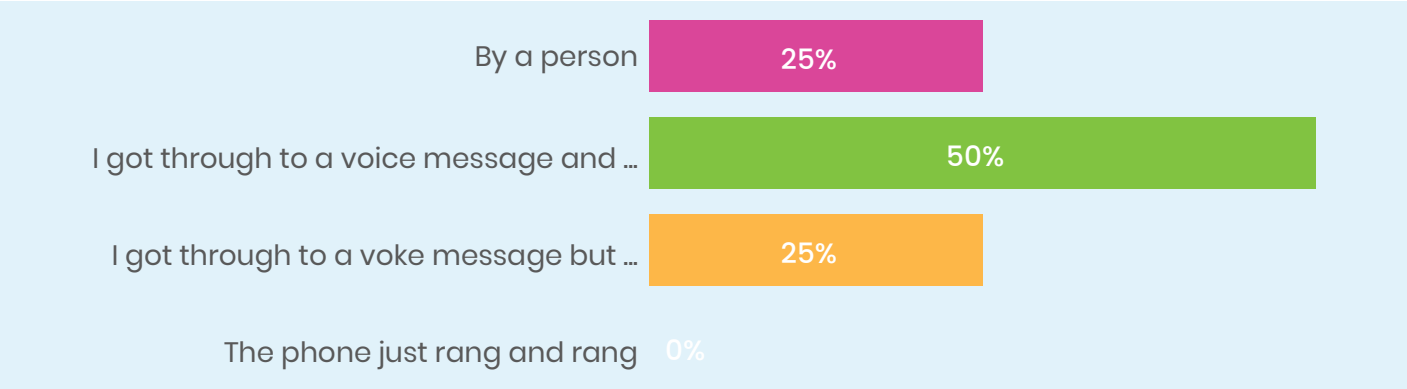
Question 6. If you had to phone the department how easy was it to get through?



40 percent of patients who had to phone the department couldn't contact the hospital, with 20 percent of patients having no number to ring. There was also 20 percent of patients who couldn't rebook and had to wait for another appointment to be sent. 20 percent of patients had no problems and received an immediate response.

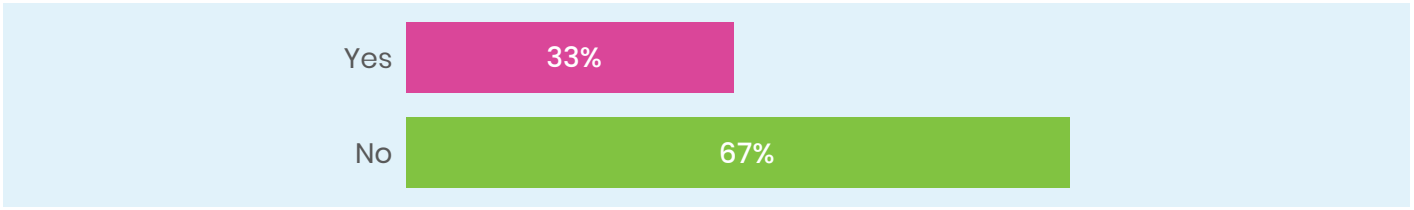
Observation: The responses to this question correlates to our survey responses, with incorrect contact information on the appointment letter or calls not being answered.

Question 7. How was the call answered?



Most patients, 50 percent, got through to a voice message and left a message. 25 percent of patients got their phone call answered by a person and 25 percent of patients got through to a voice message but there was no facility to leave a message.

Question 8. Did anyone call you back?

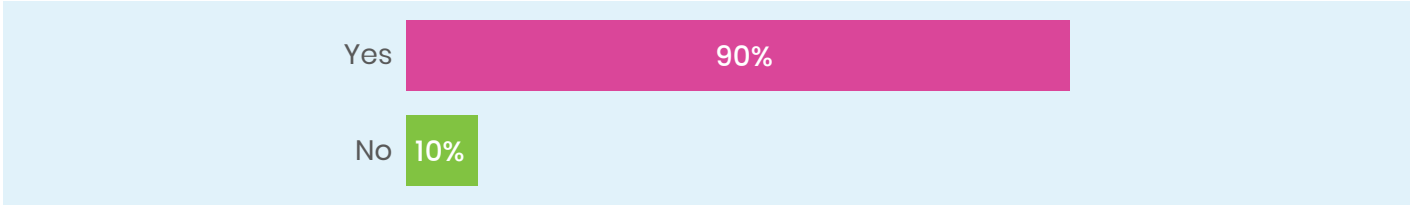


66 percent of patients did not receive a call back, 33 percent received one.

Observation: As with the managers and team members questions, the answers highlight the need for a standardised answering machine system with opening times and response time information.

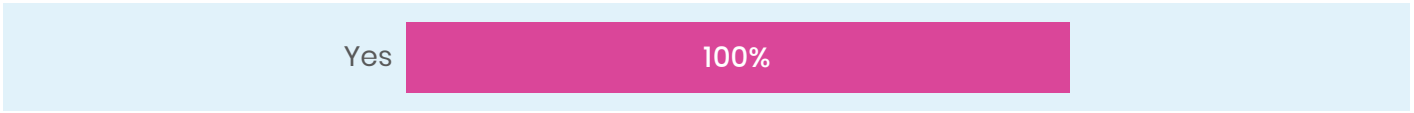
This is common complaint by patients that messages are not responded to.

Question 9. Did you receive a reminder letter, call or text about your appointment today?



89 percent of patients received a reminder about their appointment, with 10 percent not receiving one.

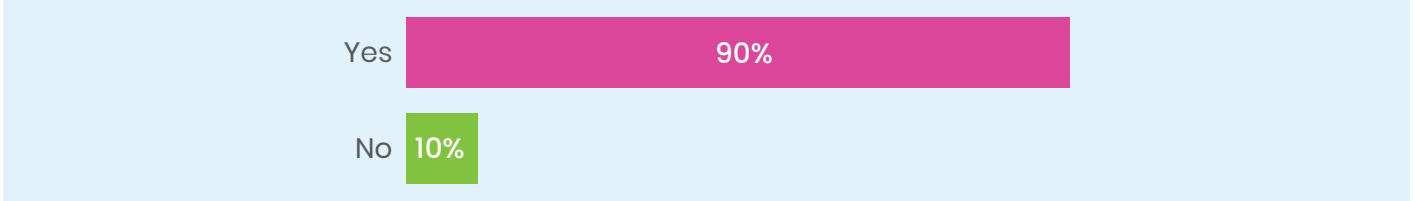
Question 10. If yes, did the information in the original letter and the reminder correspond?



All patients' information in their original letter and the reminder corresponded.

Observation: These questions do not establish how the reminder was received. It is however acknowledged that almost 90% of patients did receive a reminder and that the information was correct. This part of the system works well.

Question 11. Looking at previous appointments, did you receive follow up information in a timely manner?



89 percent of patients received their information in a timely manner, with 10 percent not receiving their information in a timely manner.

Question 12. Looking at previous appointments did your GP receive the outcome of the appointment information in a timely manner?

All 18 patients, GPs received the outcome of the appointment in a timely manner.

Question 13. Overall, how satisfied are you with the administrative process at this hospital?

The majority of respondents were satisfied with the administrative process.

Question 14. What changes would you like to see put in place.

Many patients did not have any changes that they would like to see put in place, one patient expressed that there should be, better communications between hospitals. Another expressed that the department is now much more efficient that it used to be.

Greater information on the procedure or tests that your appointment is for would be useful for patients, with approximate duration of the appointment.

Other patients would like to see more options for contacting the department, rather than just a phone number.

Conclusion

Overall, our visits to Barts Cardiology and outpatient's department were positive but there are areas of improvement required. The patients and staff were open and honest with their answers. There are clearly some areas for improvement which are offered as recommendations later in this report.

General observations

The hospital is accessible both in its location and facilities for those with mobility issues, wheelchair, pram and pushchair. There is step free access with a wide entrance hall and spacious lobby.

Signage to the department was clear inside the hospital. However, TV screens displaying information were not visible from all areas of the patient waiting areas.

Posters in the waiting area were out of date, with patient surveys closed.

External signage needs improving, with one receptionist stating that they have to redirect around 50 people a day to the main reception.

Patients

The majority of the patients we spoke to at the hospital had received good communication from the department, with few having had their appointments rescheduled or cancelled. However, results from our survey indicates that information contained in letters or communication to patients was incorrect or missing. Patients would also benefit from having more information on the nature of the appointment they are attending, e.g. a test, a scan, etc.

Administration systems

The number of the various systems used by the different admin teams is baffling. There is inconsistency of use within the department in the different disciplines, and again across the hospital with outpatients using a separate system to the department.

Text messaging remains an enigma, some of the teams used text messages, others didn't, and none were certain how the messages were sent or by what department.

The newly installed telephone system should reduce the need to leave a message for the attention of the team, it would be useful if the system is monitored over the next 3 months with a report produced detailing its effectiveness.

Patient information

There is inconsistency with the data patients can access, particularly appointment waiting times data, which isn't clearly communicated. This is an area that should be readily available on the department's website and in patient communication.

Training, supervision and performance management

There is a significant amount of variation in the training received across the department, the supervision undertaken within the teams and the management of staff performance. A consistent approach to these three areas would be beneficial to both the staff and as a consequence patients, with consistent approaches and information given.

Recommendations

Some recommendations have been made based on the observations made, and the feedback received from both staff and patients during the visit.

The Chief Nurse, was asked to respond to the following recommendations:

1. Consistency of systems used across the department.

a. There are many systems used to record duplicate information. Can the number be reduced to negate the need for duplication of information and lower the risk of incorrect information being stored.

Trust Response

We acknowledge that using different systems can lead to duplication of information and increase the risk of errors. However, it's important to note that each system currently serves specific functions and is deeply integrated into our workflows.

We will continue to ensure that our staff are adequately trained on all systems and that clear procedures are in place to minimise the risk of errors. We will also monitor the effectiveness of our current systems and identify any areas where improvements can be made.

b. Clear training schedules should be set for consistency of use of the systems

Trust Response

We agree that standardised training is crucial for consistently and effectively using our administrative systems. We are committed to ensuring that all staff receive comprehensive training on all relevant systems and procedures.

We have developed and implemented a clear induction training plan that outlines the required training for each role within the department. This plan will also include initial training for new staff members and regular refresher training for existing staff to keep them updated on any system changes or updates.

We will also ensure that our training materials are up-to-date and comprehensive and that they cover all aspects of using the systems, including:

- Accessing and navigating the systems
- Entering and updating patient information
- Scheduling appointments
- Generating and sending correspondence
- Running reports

We believe that these measures will help ensure that all staff members are confident and competent in using our systems, leading to improved efficiency and reduced errors.

c. Policies on waiting times, notice of appointment, number of telephone rings before answering, telephone answer machine response times need to be put in place, or if they are in place, available to staff and them made aware of them.

Trust Response

We have recently implemented a new telephone system which has significantly improved our ability to monitor and manage our telephone communication. This system provides valuable metrics, such as average waiting times and the number of missed calls which is reviewed on a daily basis. This data allows us to identify any inefficiencies and take corrective action.

d. The new telephone system needs to be monitored with a report produced on its effectiveness.

Trust Response

We agree that it's crucial to monitor the effectiveness of the new telephone system to ensure its meeting our objectives and identify any areas for improvement. We have a robust monitoring process in place. A daily report is generated and shared with teams, which details key metrics such as average waiting times, the number of missed calls, and call abandonment rates. This allows us to track performance and address any emerging issues promptly.
We regularly review the system's performance, analysing trends and identifying recurring problems. This helps us to make data-driven decisions and implement necessary adjustments to optimise the system's efficiency.

2. Consistency of letter templates and patient information.

a. At present each team within the department has a different patient letter template. The details in the letter i.e. consultant name and direct contact details, has to be manually added. Some teams provided a contact email address whilst others didn't, likewise with telephone numbers.

Trust Response

We appreciate your feedback on the variation in our letter templates. While we strive for consistency, it's essential to recognise that each department within the cardiology service has unique requirements and specific information that needs to be communicated to patients.

However, we agree that certain elements, such as the consultant's name and contact details (including email address and telephone number), should be included in every letter template. We have reviewed all templates across the department to ensure this information is correctly added.

b. A standard letter template for the department should be implemented with a schedule for checking the contact information is up to date.

Trust Response

While acknowledging the potential benefits of a standard letter template, we must consider each team's varying needs and specific information requirements within the cardiology department. A single template may not adequately accommodate these needs.

However, we are committed to ensuring consistency and accuracy in our patient communication. We aim to achieve this through the following measures:

Regular Reviews: We regularly review and update our letter templates to ensure they meet the evolving needs of our patients and staff.

Clear Procedures: We have clear procedures in place, including monthly audits, to check the accuracy of the information provided in our letters. This helps to identify and rectify any errors promptly.

Pre-filled Templates: Each consultant has a template with their information pre-filled, which helps to maintain consistency and reduce the risk of errors.

We believe that these measures effectively address the need for consistency and accuracy in our patient communication while allowing flexibility to meet the unique requirements of each team within the department.

c. A procedure for checking information is correct before letters are sent should be implemented.

Trust Response

We appreciate your recommendation to implement a procedure for checking the accuracy of information before letters are sent.

To ensure accuracy in our patient correspondence, we have implemented proofreading, where staff are encouraged to double-check their work or have a colleague proofread the letter before it is sent.

d. More information on the appointment should also be included in the letter, e.g. will the patient be undergoing a scan, ECG etc, how long the appointment is likely to last.

Trust Response

While we appreciate this point, it's important to consider the practical challenges involved in providing such specific details in every appointment letter. The specific procedures and tests required can vary significantly depending on each patient's individual needs and the complexity of their condition. It would be impractical to list every potential procedure in the appointment letter.

However, we are committed to providing patients with clear and informative communication about their appointments. We achieve this through the following:

General Information: Our appointment letters provide general information about the type of appointment (e.g., consultation, follow-up, etc.) and the department where it will take place.

Preparation Instructions: We include specific instructions on how patients should prepare for their appointments, such as fasting requirements or bringing a list of medications.

Contact Information: We provide contact details for the department so patients can inquire about any specific questions or concerns they may have.

e. Accessibility information should be included with the patient letter, this should include availability of patient transport, interpretation services and information in other languages.

Trust Response

We agree that providing clear and accessible information about support services is crucial for ensuring all patients feel confident and prepared for their appointments. We appreciate you bringing this to our attention, and we acknowledge that this is an area where we can improve.

We have already been in contact with the Outpatient Department, who are currently developing an equity of access program to improve accessibility across St Bartholomew's Hospital. This program will address the provision of information on requesting interpretation services or assistance for hearing or sight impairments. All patient communications, including letters, emails, and the department's website, will include this information.

We are committed to working with the Outpatient Department to implement these improvements and ensure that all patients have equal access to our services.

3. Waiting times for appointments available

a. There was an inconsistent response from staff and managers to the wait times for appointments. There should be more information available to patients on expected wait times for both standard and emergency appointments. This should be available on the departments website and included in patient communication.

Trust Response

It's important that our staff are aware of waiting times so that they can give patients accurate information. Part of the challenge for our staff is that waits for procedures can vary greatly depending on a number of factors, including which service patients are referred for, if they need to be seen by a particular clinician, if any initial diagnostics are required and the type of procedure they are being referred for.

We agree that waiting time information on our website and within our patient communication would be beneficial for our patients and will work towards implementing this where generic information will be appropriate.

4. Complaints policy and procedures

a. The managers had little knowledge of the number and nature of complaints raised with the department. A standardised complaints procedure should be put in place and a scheduled monitoring of the complaints to help to address and subsequently reduce the number.

Trust Response

Patient complaints provide real time feedback on the quality of the service we are providing for our patients and is a key tool for us to identify areas for service improvement.

Complaint trends are reviewed regularly by senior management at a service, divisional and site level in order to identify any emerging themes that require intervention; however, your report has highlighted that at a more junior management level there appears to be a gap in the visibility of complaints.

To improve general awareness of complaints, monthly service complaint data is shared more widely with the service team leaders.

5. Standardised use of text messages for patients

a. Team members were unsure how the text messaging system works both within the hospital or the Trust. Further training is needed to ensure consistency in the use of text messages for patient information.

Trust Response

We acknowledge that text messaging is an essential tool for patient communication, and we understand its value as a convenient and effective reminder for patients.

Currently, automated text messaging isn't being utilised in all of our services. As a result, not all team members are familiar with how the system works.

We are planning to roll out the text message service to all of our services once all of the required clinic standardisation work has been completed, which will ensure the information included in our text messages is accurate.

To ensure a smooth and successful rollout, we will be providing comprehensive training to all staff.

b. Ensure a robust schedule is in place to check patient contact details are up to date.

Trust Response

We understand that having up-to-date contact information is crucial for effective communication with our patients. We have procedures to ensure that our records are as accurate as possible:

Review at Every Contact: Our team members are instructed to review patient details at every interaction with the patient, whether it's a phone call, email, or face-to-face appointment. This helps to identify any discrepancies or changes in contact information.

NHS Spine Integration: We utilise the NHS Spine, a national database of patient information, to access and update patient contact details. This system relies on patients notifying their GPs of any changes to their information, such as a new address or phone number.

6. Response to patient queries via telephone or email

a. Set an automated response to emails received stating the timelines for a reply.

Trust Response

We understand the importance of providing timely replies to email inquiries and appreciate you bringing this to our attention. We have now implemented an automated response system for emails received by the department. This automated response will acknowledge receipt of the email and inform patients of our standard timeline for a reply.

b. Patients are unable to leave messages outside of working hours or over the weekend. Patients need to be informed of opening times when reaching voicemail and given a standard timeline for a response to their message.

Trust Response

We understand the importance of being accessible to our patients. Our phone lines are available from 9 am to 5 pm, Monday to Friday. During these hours, our staff can answer calls and assist patients.

Outside of these hours, we have alternative contact options:

Email: Patients can email the department with non-urgent inquiries. Our automated response will acknowledge receipt and inform them of our standard response time.

NHS 111: For urgent medical advice or assistance, patients can contact NHS 111.

Emergency Services: In a medical emergency, such as if a patient is experiencing chest pain, patients should call 999 or go to their nearest Accident & Emergency department. If patients call out of hours this is explained on the automated message.

We believe these measures ensure patients can access medical advice or assistance even when our phone lines are closed. We will continue to review our communication systems to ensure they meet the needs of our patients.

7. Increased patient information in the waiting area

a. In the main outpatient's department on the ground floor, there was only one visible screen displaying patient information. Visible prompts for patient information needs to be increased including increased numbers of television screens with department contact information.

Trust Response

This feedback was echoed by a 'Secret Shopper' exercise conducted by the Specialised Cardiology Leadership and Service Improvement Team. This has been fed back to the Outpatient Matron and Service Delivery Manager to undertake a full environmental review of the Clinic 1 and 2 waiting areas in January 2025. This will include the patient call screens and their content.

8. Patient information available in the hospital

a. In the waiting area some of the posters were out of date, one poster asked for patient feedback but when you accessed the survey via the QR code the survey had closed. A schedule in place to update patient information via posters in the waiting area.

Trust Response

We acknowledge the importance of keeping our patient information up to date via the posters in our waiting areas.

Since receiving the report, we have reviewed the posters in our waiting area and have removed and replaced any of the posters that were out of date, including the poster with the QR code linked to a closed survey. A schedule has now been put in place to review the information in our waiting area on a monthly basis.

b. Patient information in the waiting area was only available in English, there was no opportunity offered for accessible information for those with visual impairments, or in an alternative language.

Trust Response

As mentioned, the Outpatient Department is currently developing an equality of access program to improve accessibility across St Bartholomew's Hospital. This program will address the provision of information on requesting interpretation services or assistance for hearing or sight impairments. All patient communications, including posters will be included in this program of work.

9. Accessible information and interpretation services.

a. There is no information (that we could find) on the website or included in letters to patients on how to request interpretation services, or assistance for hearing or sight impairments. This needs to be included in all patient communication including letters and emails, and on the department's website.

Trust Response

As mentioned, the Outpatient Department is currently developing an equality of access program to improve accessibility across St Bartholomew's Hospital. This program will address the provision of information on requesting interpretation services or assistance for hearing or sight impairments. All patient communications, including letters, emails, and the department's website, will include this information.

b. Our findings show that there is a disparity of training of the team on this area. This must be a consistent across all teams, patients who are not told of this could miss appointments and not understand the information given to them.

Trust Response

Consistent training on accessibility information is crucial for all team members. It ensures that patients are well-informed and can access the support they need, leading to a positive experience. Based on this report we will provide our team refresher training on how they can provide accessible information for our parents.

10. Training, supervision, and performance management

a. A clear and standardised training schedule for all teams should be implemented. Currently there is disparity in the training received on patient information, accessible information standard and dealing with complaints.

Trust Response

The Trust provides staff members with mandatory training on all relevant systems based on their specific roles and responsibilities. Locally, we will continue to provide our staff refresher training where applicable. We are committed to improving the consistency and quality of training across all our teams.

b. Training needs to happen on all the systems used across the department to ensure consistency of procedures and patient information.

Trust Response

We acknowledge the importance of ensuring our staff are adequately trained on all systems used within the department. This is to ensure consistency in procedures and accuracy of patient information. The Trust provides staff members with mandatory training on all relevant systems based on their specific roles and responsibilities.

In addition to the initial training, the Trust provides refresher training opportunities to address knowledge gaps or system updates. We are committed to continuous improvement in our training programs. We will continue to assess and address our staff's training needs to maintain high service delivery standards.

11. Clearer hospital entrance signage

a. Entrances to the hospital need increased and clearer signage from Giltspur Street and the West Smithfield.

Trust Response

The buildings on Giltspur Street and the entrance through King Henry VIII Gate in West Smithfield are grade listed, so we are not permitted under City of London planning regulations to fit signage to listed properties. All other types of external signage are the responsibility of the City of London /TFL.

Healthwatch City of London will follow up with Barts Cardiology department on the response to the recommendations within six months of publication of this report.

healthwatch
City of London

Healthwatch City of London
Portsoken Community Centre
20 Little Somerset Street
London E1 8AH
www.healthwatchcityoflondon.org.uk
t: 020 3745 9563
e: info@healthwatchcityoflondon.org.uk
@Healthwatchcity
CoLHealthwatch
Healthwatchcity
Design and layout: Pivitt
Cover photo: © Healthwatch England

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank