Public Document Pack

Health and Wellbeing Board

Date: **WEDNESDAY, 4 FEBRUARY 2026**

Time: 1.45 pm

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

Members:

Deputy Helen Fentimen OBE JP (Chair)
Sarah Gillinson (Deputy Chair)
Gail Beer
Matthew Bell
Dr Stephanie Coughlin (External Member)
Simon Cribbens
David Curran (External Member)
Dawn Frampton
Deputy Marianne Fredericks
Judith Finlay
Jed Francique (External Member)
Dr. Sandra Husbands
Gavin Stedman
Tony de Wilde
Deputy Ceri Wilkins
Amy Wilkinson

Enquiries: **Emmanuel.Ross@cityoflondon.gov.uk - Agenda Planning**
Sorrel.Cooper@cityoflondon.gov.uk - Governance Officer/Clerk to the Board

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. **MINUTES**

To agree the public minutes and non-public summary of the previous meeting held on 19 September 2025 as a correct record.

For Decision
(Pages 5 - 10)

4. **BETTER CARE FUND 2025-26 QUARTER 2 PROGRESS REPORT**

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

For Decision
(Pages 11 - 24)

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

Report of Healthwatch, City of London.

For Information
(Pages 25 - 110)

6. **CITY & HACKNEY SAFEGUARDING CHILDREN PARTNERSHIP ANNUAL REPORT 2024-25**

Report of the City & Hackney Safeguarding Children Partnership Board (CHSCP).

For Information
(Pages 111 - 272)

7. **CITY AND HACKNEY SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2024-25**

Report of the independent Chair of the City and Hackney Safeguarding Adults Board.

For Information
(Pages 273 - 318)

8. **ADULT MENTAL HEALTH JOINT STRATEGIC NEEDS ASSESSMENT**

Report of the Director of Public Health.

For Information
(Pages 319 - 452)

9. **UPDATE ON PROGRESS TOWARDS HEAT AND WATER STRESS CLIMATE ADAPTATION ACTIONS IN RELATION TO HEALTH AND WELLBEING**

Joint report of the Director of Public Health and the Executive Director of Environment.

For Information
(Pages 453 - 462)

10. **CLIMATE DRIVEN HEALTH RISKS - VECTORS & VECTOR BORNE DISEASES**

Report of the Director of Public Health.

For Discussion
(Pages 463 - 486)

11. **TOBACCO AND VAPES BILL**

Report of the City Remembrancer.

For Information
(Pages 487 - 492)

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

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

14. **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

15. **NON PUBLIC MINUTES**

To agree the non-public minutes of the previous meeting held on 19 September as a correct record.

For Decision
(Pages 493 - 494)

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

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

HEALTH AND WELLBEING BOARD

Friday, 19 September 2025

Minutes of the meeting of the Health and Wellbeing Board held at Committee Rooms - 2nd Floor West Wing, Guildhall on Friday, 19 September 2025 at 11.00 am

Present

Members:
Sarah Gillinson (Deputy Chair)
Dr Stephanie Coughlin (External Member)
Dawn Frampton
Deputy Marianne Fredericks
Judith Finlay
Gavin Stedman

In Attendance
Andrew Horobin, ELFT

Officers:

Chris Lovitt	-	Deputy Director of Public Health (City and Hackney)
Ian Hughes	-	City Operations Director
Rachel Cleave	-	Healthwatch
Emmanuel Ross	-	City and Hackney
Claire Giraud	-	City and Hackney
Jayne Taylor	-	City and Hackney
Donna Doherty-Kelly	-	City and Hackney
Ellie Ward	-	Community and Children's Services
Anastasia Vinnikova	-	Environment
Rhys Campbell	-	Town Clerk's

1. **APOLOGIES FOR ABSENCE**

Apologies were received from the Chair, Deputy Helen Fentimen, Dr Sandra Husbands, Gail Beer and Jed Francique. Apologies for lateness were also received from Amy Wilkinson.

The Town Clerk also noted that there was an incorrection on the front sheet of the agenda since Dawn Frampton was a Member of the Board and was present in room.

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

Deputy Marianne Fredericks declared that she was a Bridge Watch Volunteer.

3. **MINUTES**

RESOLVED, that – the public minutes and non-public summary of the previous meeting held on 11 July 2025 were agreed to be a correct record.

Matters Arising

- Officers provided the Board with an update in relation to First Aid Interventions and discussions with Healthwatch had been scheduled for October 2025 regarding increasing access and uptake of first aid interventions in the City.

4. **BETTER CARE FUND 2024/25 END OF YEAR RETURN AND 2025/26 Q1 PROGRESS REPORT**

The report of the Executive Director, Community and Children's Services in respect of the Better Care Fund 2024/25 end of year return and 2025/26 Q1 progress report.

RESOLVED, that – the Health and Wellbeing Board:

- Approve the Better Care Fund end of year 2024/25 return and Quarter 1 2025/26 progress report.

5. **PHARMACEUTICAL NEEDS ASSESSMENT 2025-2028 FINAL REPORT**

The Board received a report of the Director of Public Health in respect of the Pharmaceutical Needs Assessment 2025-2028.

Officers advised the Board that the City was well served by community pharmaceutical provision in the City was sufficient and these pharmacies provided a range of NHS services which were accessible for both residents and workers.

A Member asked whether vaping would be considered to be de-normalised alongside smoking and officers agreed to review and respond outside of the meeting and highlighted that vaping was only recommended in terms of a smoking cessation too, and not in terms of casual usage, since vapes were provided as part of the NHS Stop Smoking Service provision. The Tobacco Needs Assessment would be able to clarify whether vaping would be de-normalised.

The Chair noted the data collected from the 69 people stated in the Equality Impact Assessment were of a majority white ethnicity and what clarity that officer's had confidence in the robustness of this assessment. Officers advised that although this was a small sample size for the City of London it was sufficient for this style of survey, and that this was the demographic which tended to respond to surveys. It was also mentioned that officers did not find any differences looking at the various characteristics between the population groups.

A Member noted the loss of pharmacies within the City due to redevelopment and that there were fewer pharmacies in the west of the City. The Member asked if there were further risks to future City pharmacies and if there were any plans to encourage new pharmacy provisions. Officers advised that even if there were to be a reduction in number of community pharmacies that the City would still be very well served and the pharmacies listed in the west were from a different Integrated Care Board (ICB) area.

RESOLVED, that – the Health and Wellbeing Board approve the draft of the City of London Pharmaceutical Needs Assessment 2025-2028 for publication.

6. UPDATE ON CITY AND HACKNEY HEALTHY WEIGHT ACTION PLAN

The Board received a report of the Director of Public Health in respect of an update on the City and Hackney Healthy Weight Action Plan.

During the discussion the following points were noted:

1. It was clarified that both workstreams were across City and Hackney and officers had begun engaging with the City of London within the first workstream at Aldgate School and the high calories foods consumed for breakfast, and work with City Of London Libraries had been undertaken to explore parent workshops.

2. A Member asked if there was work being undertaken in relation to weight gain in women particularly those undergoing menopause and officers acknowledged that this had not been considered but would consider this further.

3. Officers advised that awareness and education was included in the plan and acknowledged that it was difficult to eat a healthy diet within London given that there were many unhealthy options within London. Work was being undertaken to identify ways both children and parents could be educated to understand healthy foods, and help to support schools in providing their pupils with healthy meals. Environmental changes were needed including early year intervention and other factors at a population level which would have a massive impact on obesity.

4. With limited resources Public Health relied upon its system partners however much work had been completed regardless of this, and officers maintained their confidence that they could drive this plan forward.

5. Officers asked for a set of commitments from Board Members to include in the plan and suggestions of areas where the Board could provide support for this plan would be brought to a subsequent meeting.

6. Following a question regarding the implications of weight gain on other ailments the Chair advised Members to read the Joint Strategic Needs Assessment (JSNA) and raise any questions at a subsequent meeting.

RESOLVED, that – the Health and Wellbeing Board:

- note the progress on the City and Hackney healthy weight 'whole system' plan to date;

- comment on the proposed opportunities to progress healthy weight work in the City of London;

- advise how the Board, and its constituent Member organisations, can support the implementation of these opportunities.

7. **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.

In terms of City resident engagement Members were advised that Healthwatch communicated to residents through various formats such as Barbican Talk, Golden Lane Estate website, City resident emails and leaflets were also distributed when possible. A Member asked whether Healthwatch could be invited to City Question Time to engage with residents further and officers agreed to liaise with colleagues to ensure that Healthwatch was invited to the next City Question Time.

RESOLVED, that – the report was received and its contents noted.

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

The Board received a report of the Director of Public Health in respect of the annual update regarding suicide prevention in the City of London.

During the discussion the following points were noted:

1. An internal suicide prevention charter for the City Corporation and related bodies had been developed, and this included a review of all 70 Human Resource policies to tighten mental health and suicide prevention, and to provide further support to staff.

2. Work had been undertaken to coordinate suicide prevention engagement with businesses within the City, including SMEs, through collaboration with the Small Business and Research Enterprise Centre to provide education to staff regarding available support.

3. Regarding the built environment, a publicly accessible planning advice note was available at the time of this meeting to provide good practice guidelines on how tall structures could be made safe. Further work with building accreditors was expected to be undertaken to identify way of retrofitting buildings in line with these guidelines and that architects would be aware of the importance of these guidelines when designing future

buildings. A Member asked that this be considered to be a work stream and advice considered at the pre-application stage to prevent incurred costs caused by expensive retrofitting. The Port Health & Public Protection Director advised that discussion had been held with the Director of Planning training had been undertaken with Planning Officers to ensure advice was being provided as early as possible within the planning process.

Further information concerning the Planning Advice Note can be found here:https://democracy.cityoflondon.gov.uk/documents/s168370/Preventing

4. Regarding menopause mental health and suicide awareness event taking place the following month a Member suggested that it'd be worthwhile for officers to attend to which officers agreed and would use any relevant information to reflect the City Corporation's internal policies.

5. A Member praised the work of Bridge Watch volunteers and asked if further support could be provided from the City Corporation and the City Bridge Foundation. The Board was informed that a cross-committee group had been set up who were in a better position to investigate this further.

RESOLVED, that – the report was received, and its contents noted.

9. ***AIR QUALITY ANNUAL STATUS REPORT FOR 2024**

The Board received a report of the Executive Director, Environment in respect of the Air Quality Annual Status Report for 2024.

RESOLVED, that – the report was received, and its contents were noted.

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

There were no questions.

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

The Chair reminded the Board of the joint meeting of the City Corporation Health & Wellbeing Board, City & Hackney Health & Care Board and Hackney Health & Wellbeing Board taking place on Thursday, 23 October 2025.

12. **EXCLUSION OF PUBLIC**

RESOLVED, – That under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following item(s) on the grounds that they involve the likely disclosure of exempt information as defined in Part 1 of the Schedule 12A of the Local Government Act.

13. **NON PUBLIC MINUTES**

RESOLVED, that –the non-public minutes of the previous meeting held on 11 July 2025 were agreed to be a correct record.

14. *** SECURE CITY PROGRAMME (SCP) ISSUES REPORT SEP25**

The Board received a joint report of the Executive Director of the Environment Department and Commissioner of City of London Police in respect of the Secure City Programme Issues report.

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

There were no non-public questions.

16. **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 12:47pm.

Chairman

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

City of London Corporation Committee Report

Committee: Health and Wellbeing Board	**Dated:** 04/02/2026
Subject: Better Care Fund 2025/26 Q2 progress report	**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: Zoe Dhami Strategy and Projects Officer	

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 Care (DHSC). 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 2025/26 Q2 progress report.

Recommendation(s)

Members are asked to:

- Approve the Better Care Fund Quarter 2 2025/26 progress report.

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 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. Summary table of funding for 2025/26

Year	Total pooled budget	Amount spent on ASC services (excluding iBCF and DFG)	Minimum amount required to be spent on ASC services
2025/26	£1,505,755	£374, 076	£175,544

2025/26 Q2 return

5. The Q2 return (Appendix 1) provides an update on delivery of the agreed 2025/26 Better Care Fund plan. It focuses on confirming continued compliance with the national BCF mandatory conditions, reviewing expenditure against plan, and assessing whether any changes are required to the agreed targets, metrics, or demand assumptions approved by the HWBB.
6. All Better Care Fund mandatory conditions are met. The Section 75 agreement between the City of London Corporation and NHS partners has now been signed and is fully in place. There are no outstanding issues in relation to governance, pooled budget arrangements, or compliance with national BCF requirements.
7. Performance against the national Better Care Fund metrics, as reported in the Q2 return, indicates that delivery in the City of London remains broadly on track, with no material concerns identified at this stage.
8. Emergency admissions to hospital for people aged 65 and over are in line with plan and compare favourably with national performance. The City's four-month

average rate (April–July) of approximately 1,162 per 100,000 is slightly below typical England averages, which generally range between 1,200 and 1,300 per 100,000 for the same cohort (NHS England – Better Care Fund Metrics Dashboard).

9. Discharge performance shows continued improvement. While the proportion of adult patients discharged on their discharge ready date (82%) remains slightly below the locally agreed ambition (86%), the average number of days from discharge ready date to discharge (4.67 days, excluding same-day discharges) is lower than national averages, which typically range between six and eight days (NHS England – Discharge SitRep and Discharge Data Collections). This reflects a small number of complex cases and outliers, which can have a disproportionate impact in a system with a relatively small resident population.
10. Admissions to long-term residential and nursing care for people aged 65 and over are assessed as on track against the locally set plan for Q2. The underlying rate remains low compared with England and London averages (NHS Digital / OHID Fingertips – Adult Social Care Outcomes Framework); however, small absolute changes in placement numbers continue to have a significant impact on quarterly rates given the City's small population size.
11. Overall, benchmarking against national data indicates stable performance across the core BCF metrics, with City of London outcomes comparing well to national trends.
12. Members of the Health and Wellbeing Board are asked to approve the Q2 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 but this year (2025/26) included £100,000 which was funding carried forward from the previous year under iBCF.

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

13. The Q2 Better Care Fund return confirms that the City of London Corporation continues to meet all mandatory requirements, with pooled budget arrangements now fully in place and services delivering as planned.
14. Performance against national metrics remains stable, with emergency admissions and discharge outcomes comparing favourably to England averages, and residential admissions remaining low despite expected volatility linked to small population size.
15. No changes to agreed schemes, targets or funding allocations are proposed at this stage. Members of the Health and Wellbeing Board are asked to note the contents of the Q2 return and approve its submission.

Appendices

- Appendix 1 – BCF 2025/26 Q2 report

Zoe Dhami

Strategy and Projects Officer, Department of Community and Children's Services

E: zoe.dhami@cityoflondon.gov.uk

HM Government

Better Care Fund 2025-26 Q2 Reporting Template

2. Cover

Version 1.0 [unlocked]

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	City of London	
Completed by:	Ellie Ward	
E-mail:	ellie.ward@cityoflondon.gov.uk	
Contact number:	020 7332 1535	
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Fri 23/01/2026	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

[<< Link to the Guidance sheet]

[^^ Link back to top]

Better Care Fund 2025-26 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: City of London

Confirmation of Nation Conditions			Checklist Complete:
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) Plans to be jointly agreed	Yes		Yes
2) Implementing the objectives of the BCF	Yes		Yes
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes		Yes
4) Complying with oversight and support processes	Yes		Yes

Better Care Fund 2025-26 Q2 Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board: City of London

For metrics time series and more details: BCF dashboard link

For metrics handbook and reporting schedule: BCF 25/26 Metrics Handbook

4.1 Emergency admissions

Plan		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	Rate	1,076.0	1,076.0	1,434.7	1,076.0	717.4	1,793.4	1,434.7	1,434.7	1,076.0	1,076.0	717.4	1,076.0
	Number of Admissions 65+	15	15	20	15	10	25	20	20	15	15	10	15
	Population of 65+	1,394.0	1,394.0	1,394.0	1,394.0	1,394.0	1,394.0	1,394.0	1,394.0	1,394.0	1,394.0	1,394.0	1,394.0

		Checklist
Assessment of whether goal has been met in Q2:	On track to meet goal	Yes
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.		Yes
You can also use this box to provide a very brief explanation of overall progress if you wish.	Data is available for April-July. The 4-month average is 1161.5 against a plan average of 1165.7	Yes
Did you use local data to assess against this headline metric?	No	Yes

Complete:

If yes, which local data sources are being used?	

4.2 Discharge Delays

Original Plan	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 (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	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	86.00%	86.00%	86.00%	86.00%	86.00%	86.00%	86.00%	86.00%	86.00%	86.00%	86.00%	86.00%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	6	6	6	6	6	6	6	6	6	6	6	6

Assessment of whether goal has been met in Q2:	Not on track to meet goal	Yes
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.	From April to August the proportion of adult patients from acute hospitals discharged on their ready discharge date is 82% - this is slightly below the 86% target. The average number of days from DRD to discharge, excluding 0 day delays was 4.67 days. This is an improvement upon a plan of 6 days. A small number of delays and a few outliers significantly impacts on the data. Patient and family choice and equipment are top reasons for delays. Commissioners will be considering whether there are any mitigations to manage patient and family choice.	Yes
You can also use this box to provide a very brief explanation of overall progress if you wish.	N/A	Yes

Did you use local data to assess against this headline metric?	Yes	Yes

If yes, which local data sources are being used?	MOSAIC. We reviewed national and local data sources.

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
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	143.5	143.5	286.9	286.9
	Number of admissions	3.0	10.0	2.0	2.0	4.0	4.0
	Population of 65+*	1394.0	1394.0	1394.0	1394.0	1394.0	1394.0

Assessment of whether goal has been met in Q2:	On track to meet goal	Yes
If a goal has not been met please provide a short explanation, including noting any key mitigating actions.		Yes
You can also use this box to provide a very brief explanation of overall progress if you wish.	Met Target	Yes

Did you use local data to assess against this headline metric?	Yes
If yes, which local data sources are being used?	MOSAIC

Yes

Better Care Fund 2025-26 Q2 Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board: City of London

Source of Funding	2025-26 Planned Income	Updated Total Plan Income for 25-26	DFG Q2 Year-to-Date Actual Expenditure	Checklist Complete:
DFG	£46,024	£46,024	£33,055	Yes
Minimum NHS Contribution	£960,444	£960,444		Yes
Local Authority Better Care Grant	£399,287	£399,287		Yes
Additional LA Contribution	£100,000	£100,000		Yes
Additional NHS Contribution	£0	£0		Yes
Total	**£1,505,755**	**£1,505,755**		

	Original	Updated	% variance	
Planned Expenditure	**£1,505,755**	£1,505,755	**0%**	Yes

		% of Planned Income	
Q2 Year-to-Date Actual Expenditure	£752,878	**50%**	Yes

If Q2 year to date actual expenditure is exactly 50% of planned expenditure, please confirm this is accurate or if there are limitations with tracking expenditure.	There are transaction movements required for us to track actuals in some project areas. We forecast to spend in full.	Yes
If planned expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is	No change	Yes

greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	

This page is intentionally left blank

City of London Corporation Committee Report

Committee(s): Health and Wellbeing Board – For information	**Dated:** 04/02/2026
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 Q3 2025/26

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 Charities Commission register of charities as a Charitable Incorporated Organisation and is Licensed 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

The HWCoL team continues 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 is currently undergoing several changes in personnel but is still delivering on requirements of the contract.

The future of Healthwatch

An online meeting is scheduled for early February with the DHSCC with Healthwatch England and local Healthwatch. The department will give the latest update on timescales for the new Health and Social Care Act to be put to parliament.

A survey has been devised to gather residents' opinion on what they would want to see from Healthwatch in the future. You can view the survey here https://www.smartsurvey.co.uk/s/HWCoLRebrand/

Gail Beer and Rachel Cleave will be meeting with City of London officers next month to discuss options for the future.

Public Board Meetings

HWCoL held its AGM at St Giles Church, Barbican in October. The event was attended by both residents and colleagues from health and social care providers across the City.

Gail Beer updated the meeting on our work over the previous year, including our reports on Digital Apps, Enter and Views and the Patient Advice and Liaison Service (PALS), our Patient Panel series, public meetings and events.

Dame Marie Gabriel, Chair North East London Integrated Care Board (NEL ICB) joined us as our guest speaker to talk about the NHS 10 Year Health Plan and how NEL ICB will be implementing changes. The changes incorporate the three shifts from treating sickness to preventing illness, moving acute care to community-based services and the aim to develop a long-term health strategy which is aligned with the health priorities of the government.

Marie talked about how the board functions and that discussions take place on how best to allocate and deliver the £6.5 billion budget for North East London by using local neighbourhood structures. Marie recognised the need to work flexibly with residents and embrace change.

Stalls from local providers were also in place from City advice, Gloji, Imago, Dragon Café and Age UK City of London.

Projects

1) **Minor Injuries Unit at St Bartholomew's Hospital**

The visit to the Barts Minor Injuries Unit (MIU) took place in August. One Trustee and an Associate Board member undertook the visit to research opening hours, who can access the services, what services are provided and pathways for follow up treatment/appointments. The research looked at staffing levels, funding, how the unit integrates with the Royal London A&E department, who funds the unit, usage and how uptake might be increased. The team met with David Curran, Director of Nursing, and Sam Atkinson, Associate General Manager, Emergency Department and pre-hospital care, at the Royal London.

The report has now been published and shared with the team at the MIU.

The team will be commencing a major project on access to urgent care across the City in early 2026 and this work with Barts supports the first part of the programme.

The final report is attached.

Support to the City of London Corporation

1. **Adult Social Care Advisory Group**

In November HWCoL held the inaugural Adult Social Care Advisory Board, following our information events in the summer which were held at the Golden Lane Community Centre, the Guildhall and the Portsoken Community Centre.

Representatives from both residents and the City of London Corporation Adult Social Care team, joined to discuss how best to communicate with City residents about the services offered, how to widen the membership ensuring representation of all communities, and the remit of the group. It was agreed the meetings will be held quarterly with the next one scheduled for March 2026.

On the agenda was deciding the Terms of reference (TOR) for the group, the scope of the group, ensuring representation from all communities in the City, the name of the group and the priorities for the first year.

The draft TOR will be distributed to the group in Q4.

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.

1. **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 was launched on 18th November at an event at the Ralph Perring Room on Golden Lane. HWCoL were joined by Dr Chor, Dr Hillier and Sinead Downes, the Practice Manager. The event was well attended with the Partners answering lots of questions from residents. The report has been distributed in the community centres, at the Practice and on our website.

The main recommendations made in the report are:

1) Improved communications with patients.
2) Clarification on the booking process for follow up appointments
3) Consistency in staff knowledge on processes used at the surgery i.e. medicines reviews
4) Private space for patients in the reception area

The report is attached.

2. St Bartholomew's Hospital Cardiology Department Enter and View launch

On Thursday 9th October HWCoL held an event in the conference room at St Bartholomew's hospital to officially launch the Cardiology Department enter and view report. Hosted by Charles Knight, CEO St Bartholomew's Hospital and David Curran, Director of Nursing. The report made several recommendations regarding administration practice within the team, namely improving communication with patients and around training, which have now not only been adopted within the department but across all outpatient departments across the Trust. The report was strongly welcomed by the Trust. The report is attached.

3. St Leonard's Physiotherapy Department

HWCoL are carrying our research to enable a team to undertake an Enter and View at the Physiotherapy Department at St Leonard's. The survey for residents to give feedback on their experiences of the department is now live and discussions with the department are underway. The visit will take place in Q4.

Communications and Engagement

Christmas Communications

Held at the Portsoken Community Centre, HWCoL hosted a really well attended Christmas celebration event, with over 15 residents attending for lunch and chat. Through this event new connections were made with several Portsoken Residents.

Christmas Leaflet

The team produced and distributed an information leaflet on accessing services over the Christmas and New Year period.

HWCoL Events

1. 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 attracts new residents at every event. Reports from all Patient 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 Diet and Nutrition Session

Held on 3rd October with Joe Alvarez, First Contact Dietician at the Neaman Practice and Shoreditch Park and City Primary Care Network. A very informative and well attended session. The session focussed on the essentials of healthy eating, vitamin and nutrient guidance and the key food groups.

1.2 Together Better and VCH Befriending Service

Held at Golden Lane Community centre, a very well attended session with Yasmin Yauser, Together Better and Ragini Kharuna, Hackney VCS who outlined their services for the community. The Befriending service is new to City residents and created a lot of interest.

Upcoming patient panels

Adult Rehabilitation Team and Wheelchair Services, Homerton Hospital NHS Trust – January 29th

Upcoming events

Men's Health Event

This event was scheduled for 18th November but had to be postponed due to speaker unavailability. This has now been rescheduled for early February at St Bartholomew's Conference room. The main speakers at the event will be Dr Chor, Partner, Neaman Practice and Dr Samantha Strumeier the Lead Clinical Nurse for Prostate, Testes and Bladder Cancer from Barts Health NHS Trust. There will also be a wide range of stallholders from local service provider including from City Dudes and the Proper Blokes Club who both provide exercise and support groups for Men.

Portsoken Community Engagement

MATCH Programme – Health literacy in the Portsoken Area

HWCoL are working with NEL NHS Trust and the City and Hackney Population Health Hub on Health Literacy in the Portsoken area.

Good progress was made with this project. An online focus group was held with three residents and Imago, feedback was also obtained from the residents via email, who advised that access to dentistry, women's health, diabetes/healthy eating and blood pressure were the main concerns of the residents they represented. A follow up steering group meeting is scheduled for mid January.

A very useful meeting was held with Deputy John Fletcher and Councilor Munsur Ali on 16th October to discuss engagement with Portsoken residents. It was agreed that a leaflet should be produced for residents to give feedback on their priority area for information.

Three resident engagement events will be planned, one to be held in the Artizan Library, one in the Iveagh Room on the estate and one in the Portsoken Community Centre, the sessions will be aimed at different communities with one in English, one with a Sylheti interpreter and one with a Spanish interpreter.

The leaflet was produced and distributed by Deputy Fletcher. The three main health areas that residents identified in this survey were diet and nutrition, cancer screening and men's health.

A further meeting was held in December with Deputy Fletcher who has agreed to provide contact information to the team to organize these events.

Planned activities for Q4

- Men's Health Event
- St Leonards Physiotherapy Department Enter and View

- MATCH Project Health Literacy Events Portsoken Engagement Events
- Charity Commission return

Conclusion

The team at Healthwatch City of London have had a busy Q3 delivering events, communications and continued engagement with residents of the City of London.

Appendices

- St Bart's Minor Injuries Unit report - Final
- Neaman Practice enter and view report - Final
- Enter & View - Barts Cardiology Unit Healthwatch 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

St Bartholomew's Hospital Minor Injuries Unit Visit

Introduction

Visit Details	
Service Visited	St Bartholomew's Hospital Minor Injuries Unit Visit
Address	Kenton and Lucas Block, St Bartholomew's Hospital, W Smithfield, London EC1A 7BE
St Bartholomew's Team	**David Curran**, Director of Nursing & Governance, Barts Health NHS Trust **Sam Atkinson**, Associate General Manager, Emergency Department & Pre-Hospital Care Royal London Hospital
Healthwatch City of London Team	**Lynn Strother**, Trustee, Healthwatch City of London **Janet Porter**, Associate Board Member, Healthwatch City of London.
Date of Visit	13th August 2025
Status of Visit	Announced

Healthwatch City of London (HWCoL) are undertaking a project looking at emergency care pathways for City residents. The Minor Injuries Unit at St Bartholomew's is just one of the services available to residents who require immediate clinical care.

HWCoL have been informed by residents that the unit is not well known about and is an underutilised service.

Purpose of the visit

The principal reason for this informal visit was to find out the details of services provided by the unit, establish how it is managed and identify opportunities for it to be better utilised.

Methodology

Before the visit a preliminary meeting was held with David Curran, Director of Nursing at St Bartholomew's hospital and Healthwatch. David was fully briefed on the reason for our visit.

A questionnaire was sent to the team at St Bartholomew's Hospital beforehand to indicate the information required during the visit.

The Unit

The unit is based in the grounds of St Bartholomew's Hospital in the City of London and is to be found off the hospital courtyard, in the Kenton and Lucas block.

The unit is funded by Barts Health NHS Trust and is directly managed by Sam Atkinson, Associate General Manager, Pre-Hospital Care at The Royal London Hospital and the Emergency Care Department at The Royal London Hospital.

Care and clinical procedures carried out by the team are mainly contained within the unit, but the team has access to the X-ray department within St Bartholomew's hospital.

Staffing

This is a nurse-led facility, with an emergency nurse practitioner and another qualified nurse on duty at any one time, plus a receptionist. These are rotated from the Royal London's A&E department. No doctors are based in the unit. The team have access to advice from doctors and the team at the Royal London.

Staffing the MIU is challenging at times. On the day we visited, there was no receptionist. Instead, patients had to call the Royal London switchboard on an internal phone to book in on arrival.

Very rarely, as during the recent doctors' strike, the Royal London Hospital is unable to spare nurses from the A&E department, and so the MIU is temporarily closed.

Opening hours

The opening hours are Monday to Friday, 8am to 4pm. This is a walk in service. No appointments are required.

The waiting room has plenty of seating and is light and airy. There are leaflets and instructions on contacting the Royal London Hospital to book in if there is no receptionist on duty.

Services provided

The services provided are clearly stated on the notices in the waiting area and the informative leaflets provided.

Adults and children over the age of two can be treated for the following:

- cuts and grazes,
- broken and dislocated bones,
- minor burns and scalds,
- bites and stings,
- sprains and strains,
- minor head and facial injuries,
- minor eye and ear injuries,
- rib injuries,
- management of simple boils,
- simple back pain or injuries.

The staff are able stitch wounds, make requests from the hospital X-Ray facilities, plaster broken bones and treat minor injuries.

Conditions that are not treated include chest or stomach pain, headaches, rectal bleeding, vomiting and diarrhoea, flu-like symptoms, rashes, prescription requests and earache/ear infections.

These patients will be directed to nearby A&E departments or advised to see their GP. The nurse on duty will talk to patients and call an ambulance or arrange a taxi if required.

Only patients who are likely to be experiencing a heart attack (MI) can be transferred directly to St Bartholomew's Hospital.

Patients with minor injuries with pre-existing medical conditions will be treated.

Signposting to the unit

As stated above the unit is based in the grounds of the hospital off the main square. The unit is not immediately visible upon entering the hospital grounds.

There are prominent signs at each hospital entrance stating that there are no A&E services, and that the nearest departments are at UCLH or the Royal London. However, the same notices provide information about the MIU at Barts including opening hours.

Although there are signs within the grounds of the hospital pointing to the unit, there are none in the main hospital reception area, in the King George V building.

Utilisation

The team at Barts Health have identified that the unit is under-utilised, and they believe it could handle considerably more patients per day.
At present the unit has capacity to see eight patients an hour which is 56 patients a day. When looking at the statistics provided (see appendix), the unit treated 39 patients on its busiest day.

Based on these estimations the unit could treat 13,440 patients per year.

At the time of the visit the unit had treated 2,770 patients so far in the year.

The busiest time of day for the unit is between 11am and 2pm, but even then, it is not working to full capacity. In 2025, the highest average occupancy rate recorded has been 70% at 2pm, as a percentage of eight patients per hour that the unit could treat. Lowest occupancy rates of 32% and 26% are experienced at either end of opening hours.

Drilling down into the statistics, the information the trust uses to manage its services show that the busiest period so far this year was in March when on one particular day, 20 people arrived for treatment in a single hour. More often, it is nearer 10.

The visit

On the day of the visit, the unit was quiet, and consequently there were virtually no delays in treating patients. Two patients arrived during the visit and were seen straightaway.

Where do patients come from?

Information from the team clarified that those who attend the unit from the City are mainly local residents (some referred by the Neaman Practice) and City workers but not many tourists. Visitors to the City tend to go to one of the big London hospitals for treatment.

Most adults treated at the MIU are from Islington (587 between January and mid-August 2025), the City of London, Hackney and Tower Hamlets, but a few come from as far away as Hillingdon, Kingston, Sutton, Bexley and other outer London boroughs. It is not known if those patients travelled some distance specifically to visit the MIU or were already in the City for work or other purposes.

The majority of children treated live in Islington, the City, Tower Hamlets and Hackney.
The NHS 111 service will direct suitable patients to the MIU.

Observations

The unit is an underutilised resource with a good clinical team in place able to offer a good level of service.

Anecdotally we've heard from our population that people find it a good service and that it is highly rated. From a patient's point of view, this may in part be because it is quiet and uncrowded, with short waiting times.

Managers recognise that it is under-utilised, and probably more could be done to raise awareness of the facility.

Recommendations

1. The facility needs to be better utilised, and Barts Trust needs to raise awareness about the services available at the unit, and where it is located. HWCoL could help sign post to the relevant City channels

2. Well-written and easy-to-understand leaflets have been produced, and these could be distributed more widely in local libraries, pharmacists, the City visitor centre, offices, and other outlets.

3. Barts Health Trust needs to review its own website, as information on the unit is at the bottom of the page on accessing emergency services and not immediately visible.

4. Receptionists and/or triage nurses at the Royal London could also advise patients with minor injuries that there is an alternative treatment centre at St Bartholomew's, just two stops on the Elizabeth Line (a map would be useful).

5. Signage around the hospital needs to be improved and plans to do this are already in place once the new North Wing re-opens. HWCoL could provide some input on signage,

6. The team could consider how volunteers could support the receptionist and/or be ready to step in during staff absences. This may be as simple as being there to help patients check in over the phone.

Conclusion

Because footfall is low, there is always a risk that the MIU could be shut down as the NHS seeks savings. However, it provides a useful service in the City of London for local residents, offices, construction teams, and shop workers, as well as students and tourists.

If patients are diverted from nearby A&E and Urgent Treatment Centres this would relieve pressure in those units, in addition to this patients could avoid lengthy A&E waiting times in crowded surroundings.

It may be useful for staff to explore ways of enabling the MIU to make greater use of facilities at St Bartholomew's such as the phlebotomy clinic. This could reduce referrals from the MIU to A&E.

HWCoL could work with Barts Trust to help raise awareness by advertising the unit to ease demands on A & E services.

Appendix

Data provided by the department which has been used in this report is as follows:

Figure 1: Arrivals per hour

Year	Month	WeekSt	8	9	10	11	12	13	14	15
2025	Jan	30/12/2024	6	4	2	3	4	1		2
		06/01/2025	7	10	10	10	12	6	6	7
		13/01/2025	11	19	8	11	10	12	10	5
		20/01/2025	16	11	13	17	14	10	12	18
		27/01/2025	13	10	4	11	12	12	11	8
	Feb	03/02/2025	18	16	15	11	10	11	13	12
		10/02/2025	11	16	8	5	13	13	10	7
		17/02/2025	11	7	7	15	14	14	12	5
		24/02/2025	10	8	9	9	11	13	13	4
	Mar	03/03/2025	7	15	10	12	8	3	10	4
		10/03/2025	11	12	9	18	11	13	13	3
		17/03/2025	15	16	10	20	9	11	10	2
		24/03/2025	16	12	12	17	9	6	9	3
		31/03/2025	3	3	6	4	3	4	1	4
	Apr	31/03/2025	15	15	6	8	4	8	9	4
		07/04/2025	6	5	7	8	6	7	8	4
		14/04/2025	15	6	8	13	8	4	6	6
		21/04/2025	8	8	8	9	3	7	12	4
		28/04/2025	12	4	4	10	6	10	3	6
	May	28/04/2025	6	3	3	8	5	4	3	6
		05/05/2025	6	9	13	4	12	7	6	9
		12/05/2025	16	10	15	11	11	9	15	2
		19/05/2025	11	11	12	16	9	7	7	6
		26/05/2025	11	10	11	11	9	11	9	4
	Jun	02/06/2025	10	10	11	7	11	11	15	9
		09/06/2025	10	8	10	12	10	8	13	6
		16/06/2025	15	17	11	13	16	12	9	10
		23/06/2025	13	17	17	18	10	18	12	8
		30/06/2025	5	1	7	3	1		1	2
	Jul	30/06/2025	12	5	7	10	12	9	14	6
		07/07/2025	17	8	10	10	12	10	11	10
		14/07/2025	8	15	7	12	13	13	13	7
		21/07/2025	10	8	12	5	7	10	12	1
		28/07/2025	9	1	7	4	4	2	1	3
	Aug	28/07/2025	1	1		2	3	1	3	2
		04/08/2025	13	9	8	11	6	10	10	11
		11/08/2025	9	12	15	10	8	10	5	10
		18/08/2025	12	7	10	14	14	10	14	10
		25/08/2025	5	7	4	3	6	4	3	2
2025 Total			**410**	**366**	**346**	**395**	**346**	**331**	**344**	**232**
Grand Total			**410**	**366**	**346**	**395**	**346**	**331**	**344**	**232**

Figure 2: 2025 MIU occupancy by hour

*estimated occupancy level based on 8 patients an hour

Hour	8	9	10	11	12	13	14	15	16
Occupancy level	32%	53%	60%	66%	64%	69%	70%	59%	26%

Figure 3: Geographical impact of St Bartholomew's MIU – Adults

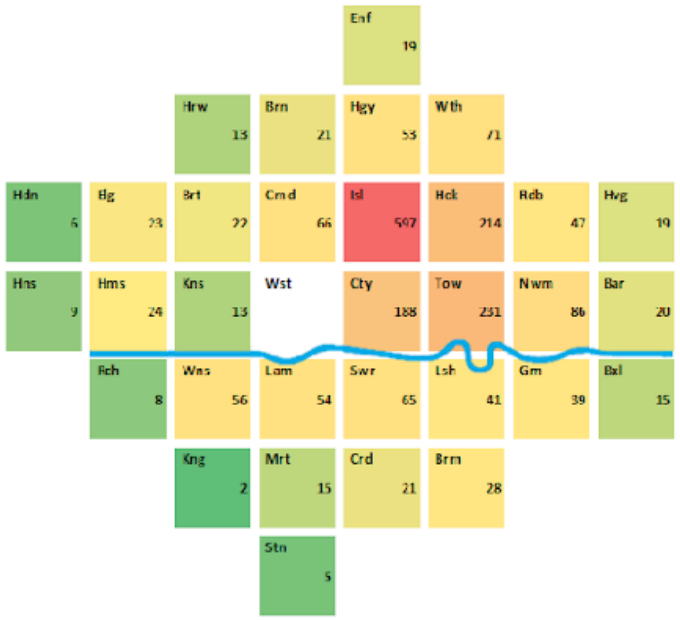
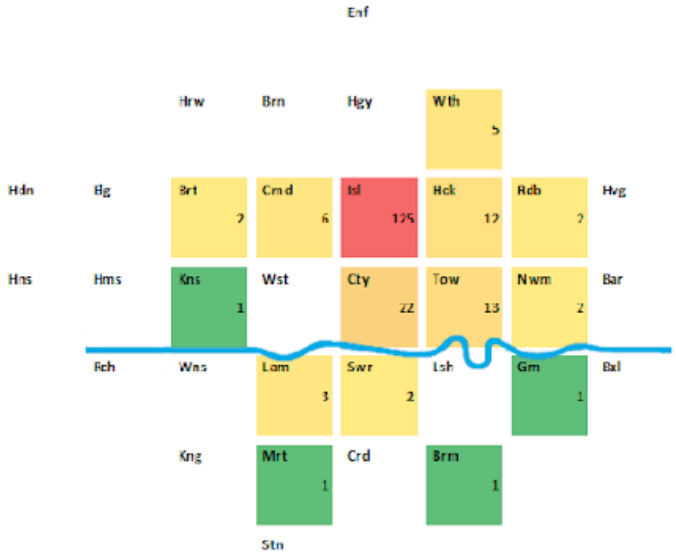


Figure 4: Geographical impact of St Bartholomew's MIU – Paediatrics


Enf
Hrw
Brn
Hgy
Wth
5
Hdn
Hg
Brt
2
Cmd
6
Isl
125
Hck
12
Rdb
2
Hvg
Hns
Hms
Kns
1
Wst
Cty
22
Tow
13
Nwm
2
Bar
Rch
Wns
Lam
3
Swr
2
Lsh
Gm
1
Bxl
Kng
Mrt
1
Crd
Brm
1
Stn

This page is intentionally left blank



Enter and View Report: The Neaman Practice

Healthwatch City of London

13th February 2025

healthwatch City of London

Contents

Introduction	1
The Practice	5
Summary of findings	6
Feedback	16
Appendix	22

Introduction

Visit Details	
Service visited	The Neaman Practice
Address	15 Half Moon Court, London, Greater London, EC1A 7HF
GP Partners	Dr Amy Hillier, Dr Paul Ugwu, Dr Chuan Chor
Operations Manager	Sinead Downes
Date & Time of Visit	13th February 2025, 9am-1pm
Status of Visit	Announced
Date of Previous Visit	14th February 2019
CQC Rating	Good
Date of CQC Report	23rd January 2017
Authorised representatives	Rachel Cleave, Liesa Sandt, Caitlan Barrow, Lynn Strother

What is Healthwatch?

Healthwatch City of London is an independent organisation that relies on feedback from the local community regarding their experience using health and social care services across the City. 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 City. 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 teams 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 will give recommendations.

Why The Neaman Practice?

Within the City of London, there are a small number of NHS services in comparison to other boroughs, meaning that a large percentage of the population will be visiting the same services. GP surgeries are limited within the City, which means The Neaman Practice is where most residents in the City are registered. Because of this, we regularly hear about any issues patients have had when accessing their GP and there are areas we were keen to look in to. We were interested to find out what patients think of their GP surgery, how well things are working and whether there are any improvements that could be made.

The Neaman Practice has also recently upgraded its appointment booking process to an online triage system. HWCoL and the surgery have been conducting focus groups with residents to get their feedback on the new system, and to create a comprehensive how to guide for those needing to use the triage service. We wanted to speak to the practice and its patients to hear first-hand how they are finding the triage system, and whether they have any feedback for improving it.

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

Process

Before we arrived at the practice, we contacted the Operations Manager to discuss the visit and the logistics of how our visits work, ensuring that we minimised the impact our presence would have on the daily running of the practice. We then created a survey to get patient insight into the practice before we undertook the Enter and View visit. This enabled us to obtain feedback from patients whom we were unable to see on the day of the visit. We had two responses from this prior to our visit and then were able to speak to six people on the day. We then conducted our visit to the practice on 13th February 2025 and used several different surveys to gain feedback from patients, the management team and staff, which we will go into in more detail below. The surveys can be found in the appendix of this report. We collated our findings along with the practice's response to our recommendations into this report, and we will be sending it to our commissioners, North East London Integrated Care Board, City of London Health and Wellbeing Board, Shoreditch Park and City Primary Care Network, Healthwatch England and other relevant people.

Acknowledgements

Healthwatch City of London would like to thank The Neaman Practice management team, patients and staff for their contribution and hospitality in enabling this Enter and View visit to take place. We would also like to thank Generoso Roberto for his contribution in analysing the data and completing a write-up for this project.

The Practice

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.

The Neaman Practice

On 13th February 2025, we visited The Neaman Practice, a medical practice located in the City of London, within the Shoreditch Park and City Primary Care Network. The practice is commissioned by the NHS North East London Integrated Care Board and works closely with it. The City of London has an estimated 8,000 residents. However, the practice has approximately 9,350 registered patients as it also takes people from neighbouring boroughs if within the catchment area for the surgery. At the time of the visit, working at the practice there were:

- 3 GP partners
- 2 trainee GPs
- GP registrar
- 2 nurses
- 6 receptionists
- 2 administrative staff
- Operations Manager
- Business Manager

We interviewed a total of eight staff members including receptionists, nurses, GPs and the Operations Manager. The practice has recently implemented a new triage booking system for advice, appointments and administrative queries, which we will talk about further during this report. It also utilises the NHS app alongside this for repeat prescriptions and viewing medical records.

CQC Rating

The CQC is the independent regulator of health and adult social care in England. It makes sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve. At the time of the visit, The Neaman Practice had not had a formal inspection since January 2017.

There have been several informal reviews since this, but no further formal inspection has been carried out yet. This is likely due to the COVID 19 pandemic where face-to-face inspections were put on hold. A review in 2020 stated, “We did not find evidence of significant changes to the quality of service being provided since the last inspection. As a result, we decided not to inspect the surgery at this time. We will continue to monitor this information about this service throughout the year and may inspect the surgery when we see evidence of potential changes.”. All information regarding The Neaman Practice’s CQC rating can be found on the CQC website.

Online Feedback

The NHS review website for The Neaman Practice includes 14 reviews, both positive and negative, spanning from March 2023 to March 2024. The majority are positive and highlight staff compassion, receiving test results promptly and appointment flexibility. There are three negative reviews covering concerns such as the difficulty of booking appointments in a timely manner, and appointments being rescheduled multiple times. The Operations Manager has replied to many of the reviews left on the NHS website, either signposting them to additional support or explaining how their processes work.

There are also reviews for The Neaman Practice on the website, Care Opinion, which offer a very similar overview of positive and negative reviews as seen above.

Summary of findings

During our visit to the Neaman Practice, we were given a tour of the practice led by the Operations Manager, where Authorised Representatives were able to take notes and photos where appropriate. The team had a discussion with the Operations Manager about the services they offer and what support patients can access via the practice.

There are seven categories of observation. These categories include Outside and Entrance, Reception and Waiting Area, Environment, Safety, Information Displayed, Accessibility, and Staff.

Outside and Entrance

The Neaman Practice is in the City of London, a short walk from Barbican tube station and the Elizabeth Line entrance to Farringdon Station. The area is located away from traffic and is easily accessible via foot, bus and tube. There weren't many pedestrians in the area as it is tucked away from the main road and there was a minimal amount of noise.

Upon arriving at the practice, there are several signs outside stating the name of the practice, the partners and the opening hours. The opening hours don't however state the days they are open, just the hours, closing for an hour at lunch 1pm-2pm. The entrance was clean and clear of any litter or debris. To access the building, there is either a small set of stairs or an accessible ramp. The practice also has a letterbox outside for prescriptions/letters when the practice is closed.



Figure 1.

Reception and Waiting area

Once inside the practice, there is a long reception desk to the right and a waiting area to the left. Straight ahead are the lifts and consultation rooms as well as hallways/stairs leading to other parts of the practice. The ground floor waiting area is well lit and has lots of seating for patients to use. There are also leaflets and posters displayed for patients while they are waiting for their appointment, as well as in the lifts. We couldn't find any information displayed about the complaints process in the waiting area. There is one screen in the waiting room downstairs as well as one on the first floor waiting room to display information to patients. However, the screen downstairs wasn't working when we visited. The first floor waiting room screen was on when we were there, although patients report this is not always the case.

Hand sanitiser was available at reception for patients, and for staff members which was located behind reception. Tissue boxes were also located around reception.



Figure 2.



Figure 3.



Figure 4.

Environment

There are several flights of stairs, as well as lifts providing access to the first and second floors. However, these are shared with the business occupants of the floors above. The left lift is for practice patients and the right for other occupants/visitors. The lifts are reported to be unreliable, and although regularly serviced, are prone to breaking down and being out of service while repairs are arranged. The surgery is spread over three floors with multiple consultancy rooms. There is some signage, although patients are usually called in for their appointment in person and shown where they need to go.

At the time of our second visit, one elevator was out of order. The second elevator was working, which connected the Neaman Practice to the organisation (Evolve) above. Signage was available for Evolve staff to not use the Practice's floors.



Figure 5.



Figure 6.



Figure 7.

Information displayed

There were lots of leaflets and posters displayed around at the time, all advertising various support groups or services patients can access. These were in a variety of languages and advertising a range of services for both younger and older patients.

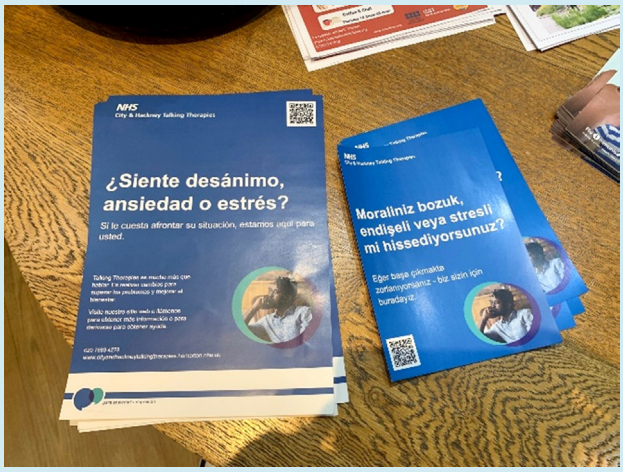


Figure 8.



Figure 9.

Accessibility

There is a hearing loop in reception with signage advertising this on the reception desk. This is also listed on their website in the disability access section. There are two lifts within the practice and an accessibility ramp to enter the building.



Figure 10.



Figure 11.

Other facilities

Baby changing facilities were located on the ground floor and second floor in the accessible toilets.

Staff

When visiting, staff were well presented, welcoming and knowledgeable about the practice. They were able to advise patients where they needed to go, as well as where the lifts are located and how to use them. Staff had name badges visible during our visit, either attached to their clothing or a lanyard. Many staff had yellow badges to enable easy reading for those with conditions such as dementia and dyslexia.

Triage booking system

The surgery now operates a triage-based appointment system where patients complete a form via Accurx to request an appointment. The online form first asks patients whether their inquiry is an administrative query, a medical issue, or a request for online advice. Patients reporting a medical issue must confirm that it is not an emergency by reviewing a list of conditions and symptoms. They then describe their problem, its duration, progression, previous remedies, and what assistance they require. Additional optional details such as photo attachments, specific concerns, and preferred contact times can also be provided before submitting the request.

A duty doctor reviews the submitted requests between 08:00 and 18:30 on weekdays and determines the appropriate course of action, which may include (based on the Neaman practice website):

- Emergency referral,
- Same-day appointments,
- Appointments within two weeks, or
- Referrals to other healthcare professionals such as nurses or pharmacists.

Patients can submit the form via the surgery's website or the NHS app. For those who struggle with digital access, appointments can also be booked via phone or in person with the assistance of reception staff.

Services offered

Phlebotomist – On site everyday – except Wednesday

Respiratory nurse – On site everyday – except Wednesday

Cardiology nurse – On site everyday – except Wednesday

Transport to Homerton Hospital – As required

Together Better – Volunteer Centre Hackney – Multiple sessions per week

Locomotor service – St Leonard's – Once per week, Tuesdays

SMI nurse – Once per week, Wednesdays

Social prescriber – PCN - Once per week, Wednesdays

Dietician – PCN – Once per week, Wednesdays

Stop Smoking service – Once per week, Fridays

First Contact Physio – Once per week, Fridays

ECHO therapy – Barts – Once per month

Toenail cutting - Homerton Health – Once per month

Young People's coach – PCN - Adhoc

Home List Care Coordinator – Adhoc

Dermatology clinic – Adhoc

Feedback

Management/GPs

During our visit, we spoke to three senior members of staff and asked them a series of questions to prompt discussions regarding the following areas:

Appointment booking/consultations

The management team emphasised that face-to-face appointments are always available for those who want them, and patients could request them through the online triage form. They just need to specify when, either by completing their form online or telling reception that they would like an in-person appointment. GPs are also able to make notes on a patient's file so they can add details such as "the patient prefers in-person appointments where possible" which will flag up every time their record is accessed by staff.

The practice has implemented several strategies to ensure appointment accessibility, including:

- Allowing patients to specify preferred dates and times as this enables patients have more control over their care.
- Designating a duty doctor with no pre-booked patients who attends to extra demand on the day.
- Collaborating with Primary Care Network (PCN) practices that provide evening and late-night appointments on a scheduled basis for those who would benefit.

Triage booking system

The management team stated that they feel the new system is efficient and effective. They highlighted several benefits, including:

- Patients needing GP consultations are seen within 72 hours.
- Those needing alternative services or treatment are signposted to the correct health professional for them in a timely manner.
- The system allows patients to specify their preferred consultation method (face-to-face or telephone).
- It reduces morning call queues, helping both patients and reception staff to communicate with each other better.
- Doctors receive more detailed patient notes in advance as the form is thorough.



Figure 12.

- The DNA (Did Not Attend) rate has decreased because only patients who need an appointment to see a GP are booked one.

Accessibility

When talking about accessibility, the management team stated that the GP surgery is committed to meeting the individual needs of its patients by ensuring accessibility, communication assistance, and tailored support for vulnerable individuals. We were told that the building is fully accessible, with staff available to assist patients as needed. One example used was showing patients where the lifts are or taking them to the room they need to go to. A flagging system is also used on patient records which enables staff to identify and accommodate patients with hearing impairments, mobility issues, or language barriers etc. The management team says this will flag up every time a member of staff clicks on the patient's record and can include details about needing an interpreter. Non-English speakers have access to Language Line, a 24-hour telephone interpreting service, while some receptionists are multilingual and can assist directly.

Training/induction

The management team talked us through the training process for GPs, which varies depending on their level of qualification/experience. For trainee GPs, they will receive a week of induction, which includes shadowing all staff members in the practice as well as any mandatory training and attending meetings as required. For qualified GPs who are just new to the practice, they will receive a three-day induction covering only the areas that may vary from practice to practice. GPs will then start to see patients, although this is still supervised for trainee GPs. GPs are also required to complete 50 hours of training per year. Some of this is mandatory, while other training is optional, with doctors able to choose what they would like to study, based on their own interests or personal development. GPs also have a biweekly meeting where they will invite a speaker to inform clinical staff about a particular subject e.g. ENT.

Staff

We spoke to several members of staff during our visit including receptionists, nurses and other support personnel. We asked them a variety of questions on the following areas:

Appointment booking/consultations

One staff member stated that they offer in-person slots for socially isolated patients to give them an opportunity to talk. However, another staff member mentioned that at times, demand for face-to-face appointments exceeds supply.

According to staff, most appointments run on time, with proactive management of delays via text messages or calls if needed. Patients are also given the option to wait or reschedule if their appointment is delayed, and they won't be penalised for cancelling an appointment if it has overrun. The doctors' schedules include a built-in 10-minute buffer every hour to help manage overruns. This isn't foolproof, however, and delays do still occur, but the practice has a good system in place for managing this, and staff stated they have no issues when trying to rebook a patient if they can't stay for their late running appointment.

Triage booking system

Overall, staff seem happy with the new triage system and how it works; they also appear confident about providing help to complete the form, with many receptionists stating they have advised patients how to fill in the form over the phone. Despite its advantages, some staff expressed concerns that certain groups may struggle with the system, particularly:

- Non-digital patients
- Patients confused by the NHS app verification process
- Working patients with restricted time availability

The practice has processes in place such as receptionists assisting patients with the form and being able to signpost them to digital support, where needed. There is also flexibility for patients who work or have caring responsibilities, trying to accommodate preferred appointment times where possible.

Accessibility

Staff mentioned there are numerous ways to support patients with accessibility or other special needs. These include use of a lift, hearing loop and interpreter services where required. They also stated that all staff have completed online training on supporting patients with disabilities, as well as some staff being aware of what hidden disabilities are. One staff member mentioned that some patients with accessibility needs struggle to know when it is their turn to go in for their appointment. So, instead of expecting these patients to rely on screens, medical or reception staff will fetch them personally from the waiting room.

Training/induction

The induction process for admin and other non-clinical staff is one week. There is a similar induction process for trainee GPs in terms of familiarising themselves with the building, shadowing other staff and completing training. Staff complete online training as part of their induction and must do required refresher training as well. When we visited, some staff said that they would like more face-to-face training as they feel it is more beneficial in some areas. There are also regular meetings with the staff team as well as reviews/appraisals completed by line managers.

Support for staff

Staff and the management team both told us that they feel supported by their line managers and feel that the team works well together. They know whom to go to for support if needed and staff report feedback being accepted well by the management team, with them working to rectify issues quickly. One member of the management team told us that they would like to do more team building activities or training days to boost team morale and strengthen the relationship of the team. Another staff member suggested that they would like more social events for staff to

attend, as this would also strengthen the team as well as creating a sense of belonging within the team.

Patients

We spoke to six patients on the day who had varying experiences at the practice. They were asked a small selection of questions on the following areas:

Appointment booking

From the patient perspective, booking experiences are mixed. While some find it easy and efficient, others struggle with the new online system or waiting to get through to reception on the phone. The practice has addressed the concerns regarding call wait times and appointment booking, which is why they have implemented their new triage system. They are working closely with their patients and Healthwatch to ensure that the new system is accessible or there is adequate support available to patients who need additional help completing the form. The reception team are welcoming and happy to assist patients however they can. Patients can either call or visit the practice in-person where they will be helped to complete the triage form. However, patients have expressed concern about privacy, particularly after introduction of the new booking system. A conversation between a patient and receptionist can easily be overheard by everyone else in the waiting area. Yet patients who are not comfortable with a digital system, and so require support from receptionists, may need to provide personal or confidential information.

Patients reported varied experiences with telephone consultations. Most respondents had telephone appointments, with some describing them as satisfactory, while others found them either excellent or poor.

Communication

Both the management team and staff indicated that the most rewarding aspect of their job was helping patients, getting to know them, and reassuring them about their conditions. This sentiment was largely reflected by patients, who described their interactions with staff as helpful and friendly. Patients reported that staff were always willing to help, and to accommodate their needs. Several patients told us that GPs explained conditions and medications well during an appointment, and they felt reassured about how to manage their health issues. Patients also praised the Together Better programme which runs weekly social activities at the practice, telling us it was "valuable to elderly residents".

We have, though, received several responses from patients regarding poor staff interactions and not feeling listened to. While we didn't see evidence of this during our visit, the management team assured us that they deal with all complaints/concerns seriously and ensure that every patient gets the opportunity to be heard. You can find their complaints procedure here on the Practice website.

Patients have also told us that they were not informed about the new triage system and had to figure it out the first time they needed an appointment following this change. Many patients expressed frustration about this, as they were then unsure how things worked and had no information on what was happening or why. Following this, we worked with The Neaman Practice to ensure patients were informed of the new changes and organised several focus groups to review the new system. Dr Hillier attended our first focus group where she explained to patients why the changes were made and how to use the triage booking system. She also took the group through the online form and explained what they needed to do in different scenarios.

Feedback

The surgery provides multiple channels for submitting feedback and complaints, including:

- Letter
- Email
- Direct conversations with staff
- Website

Complaints are handled by the management team, thoroughly investigated, and responded to within 28 days. The management team explained to us the process and how they investigate any concerns patients may have. Despite the structured process, some staff were unsure if the complaints policy was clearly visible in the waiting area, with some only noticing a suggestion box instead of clear signage. While some patients understood how to submit feedback and complaints, others were unaware of the process.

The Patient Participation Group (PPG) plays a valuable role in engaging patients and providing feedback on services. The practice told us there are 20 people signed up to the PPG although attendance may vary each meeting. The management team encourages PPG members to help spread awareness of available healthcare services and changes coming up at the practice, as well as listening to their feedback regarding the practice. However, many patients were unaware of the group, and even

among those who knew about it, most had never attended a meeting. Only two patients reported receiving text invitations, suggesting that more effective outreach and engagement strategies may be necessary to increase participation.

Conclusion

Overall, our visit to The Neaman Practice was positive with some areas for improvement identified. Below, we have highlighted some of the aspects we observed and have included our recommendations for improvement as well.

In general, staff communicate well with patients; receptionists give clear information to patients over the phone and doctors can explain matters to patients during their appointments. Patients told us that they feel listened to, and that staff take the time to understand their issues. Staff reflected this and said that they enjoy the patient interaction in their work. Indeed, this was the best part of their job for some.

Despite multiple communication channels being in place, there are indications that a large part of the patient population is not fully aware of key information, such as the feedback and complaints process or the existence of the Patient Participation Group (PPG). Management and staff are making efforts to inform patients through digital screens, posters, and direct conversations, but some patients still report a lack of awareness. This gap raises concerns that crucial changes, such as the new booking system, may not be fully understood by all patients, leading to frustration when they attempt to access care.

The transition to a triage-based appointment system has been viewed positively by most. We have heard there has been an improvement in accessibility, efficiency, and patient prioritisation. The system ensures that those requiring medical attention receive an appointment within 72 hours while also directing others to alternative healthcare professionals such as pharmacists or physiotherapists where appropriate. Additionally, it allows for GPs to manage who needs an appointment urgently as cases are assessed as they come in and triaged to the most appropriate healthcare professional. Patients report more timely responses since the new system was introduced, and greater flexibility in meeting their healthcare needs, now that they can complete the form online.

There have, however, been some issues regarding communication about these changes, as patients were left unaware of the switch to a triage-based system, which caused some confusion. The practice worked with the reception team and Healthwatch City of London to rectify this, and ensure that patients were aware, as well as assisting them, to use the new system. This is still a work in progress, and we will monitor the feedback we receive regarding the triage system to assist the practice in improving this if needed.

Within the surgery, there are three waiting areas, the rooms are well lit and there is ample seating. There are various leaflets and posters around the practice, advertising different services and changes. There are two lifts as well as stairs which are signposted from reception.

Despite this, we observed several issues with the environment at the practice which we have addressed in our recommendations. These include a lack of clear directional signage throughout the building, unclear opening hours outside the practice, and their complaints procedure which wasn't displayed. We were also told that the lifts are unreliable and often break down, having a severe impact on patients who rely on them.

There is a thorough training pathway for all personnel. This differs for GPs and other staff but covers the same practice induction. This includes reading policies, shadowing other staff to understand each role and mandatory training e.g. safeguarding, fire safety. All staff regularly complete refresher courses and have the option to complete additional training where available. Staff report feeling supported by management and can discuss any issues or concerns when needed. Staff can request additional support or training via their line manager, and this is discussed during their review meetings on a regular basis to see if there was anything that would help them in their role.

Some staff felt there was a need for more training face-to-face as much of it is online currently. In-person training can be a beneficial learning style and helpful for where a more practical approach is needed. Staff also told us that they would like to see more team-building activities.

Overall, we observed many areas of good practice, and it is clear that staff are committed to their roles as well as to helping patients. We received many positive comments from patients regarding the care and compassion from staff, and several patients told us they really felt listened to.

Below we have identified some recommendations we feel would improve the patient and staff experience at the practice.

Recommendations

Recommendations have been made based on our observations and patient/staff interviews. The Practice Manager at The Neaman Practice was asked to respond to the following recommendations:

1) We recommend reviewing how the practice communicates with patients, particularly regarding important information or changes to the practice so that patients are fully informed about what is happening. This could also be useful for identifying how to advertise services patients can access at the practice or groups like the PPG.

Practice response: Improving Patient Communication and Service Accessibility:

Effective communication with our patients is a core priority at the practice. Over the past few years, we have significantly expanded and diversified the ways we communicate with our patient population. This includes trialling and implementing SMS messaging, launching a redesigned website, introducing digital apps, updating digital and physical posters throughout the surgery, and installing a new phone system with multiple options to help direct patients according to their preferences.

One of the key developments has been the introduction of an online triage system. This new system streamlines the patient journey by eliminating unnecessary steps and allowing patients to be directed straight to the appropriate clinician or team member best suited to address their needs.

We acknowledge that a major change such as the transition to the new appointment booking system—should ideally have been communicated more widely to our patient base. Unfortunately, our ability to send mass messages via SMS was unexpectedly limited due to changes in our Accurx SMS usage cap which we discussed with Healthwatch on their visit. This occurred just as we were preparing to roll out the new system in late 2024, and as a result, we were unable to communicate the change as broadly as we had intended.

Despite this challenge, we proceeded with the triage system implementation using all available resources. We worked closely with Healthwatch, the Patient Participation Group (PPG), and relied on in-practice materials and direct communication to support patients through the transition in the absence of SMS outreach.

We remain committed to transparent, accessible, and patient-focused communication and will continue refining our methods to better serve the community. Since the change and the visit in February, the way we communicate with patients has been streamlined. Although the cap on SMS messaging still exists, we have now clarified the use of email communications, which we are able to send. At the time, the ICB had not provided clear guidance on how Accurx usage would be charged to the practice, but the surgery has now received full clarification."

The practice has reviewed the use of SMS messages within the practice. We have received consistent feedback from patients expressing concerns about receiving too many non-essential messages from the practice. A significant portion of our patient population has indicated that they prefer not to be contacted about services they are not currently using or interested in, such as the Patient Participation Group (PPG), Healthwatch activities, or other optional community services events which throughout the year organisations send consistently.

Patients have communicated this feedback both directly through complaints and informally during interactions with staff. Many have shared that they prefer a more streamlined communication approach, where the practice contacts them only when necessary for their direct care—such as appointment reminders, test results, or medication-related issues.

While we understand the importance of promoting engagement and raising awareness of available services, we must also respect the preferences of the wider patient population. Over-communication risks causing frustration and disengagement and can lead patients to ignore or opt out of important practice messaging altogether.

In response, we have adopted a more balanced strategy. We continue to promote key initiatives like the PPG through annual messages, practice posters, and targeted outreach via community channels. This ensures patients are still informed and able to engage if they choose to, without feeling overwhelmed by frequent updates they may not find relevant.

Our Patient Participation Group (PPG) has been featured on the homepage of our website for some time, and we regularly send annual messages and updates to our patients. However, to maintain a sustainable balance, we also need active engagement from our patient community.

We understand that not all patients use digital platforms, so we've taken additional steps to improve visibility. Clear signage has been placed along the route to the consultation rooms for those attending the practice in person, and we've also promoted key information through local community channels, including the Barbican.

We remain committed to keeping patients informed, but with a population of over 9,000, we encourage the use of the tools we've put in place to stay connected and involved.

2) The booking process for follow up appointments is unclear. We recommend reviewing the process for this and sharing this with patients, as they are unsure whether they need to book these, or if the practice will do this for them. There is no information available to support this.

Practice Response to Follow-Up Appointment Booking Process:

We understand that some patients have experienced confusion regarding whether they need to book their own follow-up appointments. In response, we have taken several steps to improve clarity and consistency:

- **Staff Re-briefing:** All clinical and non-clinical staff have been reminded to clearly inform patients during consultations whether a follow-up appointment has been booked for them, or if they are expected to contact the practice to arrange it themselves.
- **Website Update:** We have updated the Appointments section of our website to include clear guidance on how follow-up appointments are managed. This includes steps for patients to follow depending on whether their follow-up is clinician-led or patient-initiated.
- **Reception and Online Support:** Patients can easily indicate that they require a follow-up when submitting an online consultation form, or by informing reception who are happy to assist and clarify the process. Doctors in the practice actively monitor their patients and contact non responders when they have disengaged when needing to follow up with their health.

3) We recommend that staff are reminded of process and procedures within the practice such as the process for medication reviews, NHS health checks, follow up appointments etc, so that staff are consistent with the information they are sharing with patients.

Practice Response to Staff Consistency on Processes and Procedures:

The processes for medication reviews, NHS Health Checks, follow-up appointments, and similar procedures have remained consistent over time. There have been no recent changes to these processes themselves.

We have reminded staff to continue following these established procedures and to communicate them clearly and consistently to patients. Information is readily available online and within the practice for both staff and patients.

Any confusion observed is likely related to changes in the appointment booking system (such as the introduction of online triage), rather than the underlying clinical or administrative processes. We will continue to support staff to ensure patients receive clear, consistent information. At this time, based on my review and investigation, I have not identified any discrepancies in the information provided to me regarding this process. However, I welcome Healthwatch to share any specific observations they may have that could help highlight where any inconsistency might exist.

4) Outside the practice, the opening hours state the hours they are open, but not the days. We recommend this is updated clearly to state what days and times the practice is open, as well as what to do if they are closed. It may also be helpful to note that the practice does offer extended hours on some days.

Practice Response to Opening Hours Signage Recommendation:

We appreciate the recommendation regarding clarity of our opening hours displayed outside the practice. The current permanent signage attached to the building, referenced in the report, includes outdated times that do not reflect our current schedule.

We have previously attempted to remove or update this fixture; however, due to the age and condition of the mounting hardware, this has proven challenging. We will proceed with removing the incorrect times to avoid any confusion.

To ensure patients have easy and immediate access to accurate information, we have added the current opening times to the front doors of the practice. However, these details have not been added to the permanent external fixtures due to logistical challenges with updating them with damaging the building.

The practice operates every working day during standard hours, and these opening days remain consistent and unchanged as per NHS England guidelines to opening contracted hours. While we understand the suggestion to add further details such as extended hours and instructions for when the practice is closed, updating permanent external signage is difficult and involves significant constraints and we have taken the time due to recommendations to explore the update with the printers and the owner of the building.

We continue to provide clear and up-to-date information on opening times and out-of-hours procedures through other channels such as our website, appointment letters, and internal signage within the practice.

5) We were unable to find the complaints information displayed in the practice during our visit, we recommend that this is displayed clearly in the waiting areas in an accessible format. It may also be helpful to display these in different languages or have copies of these available upon request.

Practice Response to Complaints Information Display Recommendation:

We were surprised to learn that complaints information was not observed during the visit, as signage is displayed prominently on each floor between the lifts. Following recent management updates, we have replaced old signage featuring the previous practice managers name with updated signs reflecting the current management team these are being laminated and readded in the waiting areas, with the option to provide more informal feedback with the addition of new suggestion boxes displayed centrally on each floor as the previous suggestion boxes were outdated.

To reduce confusion caused by an excess of posters, many notices have been transitioned to digital display screens throughout the building. However, complaints information has always been maintained and is now will also be featured on digital screens additionally for greater visibility, especially for patients who may not notice wall signage.

Additionally, suggestion boxes are available within the practice for patients wishing to provide feedback or raise concerns, practice feedback in writing. Our website also offers multiple channels for patients to submit compliments, complaints, suggestions, or to express interest in joining the Patient Participation Group (PPG), further encouraging patient voices to be heard.

We are always open to adding further signage or alternative formats to enhance the accessibility and visibility of complaints information for all patients if required.

6) We recommend there be information displayed in the waiting room stating that patients can request a private space to talk, if they would prefer this. Patients have expressed concern particularly following the change to a triage system, there may be more opportunity for privacy issues to arise, and patients may not want to share details of their condition at the reception desk.

Practice Response to Privacy and Private Space Request Recommendation:

We recognise the importance of patient privacy, especially following the introduction of the triage system, and the need to support patients with additional needs.

The practice has recently completed staff training focused on understanding and accommodating patients who require private or quieter spaces to express themselves, particularly those with additional needs such as autism. The practice has been awarded an Autism Awareness badge in recognition of this training.

To support this, signage informing patients that they can request a private space is now clearly displayed at each reception area across all floors. Reception staff are also trained to proactively offer private conversations when appropriate, ensuring all patients feel comfortable and respected when sharing sensitive information. We are committed to fostering an inclusive and supportive environment where all patients feel understood and respected, and we continuously seek to improve staff skills to meet diverse patient needs.

7) Staff expressed an interest in more face-to-face training sessions as they find this a helpful learning style; we also recommend that staff complete more in-depth training on disabilities and patients who have communication needs e.g. language barrier, elderly

Practice Response to Staff Training Recommendation:

We acknowledge the value of face-to-face training, as expressed by our staff, who find this approach particularly effective for learning.

The practice actively participates in a variety of training opportunities, including those offered by Northeast London (NEL) Clinical Commissioning Group and other providers. We hold Protected Learning Time (PLT) sessions quarterly, during which the practice closes for approximately four hours to allow staff to engage in in-depth training.

Due to the COVID-19 pandemic, many training sessions and professional development activities have shifted to online formats. Despite this, we remain committed to ensuring staff receive comprehensive training. Mandatory training

8) The lifts are often out of order and are prone to breaking due to being old. We recommend a review of this, as regular breakdown can cause a significant impact to patients with access needs attending appointments.

Practice Response to Lift Maintenance Recommendation:

We acknowledge the concerns regarding the reliability of the lifts and the impact this can have on patients with access needs.

While lift engineering is not our area of expertise, we have investigated the reported issues and engaged with the current maintenance company, although their responses have been limited. To ensure a thorough assessment, we have arranged for an independent third-party inspection of the lifts and are actively in discussions with the landlord regarding necessary repairs or upgrades.

It is very rare that both lifts are out of order at the same time; typically, at least one lift remains operational to assist patients. In the unlikely event both lifts are unavailable, we have developed a strategy to manage the situation. This includes a protocol to prioritise patients with mobility difficulties by ensuring they are seen on the ground floor or in areas accessible without using the lifts, minimising disruption to their care.

We are committed to resolving these issues promptly to maintain safe and accessible services for all patients. We are currently still exploring where the issues lay in terms with the lift but are confident will be rectified with the persistent approach we have taken.

9) The PPG is a useful tool in gaining feedback from patients however most patients aren't aware of the group. We recommend advertising the PPG to all patients and ensuring it's organisation is inclusive e.g. thinking of shift workers or parents, to encourage uptake in members.

Practice Response to PPG Awareness and Engagement Recommendation:

We recognise the value of the Patient Participation Group (PPG) as a tool for gaining patient feedback. To increase awareness, we have added additional signage throughout the building to inform patients about the PPG and how to get involved.

We continue to use SMS messaging platforms annually to promote the group and encourage new members to join. Information about the PPG is also widely available on our website and is actively shared with Healthwatch and within the local community.

Although we actively ask patients for their preferences regarding participation, feedback indicates that many from the wider patient population choose not to attend for various reasons. To accommodate this, we cater to both virtual meetings and festive face-to-face events for current PPG members. And have recently received feed back that the active members prefer the virtual settings and gather at the festive time.

We remain committed to adapting to the evolving needs of the group and ensuring the PPG remains inclusive, accessible, and responsive to patient input.

Our primary focus remains on delivering high-quality patient care, and we actively promote patient engagement as an essential part of that commitment.

10) The signage within the building is limited and can be confusing for patients when accessing the practice. We recommend clearer signage to direct patients around the building and ensuring there is no confusion with external services on other floors.

Practice Response to Signage Recommendation:

There have always been signs on each floor within the building, including clear markers in the shared staircase area and doors indicating whether the services on that floor are NHS or provided by Evolve who share the same facilities as the practice.

Additionally, we n have recently added further signage, including signs identifying consultation rooms that are visible from the waiting areas, as well as signs directing patients to the stairs.

We will continue to review and improve signage where possible to ensure patients can navigate the building easily and without confusion.

Message from the Neaman Practice:

Thank You to Healthwatch !

We would like to sincerely thank Healthwatch for attending the Neaman Practice and for their continued support to both our patients and the practice over the years. Your dedication to listening to the patient voice and promoting improvements across services is greatly appreciated.

We invited Healthwatch to visit at a time when the practice was undergoing several significant changes, particularly due to a new management structure and patient access due to change in the appointment triage process. Since then, we have worked hard to address many of the items highlighted in your report and continue to build on the feedback received.

We were particularly grateful for the eye-catching and thoughtful observations made from a service user's perspective. While there may not have been a large volume of feedback, the quality and insight it provided have been very helpful in guiding further improvements.

We would be very pleased to welcome Healthwatch back to the practice at any time to see the progress we have made and to continue this valuable partnership.

We remain committed to providing a high standard of care and continuously improving the services we offer. We would like to thank all those who contributed to this review and welcome any further suggestions or feedback from patients, Healthwatch, and our Patient Participation Group (PPG) members. If there are any concerns or ideas for improvement, we encourage them to be shared directly with the management team. We are always open to constructive feedback and will actively work to make positive changes wherever possible.

Sinead R Downes – Operations Manager

Appendix

Questions for GP's/Management at the Neaman Practice

1. **Name of Authorised Representatives (if applicable):**

2. **Date:**

   Appointment booking:

3. **When booking an appointment, please explain the methods available to patients.**

4. **Do patients have the option of a face to face or telephone appointment and how do they specify this?**

5. **Is there any special provision in place for people known to have other needs? (such as disabled people, those without computers/phones, or foreign language speakers)?**

6. **Does the practice provide access to interpreters if needed? What is the process for this?**

7. **Do you have a procedure for patients that regularly cancel or don't attend appointments?**

8. **Do you have a system in place to monitor phone calls? Does this work well?**

9. **What do you feel works well about the new booking system?**

10. **What do you feel could be improved?**

Consultations:

11. **NHS England's guidelines urge practices to provide face-to-face appointments where required, or desired. What do you think are the main challenges you face – as a practice – around this?**

12. **Are patients asked if they have any preferences about the consultation method (such as in person, telephone, or video)? Are the preferences taken into account?**

13. **Is there any flexibility for people who work, or look after school-aged-children (either when booking or attending appointments)?**

14. **How long are patients allocated with the doctor? What is the procedure if this runs over? E.g how are other patients informed.**

15. **Do you know if telephone appointments are generally on time, and is there any procedure if running late?**

16. **What do you feel works well about the consultation system?**

17. **How long is the emergency appointment slot? What is the process for this being booked?**

Engagement and Feedback:

18. **Are patients encouraged to give feedback (such as compliments or concerns)? If so, how?**

19. **Is there a PPG? If so, how many attend etc?**

20. **Is there a clear complaints process in place? Is the complaints policy on display in the waiting area?**

21. **What is the procedure for dealing with complaints?**

Staffing:

22. **How many GP's and nurses are employed here?**

23. **Do you recall having received an induction?**

24. **Have you received any training, including recently?**

25. **Are you aware of the Accessible Information Standard (AIS)?**

26. **Have you been provided with training on how to support patients with:**

    Visual impairments: blind & partially sighted
    Online
    Face to face
    Both

27. **Hearing impairments: profoundly deaf & hard of hearing**

    Online
    Face to face
    Both

28. **Learning Disabilities**

    Online
    Face to face
    Both

29. **How would a patient that has a specific need be identified? i.e had hearing impairments, visual impairments or learning disability?**

30. **Is there a hearing loop in the surgery, if there is what type of loop is it?**

31. **How would a patient with a hearing impairment know that they had been called for their appointment?**

32. **Do you feel that management are supportive towards staff generally?**

33. **Regarding your work and working conditions, do you feel that anything could be improved?**

34. **Can you tell me what you enjoy most about your job?**

35. **And what do you find most difficult?**

Governance and information

36. **Have you received GDPR training? When was that?**

37. **How do patients who aren't digitally literate (don't have a phone or computer) receive test results, information about vaccinations or screenings?**

38. **How are people made aware of the other services offered e.g. Pharmacy First Scheme and the Physio First scheme?**

39. **How many patients are registered at the surgery?**

40. **(If talking to a GP) How many patients do you see on an average day?**

Questions for Staff at the Neaman Practice

1. **Name of Authorised Representatives (if applicable):**

2. **Date:**

    Appointment booking:

3. When booking an appointment, please explain the methods available to patients.

4. Do patients have the option of a face to face or telephone appointment and how do they specify this?

5. Is there any special provision in place for people known to have other needs? (such as disabled people, those without computers/phones, or foreign language speakers)?

6. What do you feel works well about the booking system?

7. What do you feel could be improved?

Consultations:

8. NHS England's guidelines urge practices to provide face-to-face appointments where required, or desired. What do you think are the main challenges you face – as a practice – around this?

9. re patients asked if they have any preferences about the consultation method (such as in person, telephone, or video)? Are the preferences taken into account?

10. Is there any flexibility for people who work, or look after school-aged-children (either when booking or attending appointments)?

11. Do you know if remote appointments are generally on time, and is there any procedure if running late?

12. What do you feel works well about the consultation system?

13. How long is the emergency appointment (call) slot?

14. How are people made aware of the other services offered e.g. Pharmacy First Scheme and the Physio First scheme?

Engagement and Feedback:

15. Are patients encouraged to give feedback (such as compliments or concerns)? If so, how?

16. Is there a clear complaints process in place? Is the complaints policy on display in the waiting area?

Staffing:

17. **Do you recall having received an induction?**

18. **Does the practice provide access to interpreters if needed?**

19. **Are you aware of the Accessible Information Standard (AIS)?**

20. **Have you been provided with training on how to support patients with:**

    Visual impairments: blind & partially sighted
    Online
    Face to face
    Both

21. **Hearing impairments: profoundly deaf & hard of hearing**

    Online
    Face to face
    Both

22. **Learning Disabilities**

    Online
    Face to face
    Both

23. **How would a patient that has a specific need be identified? i.e had hearing impairments, visual impairments or learning disability?**

24. **Is there a hearing loop in the surgery, if there is what type of loop is it?**

25. **How would a patient with a hearing impairment know that they had been called for their appointment?**

26. **Do you feel that management are supportive towards staff generally?**

27. **Regarding your work and working conditions, do you feel that anything could be improved?**

28. **Can you tell me what you enjoy most about your job?**

29. **And what do you find most difficult?**

Questions for patients at the Neaman Practice

Appointment booking:

1. **How do you book your appointments?**

2. **Were you able to make the appointment easily? (is the online system easy to use? Did it take long to get through on the phone? Was the appointment at a convenient time for you?**

3. **Were you happy with the length of the wait between trying to make the appointment and seeing the GP?**

4. **Were you offered an appointment with your usual doctor? A nurse practitioner? A specific service? (asthma clinic etc)**

5. **If you needed to book a follow up appointment, how easy was it do to?**

Consultation:

6. **Have you had online/phone consultations?**

7. **If so, how have the online/phone consultations been in terms of quality, duration and scheduling?**

8. **Have the scheduled appointments (online/virtual/phone/in person) been on time?**

9. **Are you happy with the quality of your treatment? Are there any areas of concern or improvement that you can identify?**

10. **Have you been given choice regarding where you can attend your specialist appointments? For example, X-RAYS, physio and blood tests.**

Engagement, Feedback and Experience:

11. **Are you aware of the feedback procedures available at the surgery? (For example, compliments or concerns).**

12. **Are you aware of the complaints process in place? Have you noticed the complaints policy display in the waiting area?**

13. **What is your general experience of dealing with the staff members? (Do you feel supported, well-heard, treated with dignity and compassion?)**

14. **Are you aware of the Patient Participation Group (PPG) at the Neaman Practice?**

    No
    Yes, I have attended
    Yes, I have not attended

15. **Have you ever received a text message from the Neaman Practice inviting you to their PPG meetings?**

    Yes
    No

16. **Are there any other comments you would like to make?**

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

This page is intentionally left blank



Barts Health NHS Trust Cardiology Department Enter and View Report

healthwatch City of London

Contents

Contents	1
Visit Details	4
Results	6
Interviews with the Management Team	15
Interviews with the Staff Team	20
Interviews with Patients	27
Recommendations	32

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.

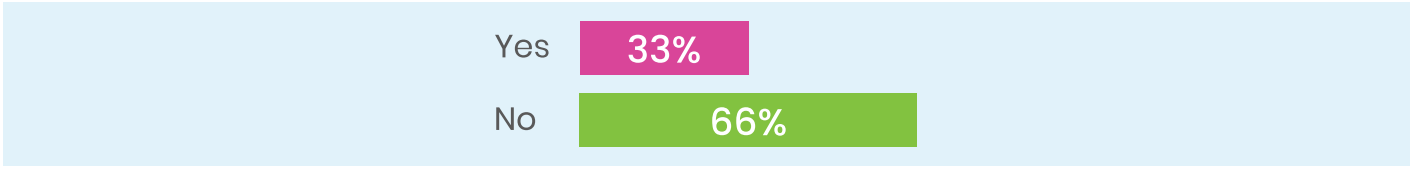
Survey Feedback

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.

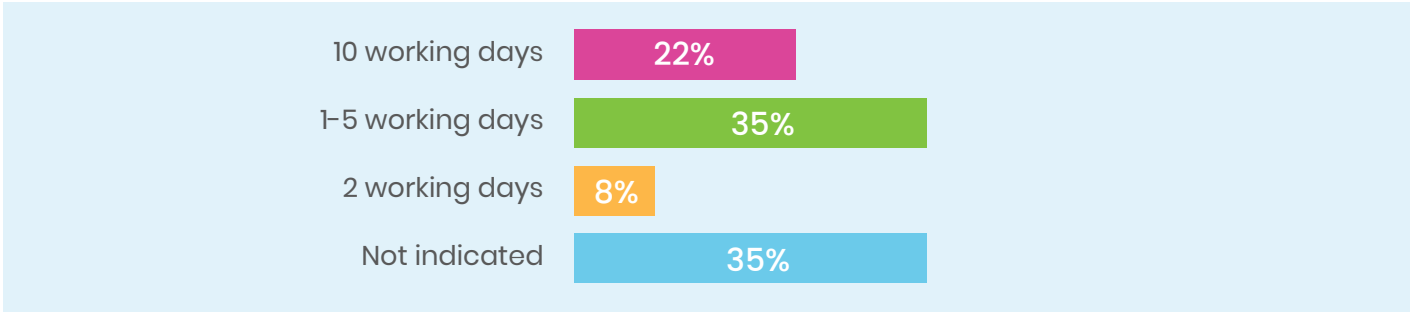
Q1 Have you received an appointment letter from the Barts cardiology department that contained incorrect information?



Comments:

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

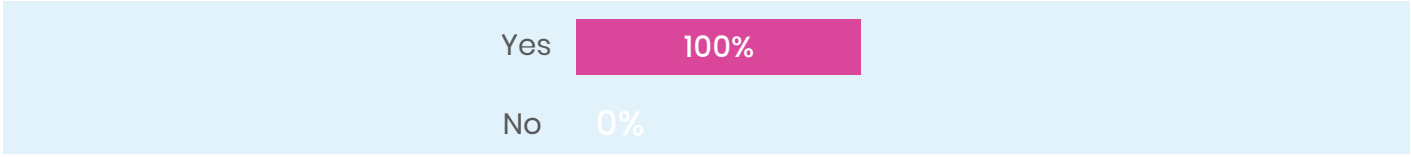
Q2 Have you received an appointment letter that was missing or had insufficient contact information in it? (no phone number for the department, no email address for the department)



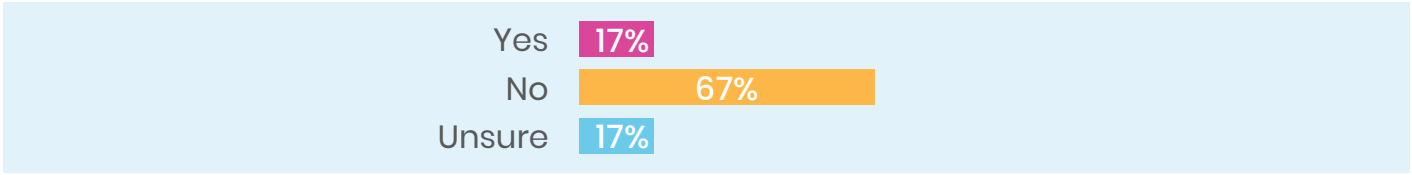
Comments:

- 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.

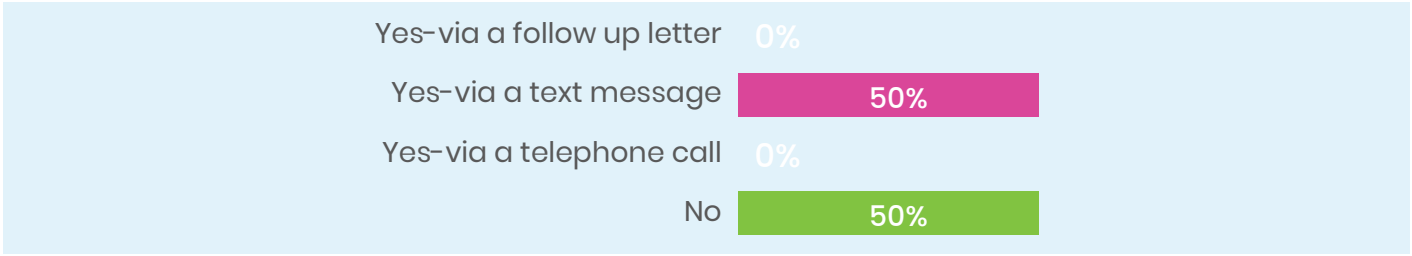
Q3 Did the letter you received stipulate if the appointment was in person or virtual (telephone or video call)?



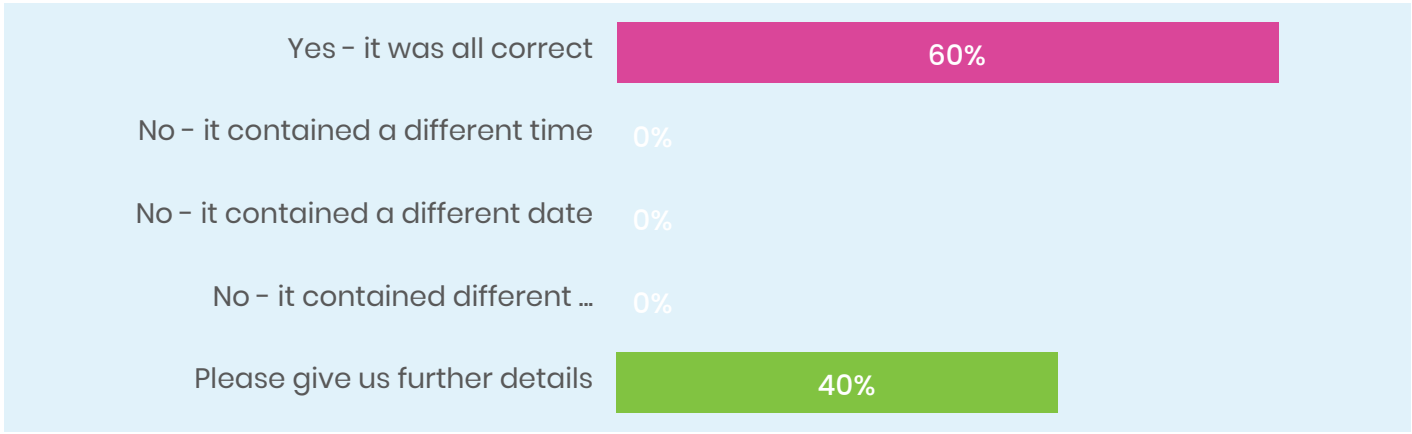
Q4 Did the letter give you the option to obtain the details in your preferred language?



Q5 Before your appointment did you receive a timely reminder?



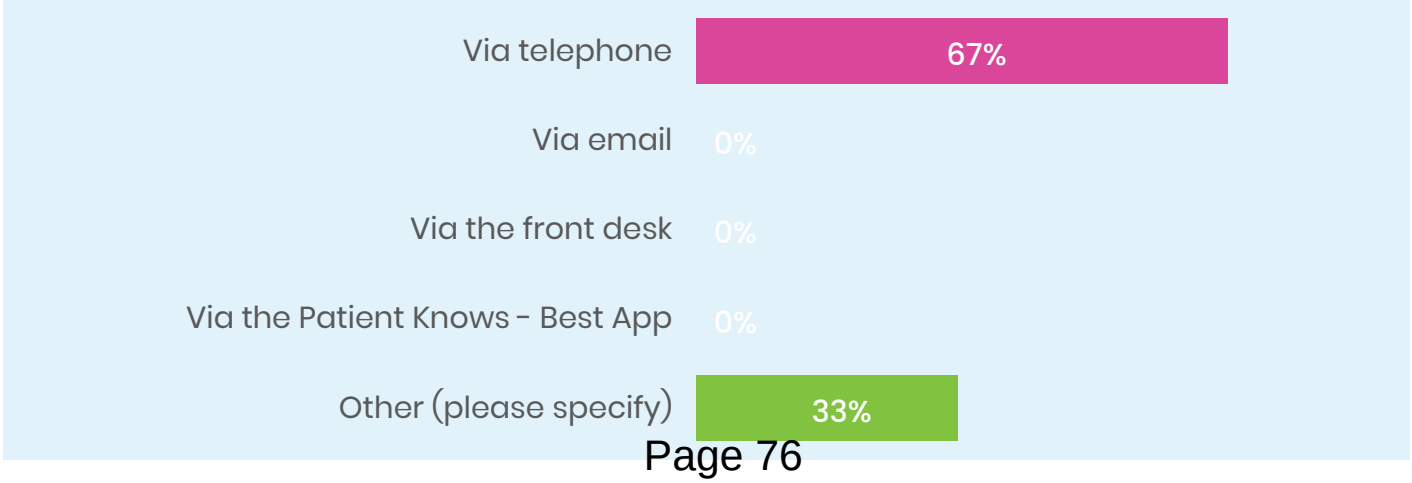
Q6 Did the reminder information contain the same information as the original appointment



Comments:

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

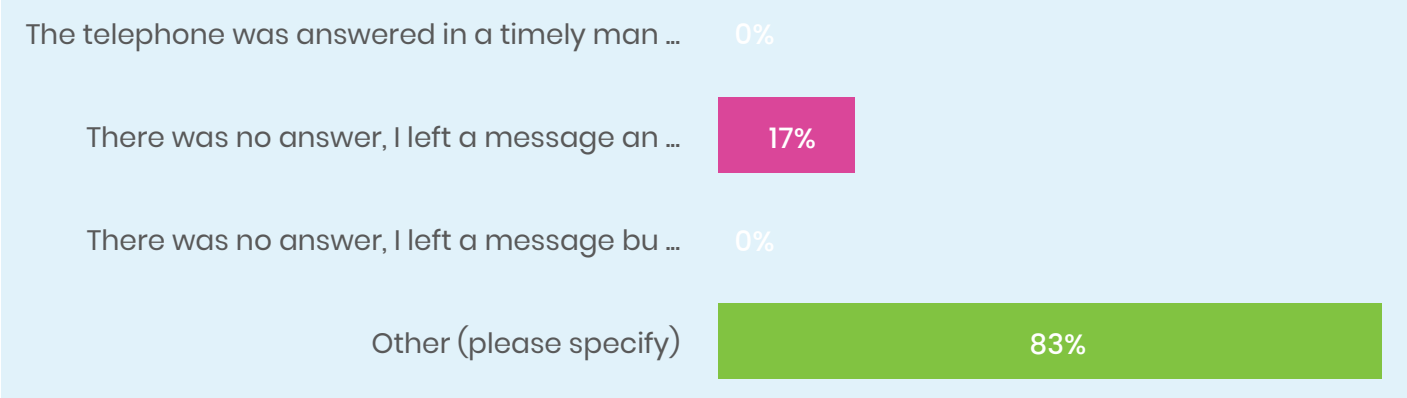
Q7 If you tried to contact the department, how did you do this?



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.

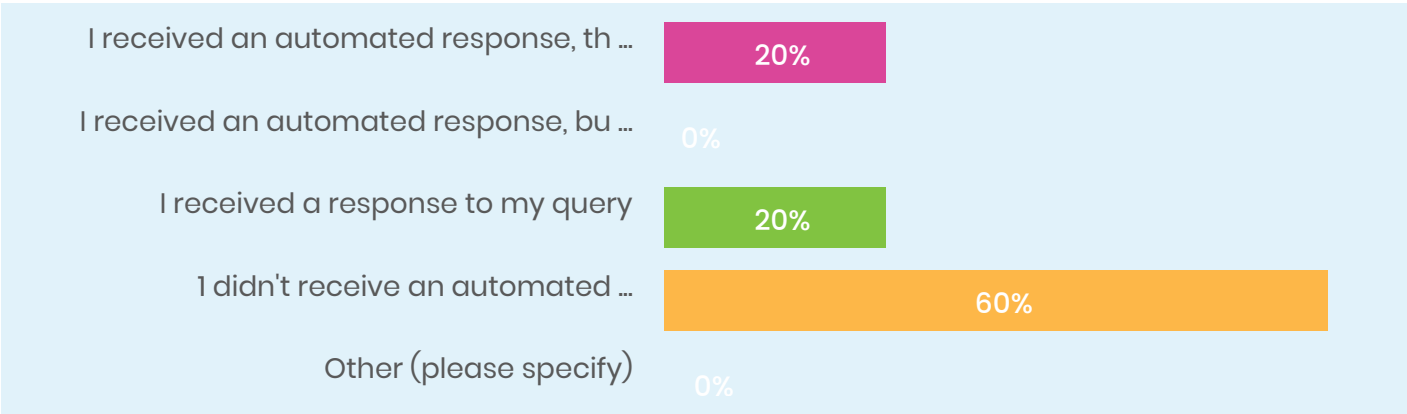
Q8 If you contacted the department via telephone, please let us know of your experience.



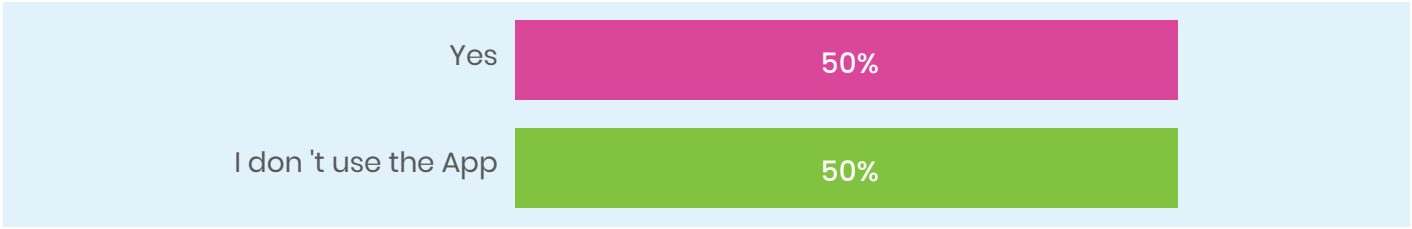
Comments:

- 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.



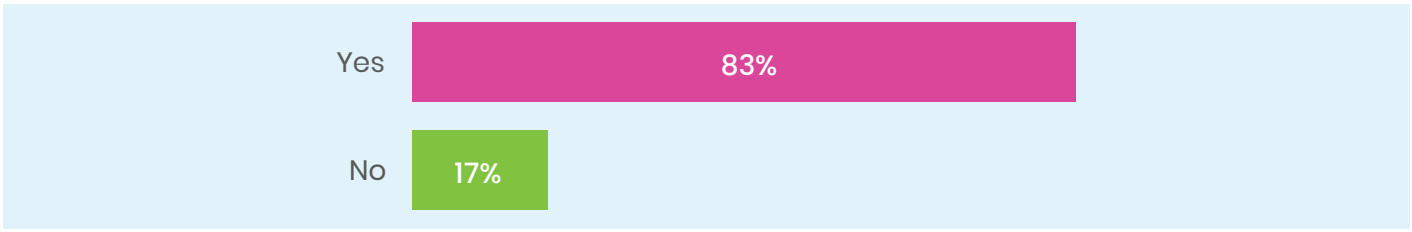
Q10 If you use the Patient Knows Best App, was your appointment information correct within it?



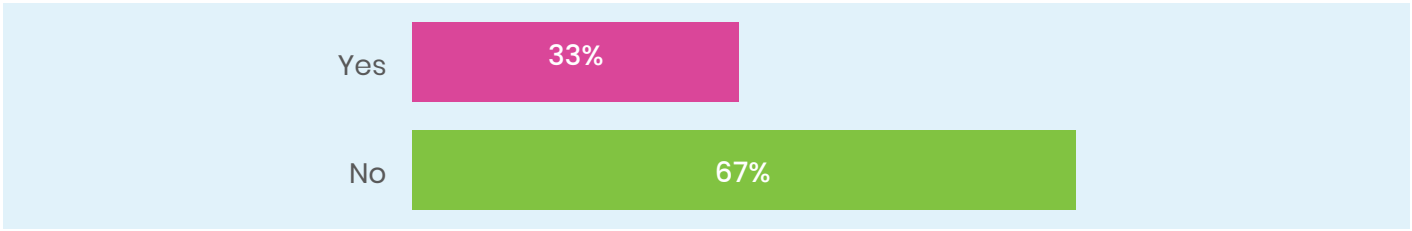
Comments:

- 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.

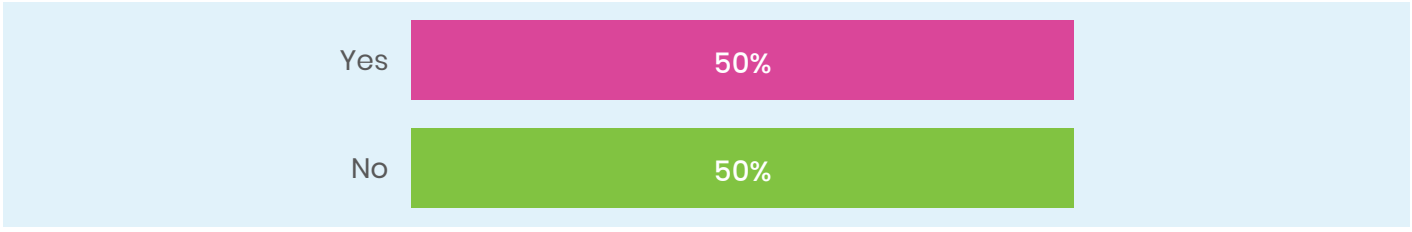
Q11 Did you receive information on how to get to your appointment and where to report to with your appointment letter?



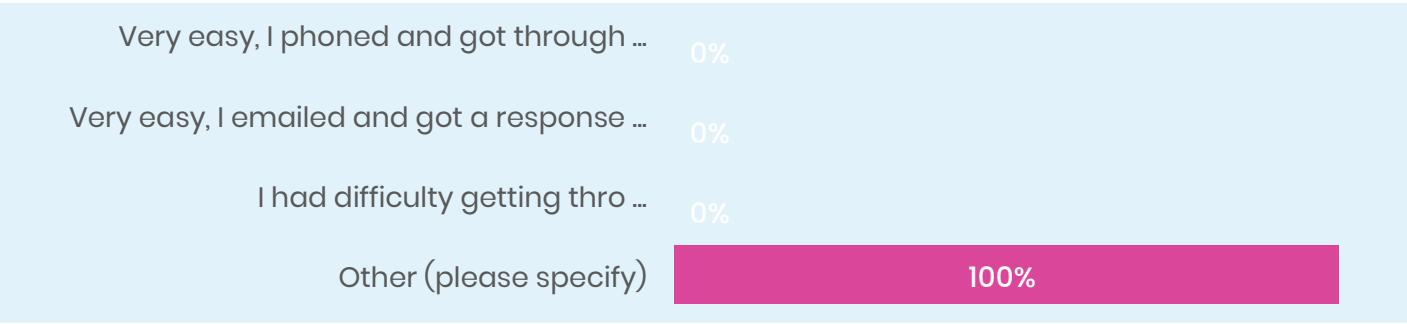
Q12 Did you receive further information with your appointment letter? Such as an information leaflet on your condition.



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.

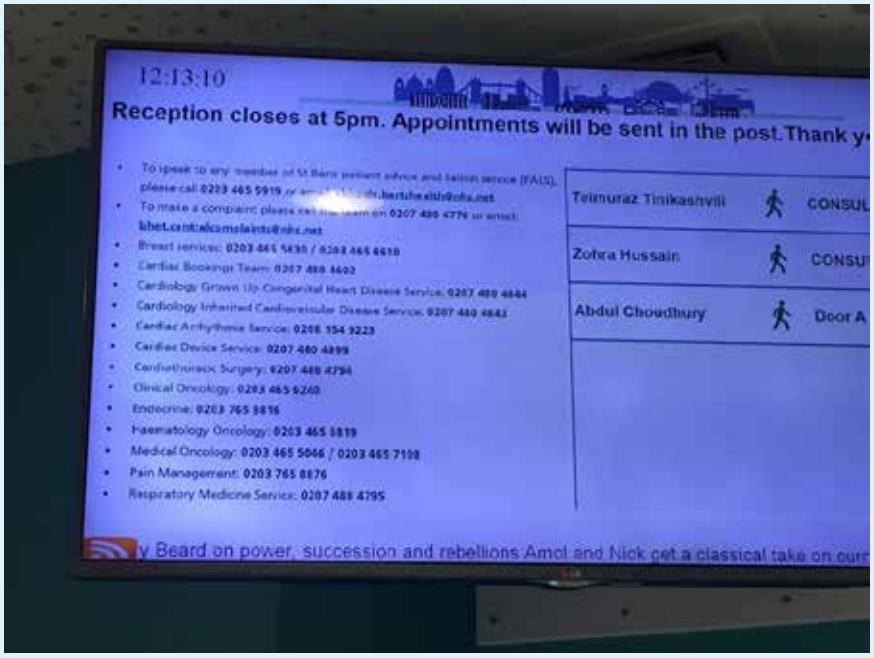


Figure 1. The screen at reception

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

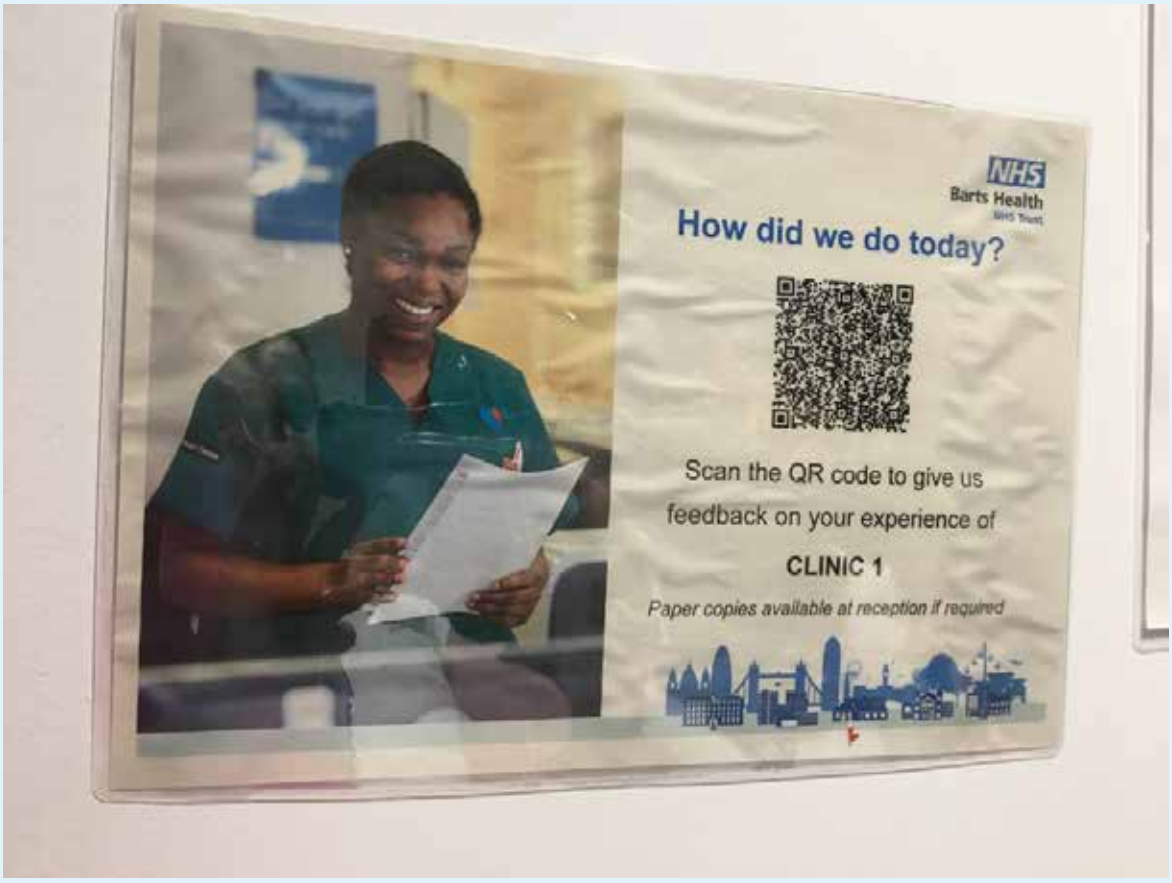


Figure 3. Barts Trust questionnaire poster with misleading QR code

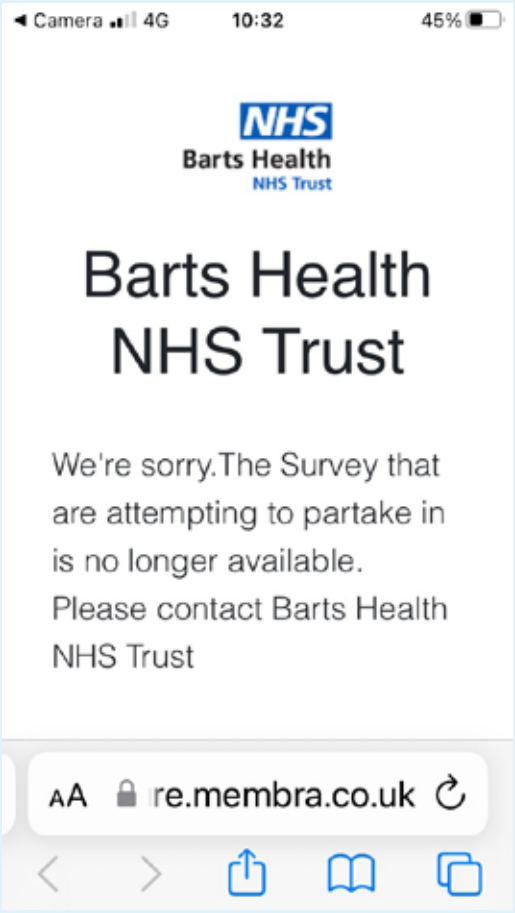


Figure 4. Screenshot of the unavailable survey when we tried to access it



Figure 5. Have your say poster

Interviews with the Management Team

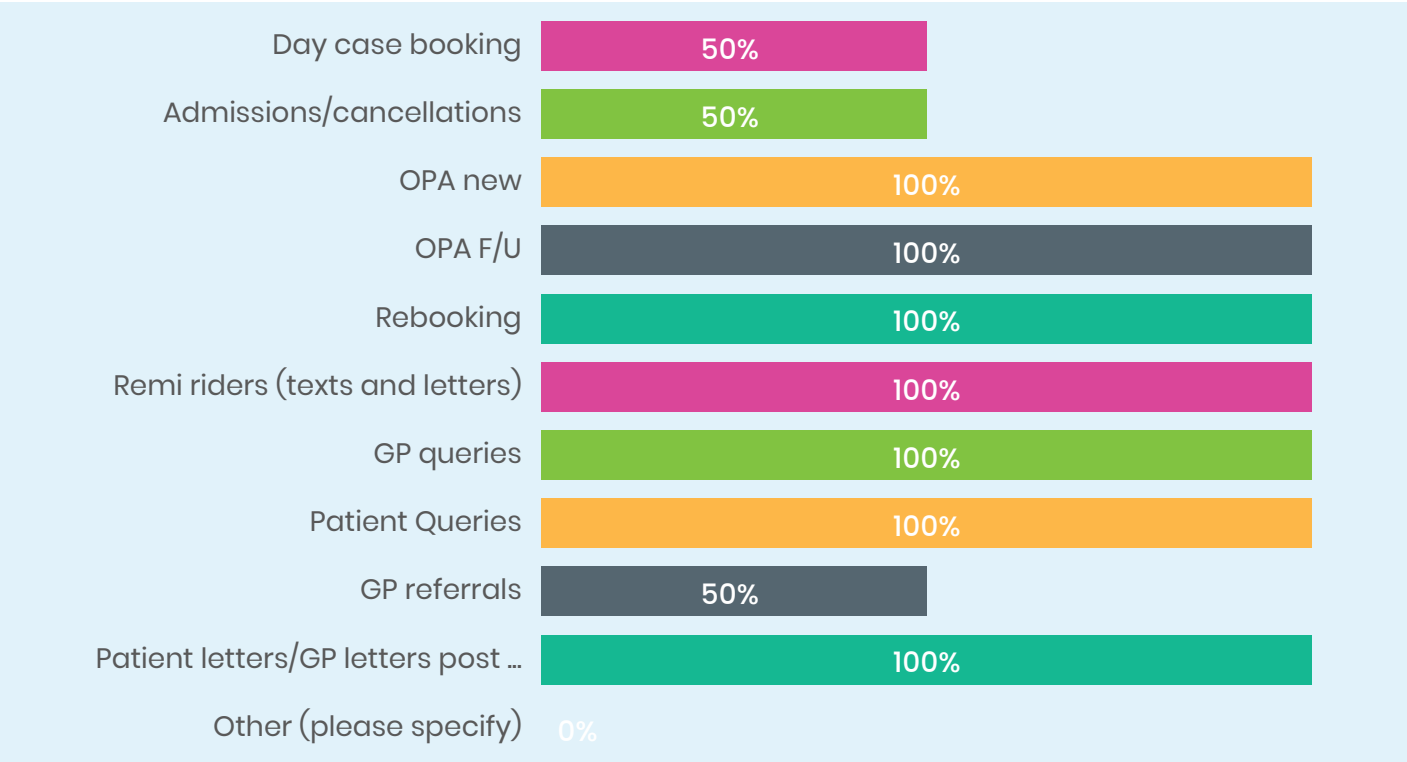
During the visit the team interviewed four managers including the General Manager for Electro Physiology, Intervention and Networked Cardiology, the Service Manager and the Delivery Manager and the Deputy Delivery Manager for that department.

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.

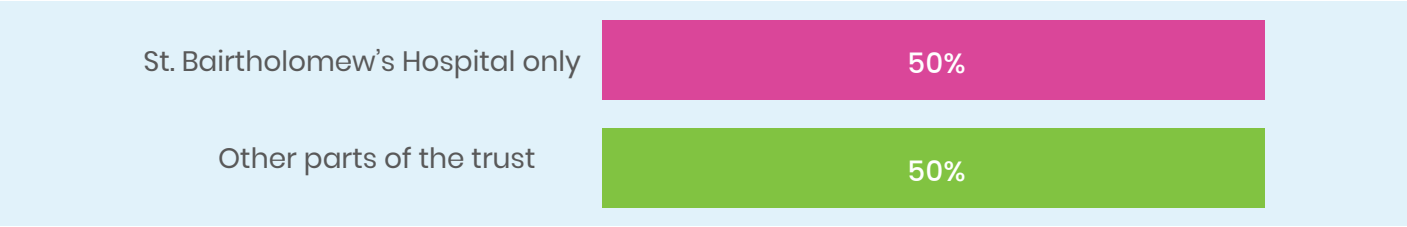
Question 2. How many patients do you see or contact a year?

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.

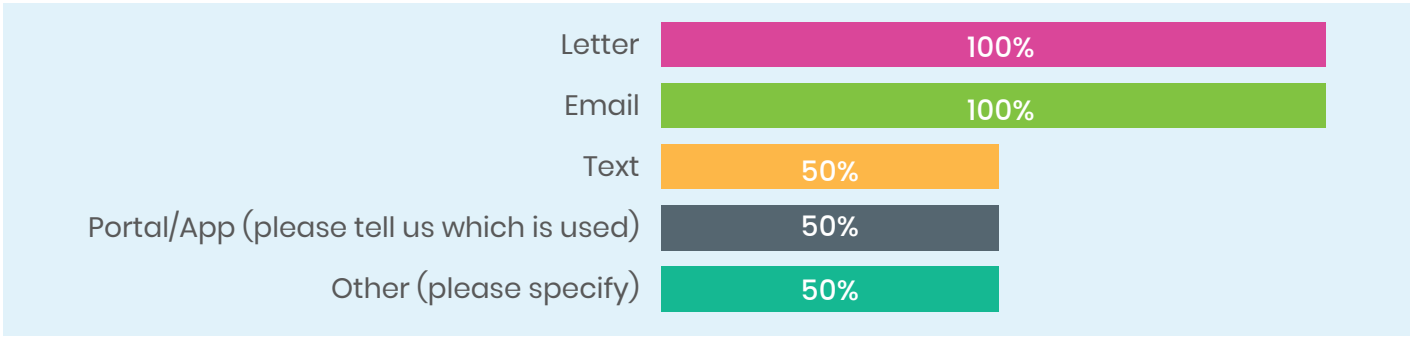
Question 6. How are patients informed of these waiting times?

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.

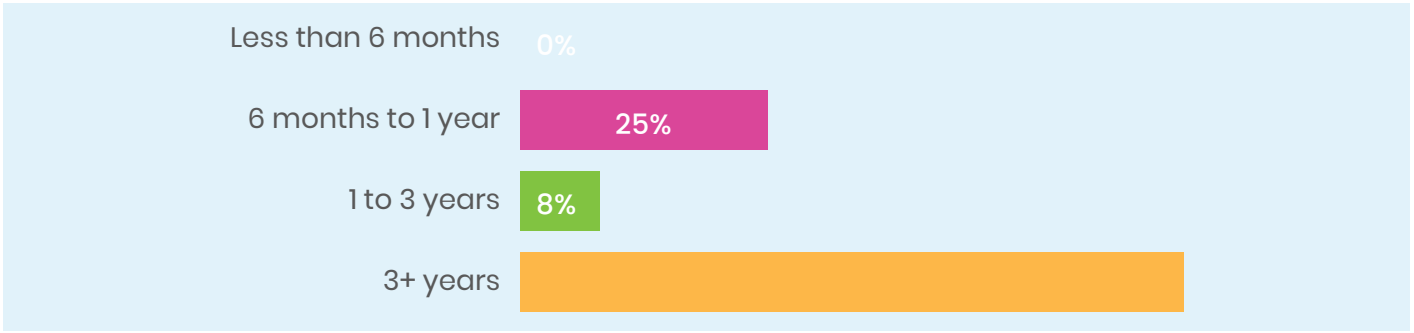
Questionnaire for staff and team members

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?



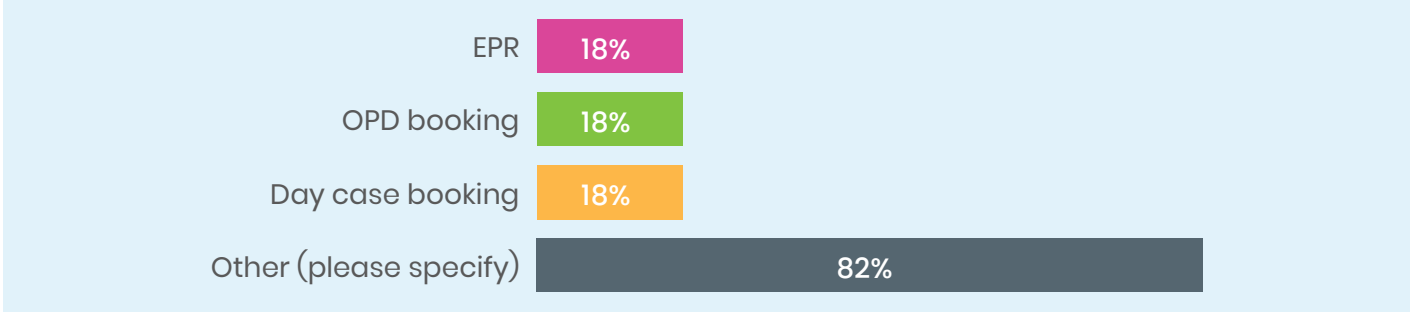
Most members of staff have worked in this department for over three years at 66 percent, whilst 25 percent have worked in this department from 6 months and 8 percent have worked in this department for 1 to 3 years.

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.

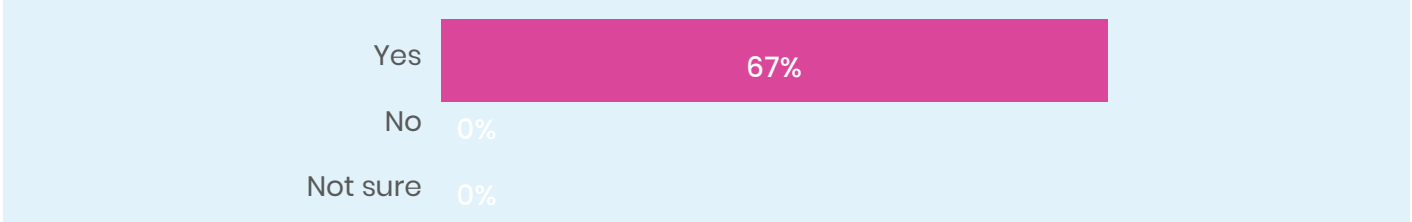
Observation: There is a high number of systems used; each system is used for different tasks. However, a reduction in the number used would streamline the process of patient communication and patient records. The fewer systems used the chances of incorrect information entered also lessens.

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."

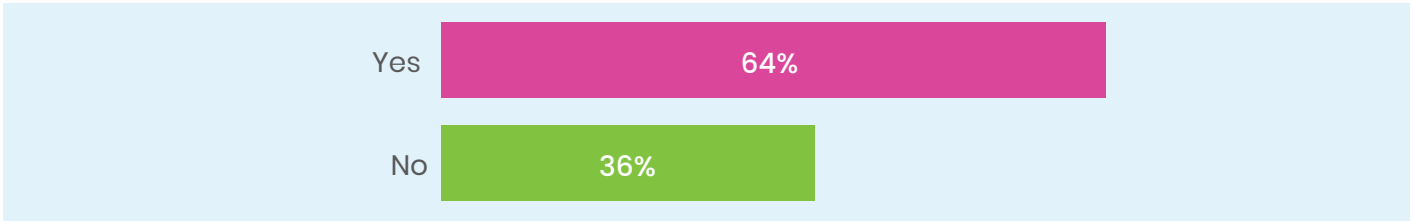
One member of staff had previously worked in Newham Hospital, so had an understanding and knowledge of the role. At Barts, they received 2 days of online training and were shown the appointment bookings and discharges which is a similar procedure to Newham Hospital.

Question 6. Do you think the training was adequate for you to carry out the role?



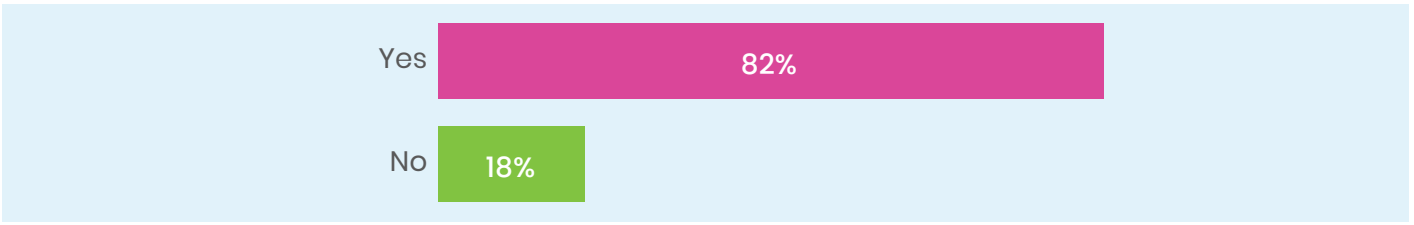
Over 60 percent of staff believe that the training was adequate for them to carry out their role, with one staff member speaking on "there has recently been an improvement in training", she went on to explain that there are new training courses available, and they have now attended more. Although not 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.

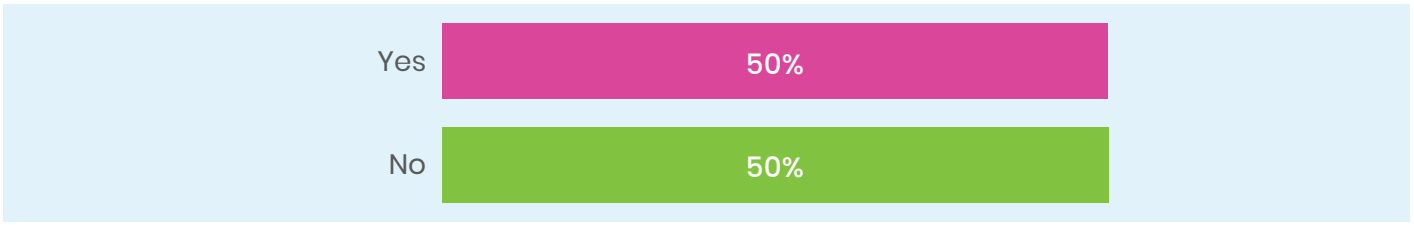
Question 8. Do you feel this is adequate?



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?



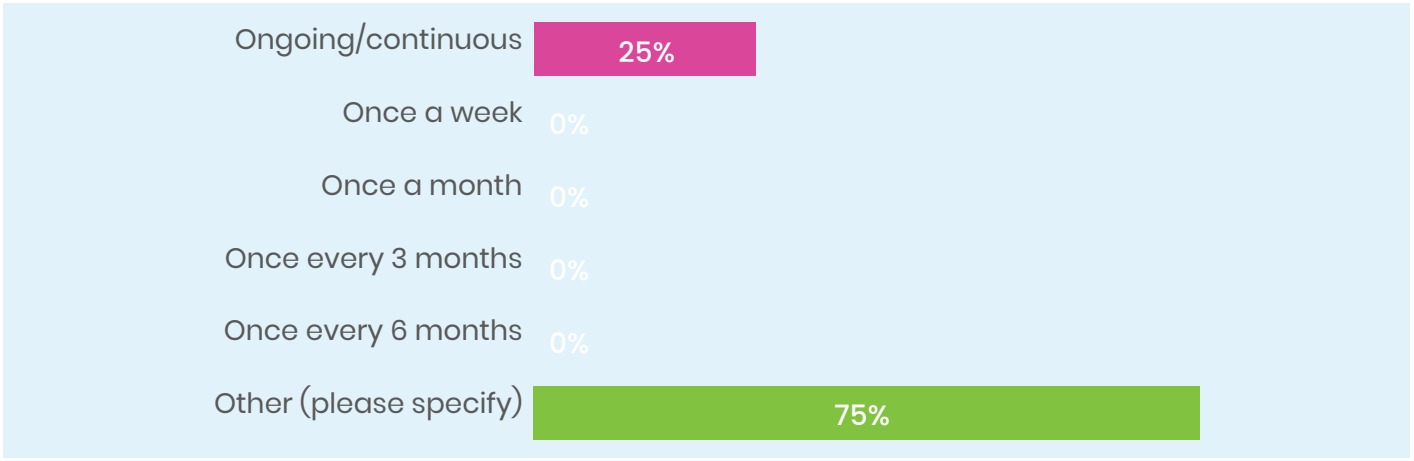
Half of the members of staff interviewed were responsible for supervising or training other members of staff, one member of staff stated that for new members of staff, they, "check what they have and what they need and encourage them to take training opportunities" whilst another experienced member of 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".

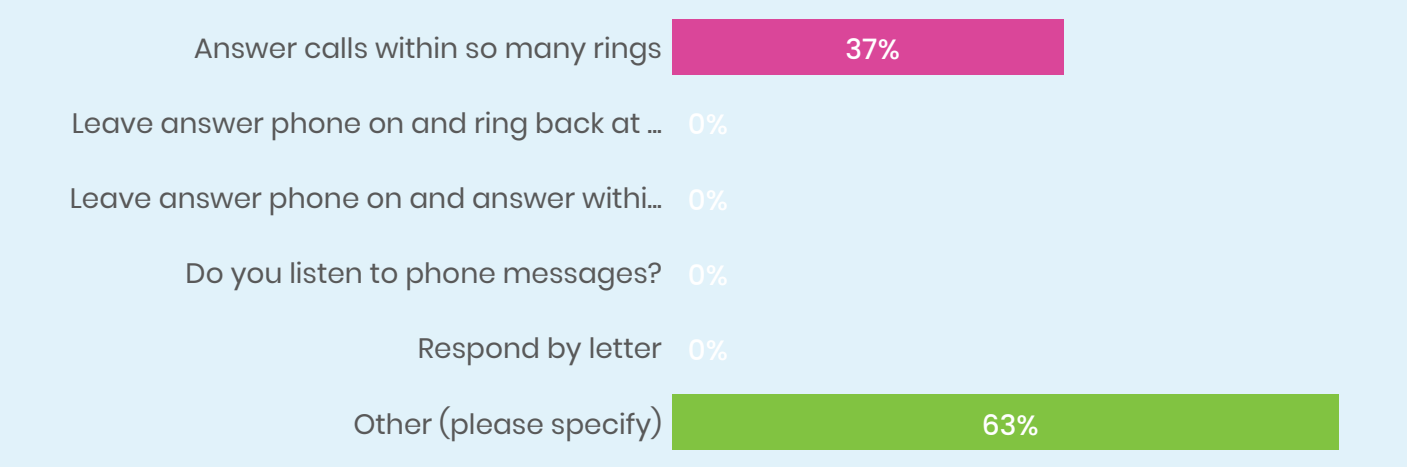
Observation: as with the responses by the team managers, a standardised approach to supervision and performance management is needed.

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."

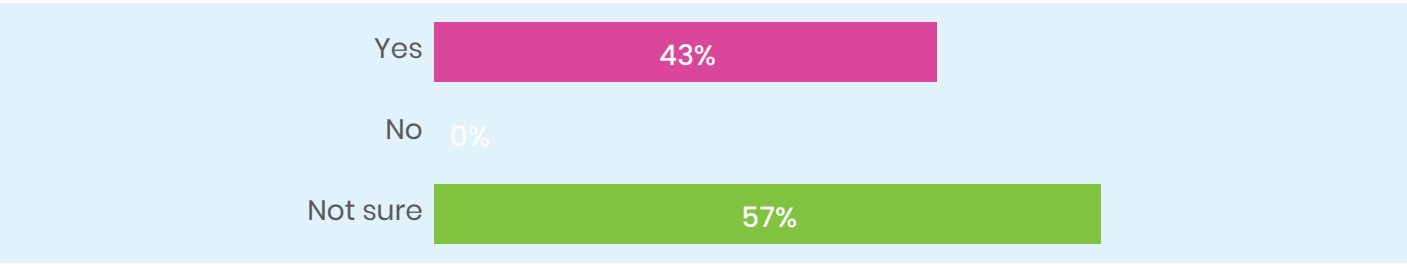
Question 13. What's the telephone policy in your department?



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?

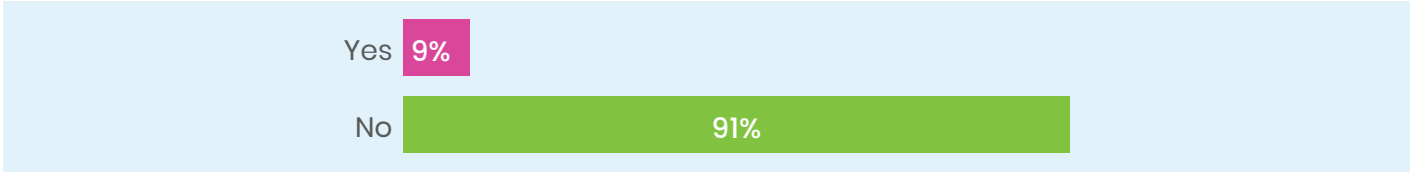
This information varied, with 2 members of staff stating, 6 to 8 weeks, 2 members of staff stating 4 to 6 weeks and one member of staff stating 5 to 6 weeks or longer. If an appointment is in two weeks or less patients will be phoned otherwise, they receive a letter. One member of staff, stating, "usually 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?

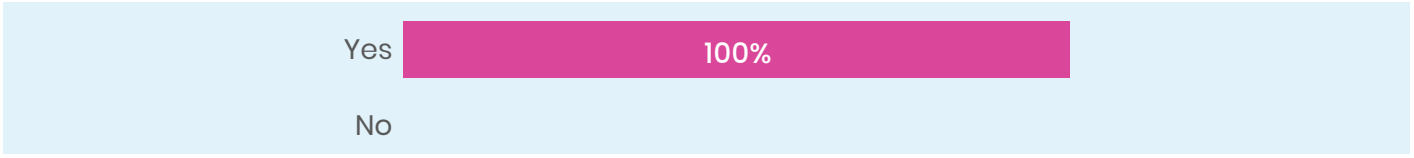
Staff members told us how they are responsible for printing and putting the letters in envelopes, then the letters are sent down to the post room, "the day after a patient leaves the ward, I will generate all the letters and add in any leaflets then send it off to be posted. This is all done within the 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.

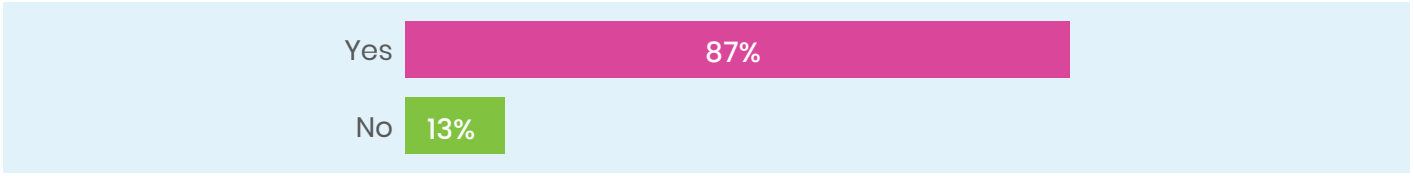


Question 20. How do you know if patient is F2F or a call?

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.

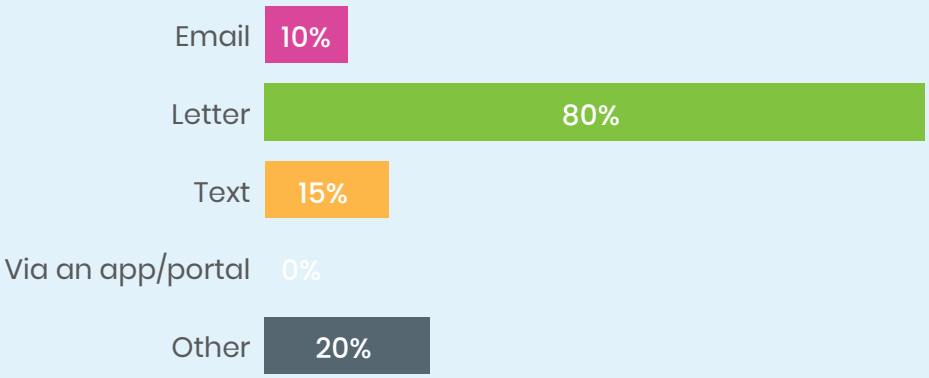
Interviews with Patients

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.

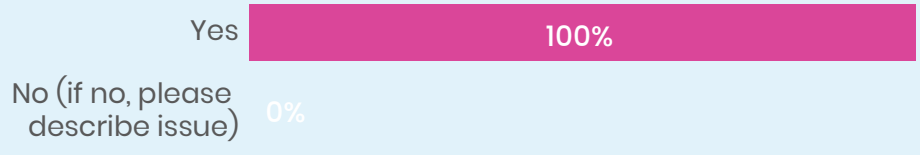
Questionnaire for patients

Question 1. How did you receive your appointment?



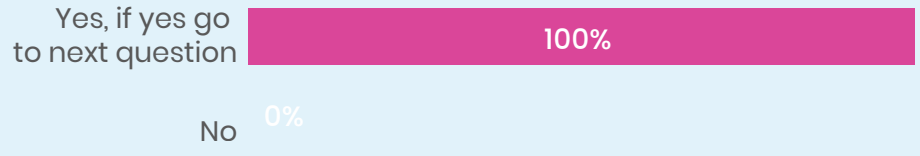
Most patients received their appointment information by letter at 80 percent, with 15 percent of patients received a text message and 10 percent receiving an email. There were three patients who received referrals, from Newham Hospital and Kings, and two patients who received phone calls.

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.

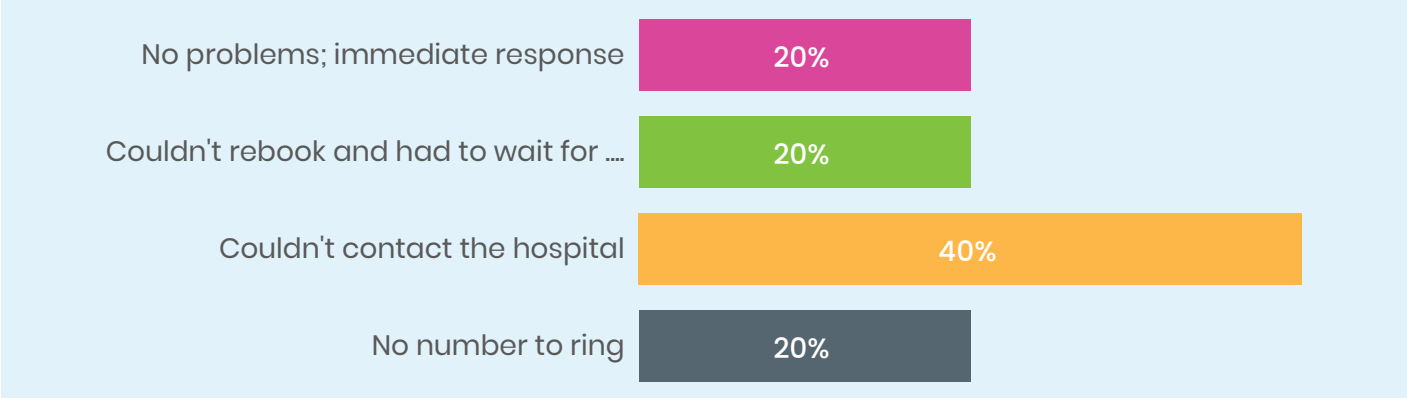
Question 4. How did you cancel your appointment?

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.

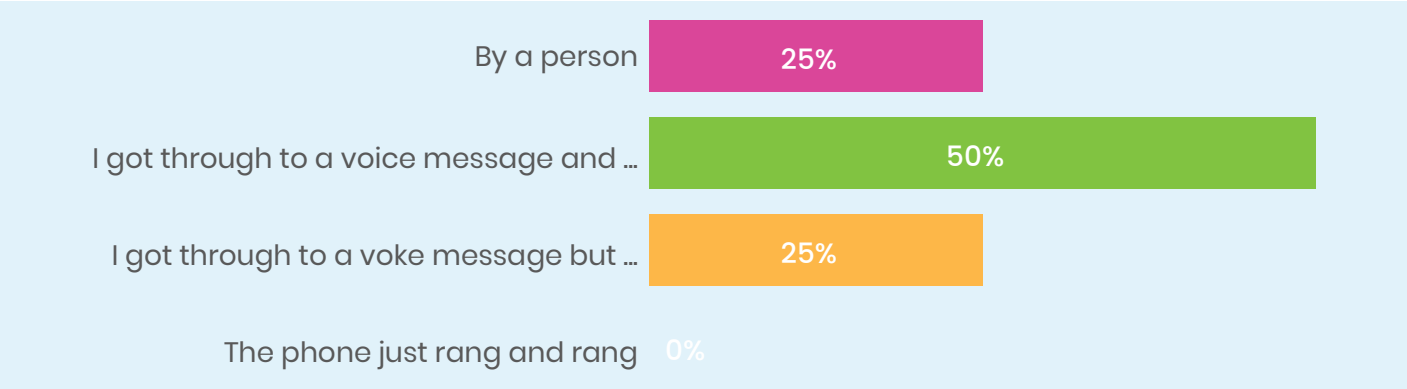
Question 6. If you had to phone the department how easy was it to get through?



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.

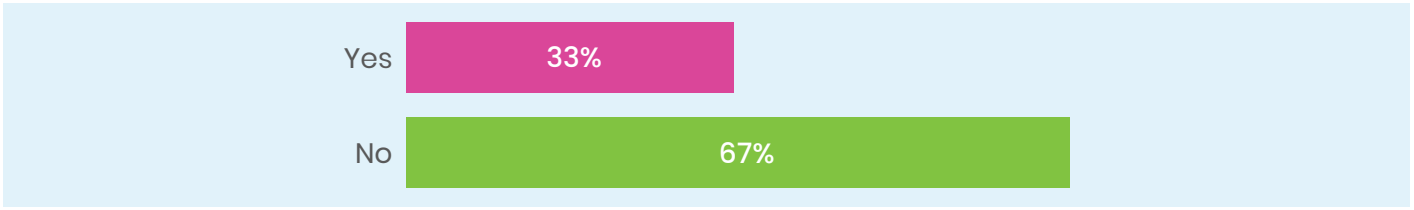
Observation: The responses to this question correlates to our survey responses, with incorrect contact information on the appointment letter or calls not being answered.

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?

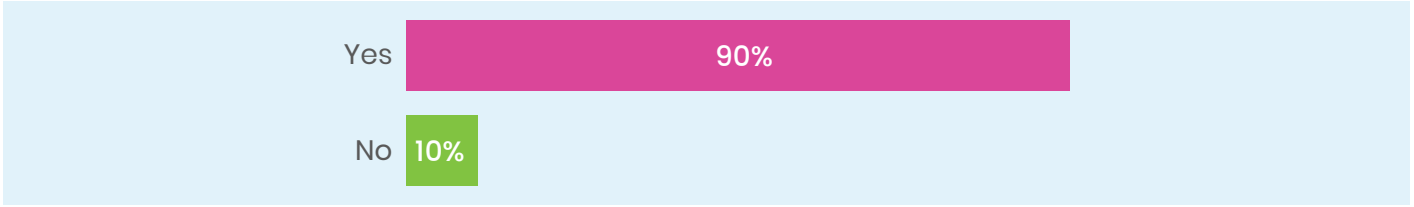


66 percent of patients did not receive a call back, 33 percent received one.

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.

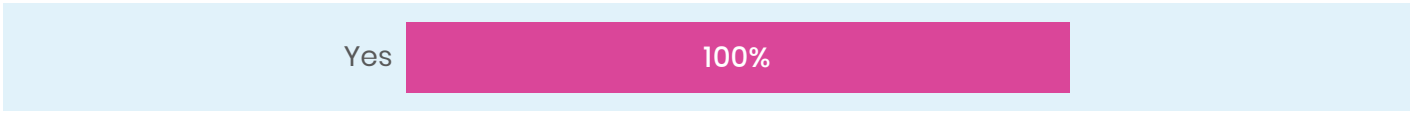
This is common complaint by patients that messages are not responded to.

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.

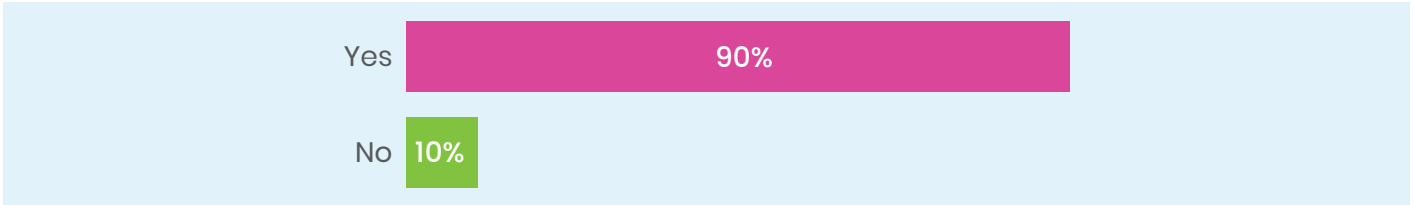
Question 10. If yes, did the information in the original letter and the reminder correspond?



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

City of London Corporation Committee Report

Committee(s): Safeguarding & SEND Sub Committee Community & Children's Services Committee Health & Wellbeing Board CoL	**Dated:** 13/10/2025 10/11/2025 04/02/2026
Subject: CHSCP Annual Report 2024-25	**Public report:** For information
This proposal: Delivers on the corporate plan outcome: 'Providing Excellent Services' enabling access to effective children's social care.	Outlines CHSCP work for period 2024-25 for the board to note.
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:	The City & Hackney Safeguarding Children Partnership Board (CHSCP)
Report author:	Rory McCallum - Senior Professional Advisor to the CHSCP

Summary

1. **Key Achievements**
   - **Strong Inspection Outcomes:** Both the City of London and Hackney Children & Families Service received positive ratings from Ofsted ("Outstanding" and "Good," respectively).
   - **Police Improvements:** The Metropolitan Police and City of London Police demonstrated marked progress in handling child-related cases and adopting a "child first" approach.
   - **Effective Governance:** Multi-agency arrangements and the commitment to independent scrutiny remained robust, providing the necessary "grit" for constructive professional challenge.
   - **Commitment to Learning & Improvement:** The partnership published two

Local Child Safeguarding Practice Reviews (LCSPRs) and continued to implement practice improvements derived from audits and reviews.

2. **Ongoing Challenges**
   - Financial Pressures.
   - Rising Complexity.
   - Context of national reform agenda.

3. **Future Priorities**

   Focus is maintained on the health and stability of the safeguarding workforce, proactively tackling racism through the Active Anti-Racist Charter, maintaining an unwavering focus on the lived experience of children, building on the foundations of good practice, strategic vulnerabilities and pathways to harm and our appetite to learn.

4. **Recommendation(s)**

   - Members are asked to note the report.

5. **Main Report:**

   - **Report here.**

Report Author	City & Hackney Safeguarding Children Partnership
Contact details	chscp@hackney.gov.uk Website: https://www.chscp.org.uk/
Appendices	Link to report here

chscp

Annual Report 2024/2025



Foreword by the Independent Safeguarding Children Commissioner

It has been a year of significant progress and considerable challenge for the City & Hackney Safeguarding Children Partnership (CHSCP) as we have worked to safeguard and promote the welfare of all our children and their families. This Foreword provides a self-assessment and commentary on our key achievements, while also highlighting the areas where we continue to face undeniable difficulties.

In 2024/25, our partnership demonstrated a strong, collective commitment to our core mission. We have seen positive movement in several key areas. Crucially, our multi-agency safeguarding arrangements, including the governance structure and the roles of our lead and delegated safeguarding partners, continue to function effectively. The enduring commitment to independence within our arrangements has been invaluable, providing the 'grit' necessary for the robust scrutiny and constructive challenge that drives our work forward. This is an approach we have chosen to maintain, as it neither weakens nor undermines the ability of our partners to fulfil their statutory functions.

We are proud of the strong performance reflected in recent inspection outcomes. The City of London Corporation received an 'Outstanding' Ofsted rating, with inspectors highlighting the excellent services that are making a significant difference in children's lives. Similarly, Hackney's Children & Families Service was rated 'Good,' a considerable improvement achieved despite a challenging period marked by a cyber-attack and community tensions. Both the Metropolitan Police Service and the City of London Police have also made notable improvements in their handling of child-related cases, with a renewed focus on a 'child first' approach and better investigation processes. These positive inspection results are a clear testament to our focus on maintaining and building upon the foundations of good practice.

Our commitment to learning is another area of progress. We have continued to implement our learning and improvement framework, identifying lessons from multi-agency audits and local case reviews to drive improvements in practice. We published two Local Child Safeguarding Practice Reviews (LCSPRs) this year, for Case A and Child V, and have actively progressed the recommendations from both, as well as from the ongoing Child Q review. This appetite to learn is central to our work, ensuring that we are a reflective and continuously improving partnership. We have once again demonstrated that our partnership will respond to questions concerning the health and wellbeing of our children whenever and wherever they arise, doing so without fear or favour.

Despite these successes, we remain grounded in the reality of the significant challenges we face. The most pressing of these are financial constraints, increased demand, and the rising complexity of cases. We know from our

partners' reports that organisations are grappling with substantial budget deficits. The Metropolitan Police Service faces a $260 million deficit, which will lead to a reduction of approximately 1,700 staff. Hackney Council needs to save $52 million over the next three years. This environment of tightening funds and growing demand is leading to difficult decisions, restructures, and concerns about staff capacity and well-being. Overlaying these circumstances with a significant national reform agenda, whilst creating opportunities, is marked with risk as well. We cannot ignore this reality.

The complexity of cases continues to increase. Agencies like the East London Foundation Trust (ELFT) and Homerton Healthcare NHS Foundation Trust (HHFT) report a sustained rise in emotional distress, self-harm, and complex mental health issues among children and young people. Many of these cases are high-risk but fall below the threshold for statutory social care intervention, creating ethical and clinical dilemmas for our practitioners. We also face ongoing challenges with data accuracy and information-sharing agreements between agencies. These issues can hinder our ability to respond effectively and in a timely manner, an area we are committed to improving.

As we look to the future, our priorities will reflect the need to navigate these challenges. We must continue to focus on the health and stability of our safeguarding workforce, ensuring that staff and volunteers are well-supported amidst ongoing organisational change and increased demand. We must also strengthen our approach to strategic vulnerabilities and pathways to harm, including child sexual abuse, adolescent safeguarding, and the ongoing risks associated with unregistered educational settings.

The CHSCP's commitment is to ensure that every child is seen, heard, and helped. We will proactively tackle racism through our Active Anti-Racist Charter, listen to the voices of children and families to inform our work, and maintain our unwavering focus on the lived experience of children. While the road ahead will be difficult, we are confident that by working together and staying true to our core principles, we can continue to make a real and lasting difference for the children and families in the City of London and Hackney.



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

Contents

About the Annual Report 5

The CHSCP 7
Summary 8
Purpose 8
Vision 9
Principles 10
The CHSCP's Active Anti-Racist Charter 12
Key Roles & Relationships 13
Statutory Safeguarding Partners 13
Lead Safeguarding Partners 13
Delegated Safeguarding Partners 14
Partnership Chair 14
The Independent Safeguarding Children Commissioner 15
Relevant Agencies 16
Schools, Colleges, Educational and Early Years Settings 17
Other Organisations 18
Designated and Named Professionals 18
The CHSCP Team 18
Independent Scrutiny 19
CHSCP Structure 2024-2025 20
Safeguarding Assurance Groups 21
The CHSCP Executive 22
Safeguarding Children Partnership Boards 22
Attendance 25
Financial Arrangements 28
Communication 29

Progress 2024/25 32
The CHSCP's Priorities 33
City of London Safeguarding Snapshot 2024/25 37
Hackney Safeguarding Snapshot 2023/24 39
Safeguarding Partners & Relevant Agencies 42
The City of London Corporation - Children's Social Care and Early Help 44
The City of London Corporation - Education and Early Years 47
The City of London Police 51
Hackney Council - Children & Families Services 53
Hackney Education 58
Young Hackney 63
Hackney Youth Justice Service 66
Hackney Housing 68
The Metropolitan Police Service 69
NHS North East London Integrated Care Board 73
Homerton Healthcare NHS Foundation Trust 74
East London NHS Foundation Trust 78
City & Hackney Public Health 81
CAFCASS 83
Probation 83
Safer Workforce 85
The City of London 87
Hackney 92

Learning & Improvement 99
Key Messages for Practice 100
SAFER - The Golden Rules of Safeguarding 104
Reviews of Practice 105
Rapid Reviews 106
Local Child Safeguarding Practice Reviews 108
Case A *108*
Child V *112*
Child Q *115*
Auditing 116
The Voice of the Child, Family & Community 125
Performance Data 131
Front-Line Intelligence 131
External Learning 132
Focus on CSA and CSE 133

Training & Development 139
Summary 140
Evaluation 146

Priorities & Pledge 148
CHSCP Priorities 2024/25 149
Our Pledge 151

What You Need to Know 153

About the Annual Report



The City & Hackney Safeguarding Children Partnership annual report for 2024/25 sets out examples of the learning, challenge, impact, evidence and improvement of the statutory safeguarding arrangements in the City of London and the London Borough of Hackney. It reports on the following activity:

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

In line with statutory requirements, the CHSCP annual report 2024/25 has been sent to the Child Safeguarding Practice Review Panel and the Multi-Agency Safeguarding Arrangements Unit in the Department for Education.



The CHSCP



Summary

The City and Hackney Safeguarding Children Partnership (CHSCP) is established in accordance with the Children Act 2004 (as amended by the Children and Social Work Act 2017) and the statutory guidance issued within Working Together to Safeguard Children 2023. The CHSCP's safeguarding arrangements define how safeguarding partners, relevant agencies and other organisations work together to coordinate their safeguarding services. These arrangements include details about how safeguarding partners identify and respond to the needs of children, commission and publish local child safeguarding practice reviews and provide for independent leadership and scrutiny. The published arrangements are available HERE.

Purpose

As set out in WT23, purpose of multi-agency safeguarding arrangements is to ensure that, at a local level, organisations and agencies are clear about how they will work together to safeguard children and promote their welfare. This means:

- There is a clear, shared vision for how to improve outcomes for children locally across all levels of need and all types of harm.
- When a child is identified as suffering or likely to suffer significant harm there is a prompt, appropriate and effective response to ensure the protection and support of the child.
- Organisations and agencies are challenged appropriately, effectively holding one another to account.
- The voice of children and families combined with the knowledge of experienced practitioners and insights from data, provides a greater understanding of the areas of strength and/or improvement within arrangements and practice.
- Information is sought, analysed, shared, and broken down by protected characteristics to facilitate more accurate and timely decision-making for children and families, and to understand outcomes for different communities of children.
- Effective collection, sharing and analysis of data, enables early identification of new safeguarding risks, issues, emerging threats, and joined-up responses across relevant agencies.
- Senior leaders promote and embed a learning culture which supports local services to become more reflective and implement changes to practice.
- Senior leaders have a good knowledge and understanding about the quality of local practice and its impact on children and families.

Vision

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



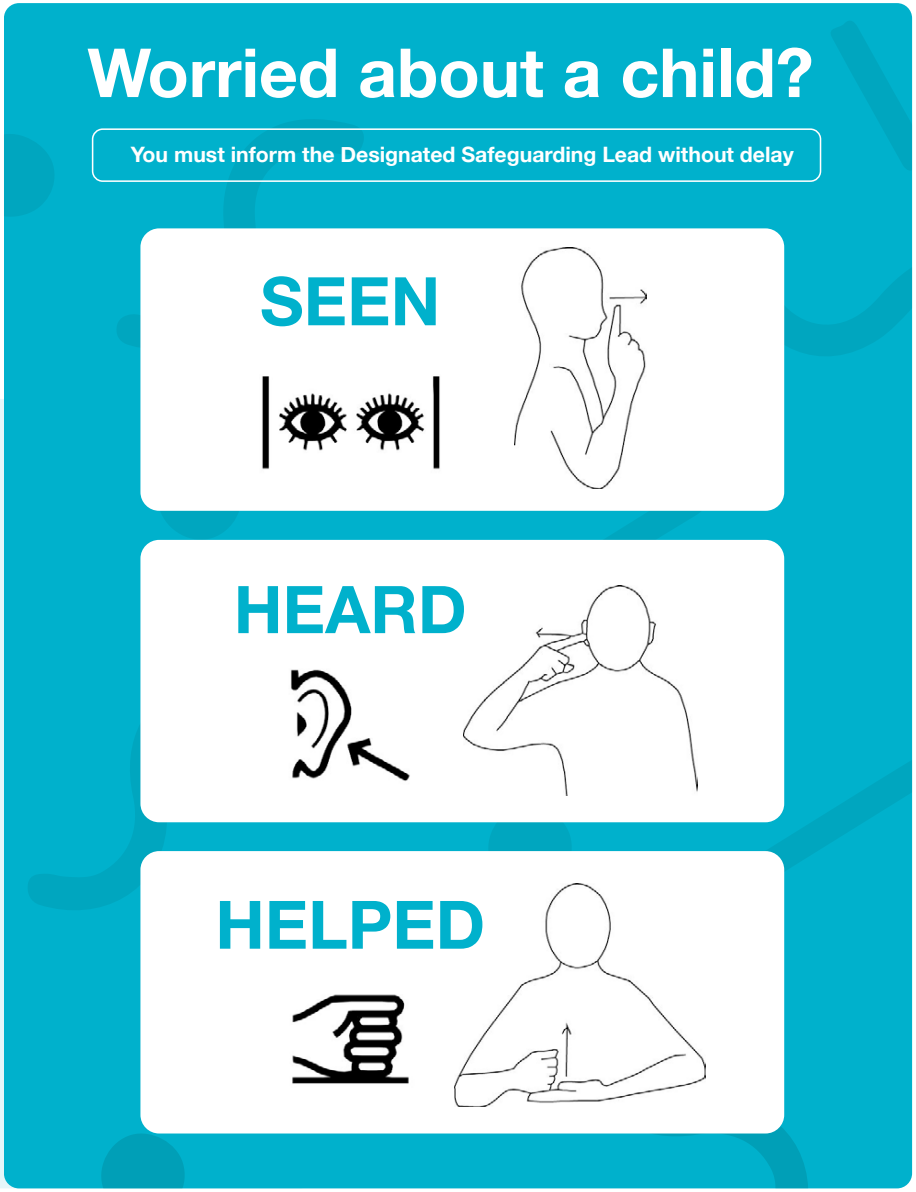
Principles

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

Seen; in the context of their lives at home, friendship circles, health, education and public spaces (both off-line and on-line).

Heard; by professionals taking time to hear what children and young people are saying - putting themselves in their shoes and thinking about what their life might truly be like.

Helped; by professionals remaining curious and by implementing timely, effective and imaginative solutions that help make children and young people safer.



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

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

The CHSCP's Active Anti-Racist Charter

As a partnership responsible for safeguarding and promoting the welfare of all children, we have zero tolerance for racism, and we are committed to playing our part in eradicating it. The CHSCP's Active Anti-Racism Charter sets out a framework to help us do just that. It describes a range of expectations for how racism can be tackled and how we can help children and their families see, hear and feel the change we seek. It also recognises the demographics of our local workforce and how for many of them, the impact of racism resonates in both their personal and professional lives. Given the range of activity that is ongoing in this space, the Charter does not replace any single-agency initiatives, rather it provides the 'umbrella architecture' against which organisations can test and create their own guidance. All agencies represented on the CHSCP have formally agreed to its contents. The Charter is referenced within our written safeguarding arrangements, and we expect all agencies to adhere to it.



Key Roles & Relationships

STATUTORY SAFEGUARDING PARTNERS

A statutory safeguarding partner in relation to a local authority area in England is defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as the local authority, an integrated care board and the chief officer of police. 7.2 These three partners have a joint and equal duty to work together as a team (and with other organisations) to safeguard and promote the welfare of all children. Given the CHSCP covers both the City of London and the London Borough of Hackney, our local safeguarding partners comprise the following:

- **Hackney Council**
- **The City of London Corporation**
- **NHS North East London Integrated Care Board (ICB)**
- **The Metropolitan Police Service (MPS)**
- **The City of London Police**

LEAD SAFEGUARDING PARTNERS

Lead Safeguarding Partners (LSPs) speak with authority for the safeguarding partner they represent, take decisions on behalf of their organisation or agency and commit them on policy, resourcing, and practice matters. They also hold their own organisation or agency to account on how effectively they participate and implement the local arrangements. LSPs are expected to play an active role in the CHSCP's arrangements. This is achieved via leadership within their respective agencies, 1:1s with the Independent Safeguarding Children Commissioner (ISCC) and the LSPs formally meeting as part of a 'Safeguarding Assurance Group'. Safeguarding Assurance Groups include Delegated Safeguarding Partners (see below) and are held separately in the City of London and Hackney. These arrangements help to ensure that LSPs are fulfilling their joint statutory functions. Over 2024/25, the LSPs for the CHSCP were:

- Dawn Carter McDonald, Chief Executive of Hackney Council
- Ian Thomas CBE, The Town Clerk of the City of London Corporation
- Zina Etheridge, CEO Designate of NHS NEL
- Matt Twist, Assistant Commissioner of the MPS
- Pete O'Doherty, Commissioner, City of London Police

CHALLENGE

For the MPS and ICB LSPs, given their spans of control and responsibility for numerous jurisdictions, they are unable to fulfil their functions (in a local context) as defined in WT23. This sets out how LSPs should meet 'sufficiently regularly' with other LSPs, be 'jointly responsible for ensuring the proper involvement of and oversight of all relevant agencies', sign off key partnership documents, set the budget and 'act as a team, as opposed to a voice for their agency alone'. Given these circumstances, the delegation of LSP functions is required. Paragraph 57 of WT23 allows for such delegation via its definition of a Delegated Safeguarding Partner.

DELEGATED SAFEGUARDING PARTNERS

Whilst remaining accountable for any actions or decisions taken on behalf of their agency, LSPs have each nominated a senior officer to deliver the CHSCP's safeguarding arrangements. Known as Delegated Safeguarding Partners (DSPs), this group meets as the CHSCP Executive. They can speak with authority, take decisions on behalf of the LSPs and hold their sectors to account. The joint functions for DSPs are set out on page 29 of WT23. For 2024/25, the statutory DSPs were:

- Judith Finlay, Executive Director of Children's and Community Services (The City of London Corporation)
- Jacquie Burke, Group Director of Children & Education (Hackney Council)
- Diane Jones, Chief Nursing Officer (NHS NEL)
- James Conway, Commander (Central East BCU, MPS)
- Umer Khan, Commander (City of London Police)

Jason Marantz, Hackney's Director of Education and Inclusion and Mark Emmerson, the Chief Executive of the City of London Academies Trust were also standing members of the CHSCP Executive during 2024/25. This arrangement helped to ensure the engagement of education within the CHSCP's safeguarding arrangements.

PARTNERSHIP CHAIR

WT23 sets out that LSPs should appoint a DSP to be the partnership chair, with one of its core functions being to chair all meetings involving DSPs. By introducing the partnership chair, WT23 states that this 'arrangement removes any need for a local area to maintain another chair or independent chair.'

CHALLENGE

Locally, it has been agreed there are exceptional circumstances that justify divergence from WT23. Supported by advice obtained from legal counsel, the CHSCP has decided to maintain its existing system of chairing. Over 2024/25, the Independent Safeguarding Children Commissioner continued to 'facilitate and coordinate' the Executive as part of his existing duties linked to independent leadership and scrutiny. This approach neither weakens nor undermines the ability of DSPs to deliver against their defined functions as set out in WT23. Further detail on the rationale supporting this arrangement has been published on the CHSCP's website HERE.

THE INDEPENDENT SAFEGUARDING CHILDREN COMMISSIONER

The CHSCP's approach to independent scrutiny is built on the fundamental premise that multiagency working neither happens by itself nor via the good will of dedicated staff. Multi-agency work needs to be harnessed and driven and must at its heart be open to independent challenge to do better. It was for these reasons that the role of the Independent Safeguarding Children Commissioner (ISCC) was created in 2019, and whilst its functions incorporate those of an independent scrutineer, they extend beyond this. During 2024/25, Jim Gamble QPM continued as the ISCC. He continued to provide independent leadership, advocacy and scrutiny and supported the CHSCP's unambiguous focus on independence, whilst helping to deliver the necessary 'grit' in our system that drives our multi-agency working. The ISCC's functions include:

- Independently advocates by, for and on behalf of our children and families.
- Provides assurance in judging the effectiveness of services to protect children.
- Provides a rigorous and transparent assessment of the sufficiency of systems and processes that enable partner agencies to fulfil their statutory duties and ensure that children are protected.
- Assists when there is disagreement between the leaders involved in multi-agency arrangements.
- Supports a culture and environment conducive to robust scrutiny and constructive challenge.
- Assesses whether the safeguarding partners are fulfilling their statutory obligations.
- Evaluates arrangements for the operation of the safeguarding partnership, including the purpose and functions of meetings, and recommend appropriate changes.
- Confirms, or not, that effective performance management, audit and quality assurance mechanisms are in place within partner organisations which will support the safeguarding partners to fulfil their statutory obligations, and which will enable the partnership to identify and measure its success and impact.
- Ensures that the safeguarding partners provide independent, robust and effective challenge to each other and to relevant agencies and other organisations.

RELEVANT AGENCIES

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

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

SCHOOLS, COLLEGES, EDUCATIONAL AND EARLY YEARS SETTINGS

The CHSCP recognises the vital role of schools (including independent schools, academies, and free schools), colleges, educational establishments and early years settings in safeguarding and promoting the welfare of children and young people. All are designated as relevant agencies within the CHSCP's safeguarding arrangements and have a statutory duty to cooperate with safeguarding partners. Whilst work is ongoing to explore better ways to involve education within our arrangements, the following mechanisms are in place to help achieve this:

- The Director of Hackney Education and Inclusion and a CEO of an Academy Trust being standing members of the CHSCP Executive
- In the City of London, engagement of all schools (and the City of London Corporation's Children's Centre) is secured through its Safeguarding Education Forum.
- In Hackney, schools and Children's Centres continue to be supported via the Designated Safeguarding Leads Forum, Head Teacher briefings and the work of Hackney Education.
- For Private, Voluntary and Independent Early Years settings in both the City of London and Hackney, support and services are available through the work of the Hackney Education and respective forums in both local authority areas.
- Schools, educational establishments and early years settings are also engaged as part of the CHSCP's Learning and Improvement Framework and other activity as required. This may include representation at CHSCP Sub Groups and Thematic Groups.

EVIDENCE AND IMPROVEMENT

Further to the implementation of Working Together to Safeguard Children 2023, and the proposed changes in the Children's Wellbeing and Schools Bill, the CHSCP is seeking to change the way it engages Headteachers within its key governance forums. It was recently agreed that a headteacher representative will be sought for the CHSCP Executive group and expressions of interest have been encouraged from those wanting to join the Hackney Board. Integrating Headteachers more formally into the CHSCP's architecture reinstates a successful arrangement that was in place before 2019. We believe their reintroduction will provide the partnership with crucial expertise, advice, and constructive challenge.

Furthermore, Headteachers will serve as a vital link to the broader education system. Their direct experience of the daily realities faced by children and young people, coupled with their insight into school-based safeguarding practices, will significantly strengthen the CHSCP's strategic oversight and decision-making. This ensures the voice of education is clearly heard and fully integrated into our collective efforts to protect our children.

OTHER ORGANISATIONS

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

DESIGNATED AND NAMED PROFESSIONALS

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

THE CHSCP TEAM

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



Independent Scrutiny

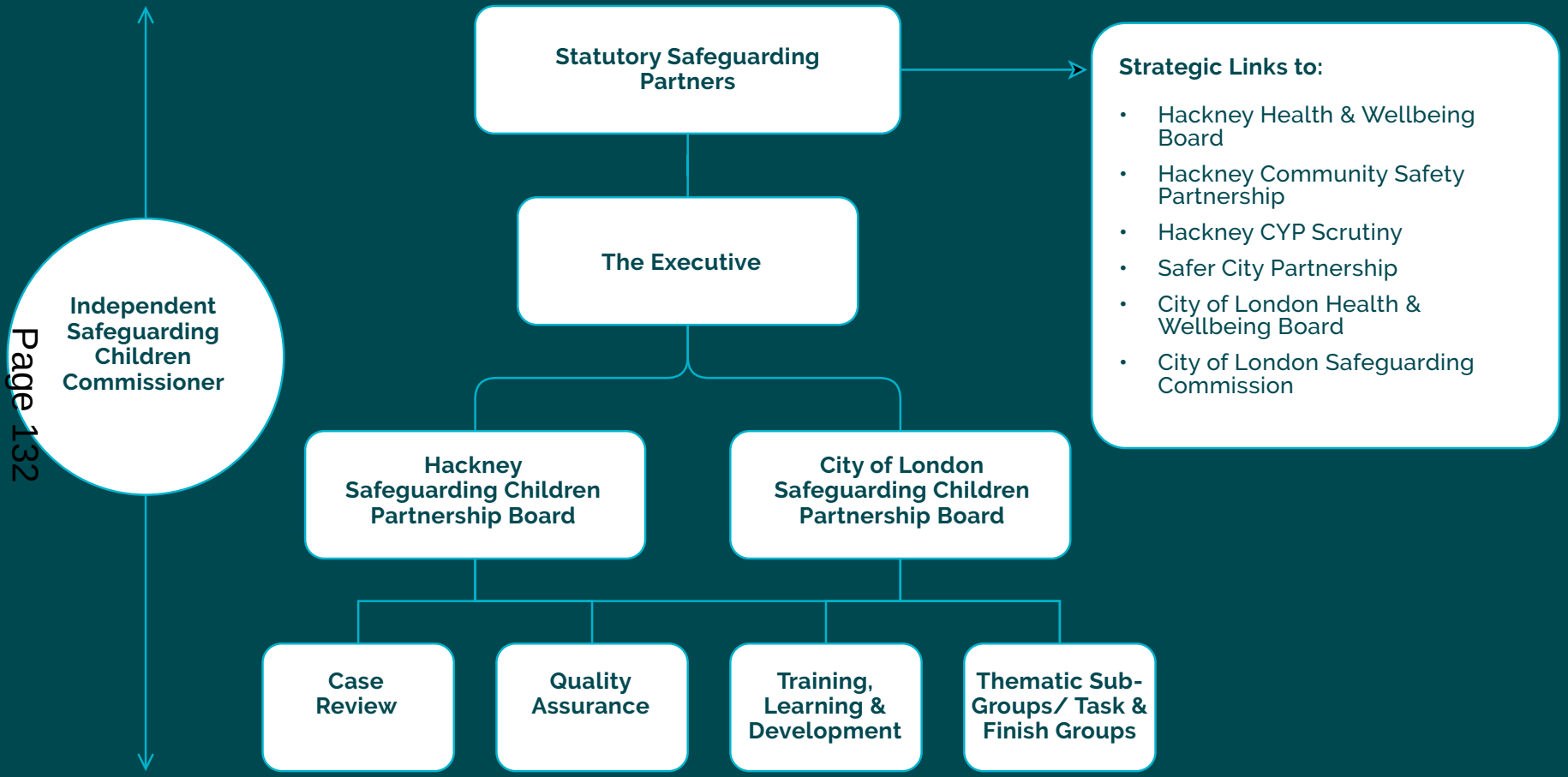
In terms of independent scrutiny of the CHSCP's arrangements, activity acts as a constructive critical friend. Such scrutiny is embedded in the culture of how the CHSCP operates and how cross-agency challenge from one agency to another can provide both a level of independence and the support needed for improvement. It is also part of a wider system which includes the independent inspectorates' assessment of safeguarding partners, relevant agencies, and the partnership itself via the Joint Targeted Area Inspection's regime. It similarly features as a fundamental principle of the CHSCP's approach to learning and improvement, reflecting the partnership's commitment to independent challenge and support. It includes:

Agencies being subject to external inspection and positively responding to any findings and recommendations for practice improvement.

An ISCC being appointed by LSPs, reporting to them and given the authority to coordinate the independent scrutiny of the local child safeguarding arrangements. This includes the ISCC's 'right to roam' and their ability to access relevant information that tests the sufficiency of the CHSCP's safeguarding arrangements.

- The ISCC being fundamentally independent from local organisations and holding significant experience of operating at a senior level in the strategic coordination of multi-agency safeguarding services. •
- The ISCC providing independent leadership (through engagement, commentary, and lobbying) in respect of local matters relevant to the safeguarding of children and young people.
- The ISCC holding both safeguarding partners and relevant agencies to account for their effectiveness in safeguarding children and young people. This will ensure ongoing alignment with the existing statutory arrangements for safeguarding adult boards.
- The ISCC engaging with LSPs partners as part of routine 1:1 sessions, and as part of the Safeguarding Assurance Group meetings.
- The ISCC chairing the CHSCP Executive.
- The ISCC chairing the Safeguarding Children Partnership Boards in the City and Hackney.
- The ISCC chairing the Case Review Sub Group to ensure fundamentally independent decision making in respect of the instigating and oversight of reviews.
- A Senior Professional Advisor (SPA) being appointed by safeguarding partners and working on behalf of the ISCC to lead the CHSCP support team.
- The SPA chairing the Quality Assurance Sub Group and being responsible for the delivery of the CHSCP's overall Learning and Improvement Framework.
- The ISCC providing an objective and independent assessment of the effectiveness of the safeguarding arrangements as part of an annual reporting cycle.
- The ISCC being engaged in resolving operational disputes through the CHSCP's dispute resolution protocol.
- Safeguarding partners, relevant agencies and the ISCC actively strengthening networks and building opportunities for local peer review and sector-led support. Where available, this includes independent support as negotiated with safeguarding partners in other local authority areas and/or any such support coordinated via the Local Government Association and the London Safeguarding Children Partnership.
- The CHSCP commissioning external scrutiny as part of its Learning and Improvement Framework to help provide independent reassurance on the quality of practice.

CHSCP Structure 2024-2025



Strategic Links to:

- Hackney Health & Wellbeing Board
- Hackney Community Safety Partnership
- Hackney CYP Scrutiny
- Safer City Partnership
- City of London Health & Wellbeing Board
- City of London Safeguarding Commission

SAFEGUARDING ASSURANCE GROUPS

LSPs in Hackney and the City of London formally meet with the ISCC and DSPs to collectively consider the sufficiency of the local safeguarding arrangements and to fulfil their defined functions as set out on page 27 of Working Together to Safeguard Children 2023. LSPs are jointly responsible for ensuring the proper involvement of and oversight of all relevant agencies, and should act as a team, as opposed to a voice for their agency alone. They

- Set the strategic direction, vision, and culture of the local safeguarding arrangements, including agreeing and reviewing shared priorities and the resource required to deliver services effectively.
- Lead their organisation's individual contribution to the shared priorities, ensuring strong governance, accountability, and reporting mechanisms to hold their delegates to account for the delivery of agency commitments.
- Review and sign off key partnership documents: published multi-agency safeguarding arrangements, including plans for independent scrutiny, shared annual budget, yearly report, and local threshold document.
- Provide shared oversight of learning from independent scrutiny, serious incidents, local child safeguarding practice reviews, and national reviews, ensuring recommendations are implemented and have a demonstrable impact on practice (as set out in the yearly report).
- Ensure multi-agency arrangements have the necessary level of business support, including intelligence and analytical functions, such as an agreed data set providing oversight and a robust understanding of practice.
- Ensure all relevant agencies, including education settings, are clear on their role and contribution to multi-agency safeguarding arrangements.
- Ensure how the experiences of children and families shape the delivery of local arrangements, in particular how those with protected characteristics engage in service design.
- LSPs will also maintain oversight of the key risks within the local safeguarding arrangements and the effectiveness of the partnership in mitigating these.

THE CHSCP EXECUTIVE

The CHSCP Executive comprises the DSPs from both the City of London and Hackney and includes representation from the education sector. It is established for the purposes of DSPs discharging their functions as set out on page 29 of Working Together to Safeguard Children 2023. DSPs are sufficiently senior to be able to speak with authority, take decisions on behalf of the LSP and hold their sectors to account. The DSPs should have the authority to carry out these functions, while ultimate accountability remains with the LSP as the individual responsible for the delivery of the statutory duties of the safeguarding partners. Through the CHSCP Executive, DSPs maintain oversight of the quality and compliance of the delivery of agreed shared priorities. Processes are in place to provide assurance that multiagency practice is reviewed and operating well. Where this is not evident, DSPs should have the capacity and resource from their own agencies to engage, respond and improve operational systems and practice. The Terms of Reference for the CHSCP Executive can be read HERE.

As part of its continued commitment towards transparency, the CHSCP Executive publishes summaries of its meetings. These can be found HERE.

SAFEGUARDING CHILDREN PARTNERSHIP BOARDS

The Safeguarding Children Partnership Boards in Hackney and the City of London are established by safeguarding partners to drive the work of the CHSCP. They are tasked with ensuring ongoing collaboration of safeguarding partners and relevant agencies in their work to safeguard and promote the welfare of children and young people. These groups comprise representatives from safeguarding partners and several relevant agencies. They include named and designated professionals. Both are independently chaired by the ISCC and are responsible for delivering the CHSCP business plan. The Terms of Reference for both Boards can be found HERE, with the core membership of each being available HERE.

EVIDENCE

The Boards in the City of London and Hackney met quarterly during 2024/25. For each meeting, Board members are expected to submit partner agency updates that focus on key issues within their respective agencies alongside a specific theme identified for deeper scrutiny. Over the reporting period, these themes included a focus on how agencies were communicating and responding to the lessons identified by the CHSCP's learning and improvement framework, the support and services provided between 3pm and 7pm (where the risk of youth violence, exploitation and extra-familial harm can increase), how agencies are engaged in the Prevent agenda and a general update on progress.

EVIDENCE

The **Hackney Safeguarding Children Partnership Board** and the **City of London Safeguarding Children Partnership Board** repeatedly discussed the impact of the new national guidance, Working Together to Safeguard Children 2023, particularly the proposal for a partnership chair. This raised concerns about decision-making authority. The unique dual-borough partnership between Hackney and the City of London was a key consideration in these discussions. By March 2025, new arrangements were approved, and the risk of the CHSCP being uninfluential as a strategic body was lowered from red to amber.

The CHSCP's **Risk Register and Operational Risk Register** were standing items, with some concerns focusing on data. A new risk was added for the Met Police's Connect system due to challenges with data accuracy and delays in reporting. Disagreements over the risk rating of birth data also highlighted persistent issues with data-sharing agreements between agencies.

Updates on **case reviews** were also a consistent agenda item. The boards considered Rapid Reviews and Local Child Safeguarding Practice reviews. A significant concern discussed at both boards was the potential for an Information Sharing Protocol (drafted in response to the Child Q review) to undermine the independence of learning reviews. This was resolved through engagement with the Child Safeguarding Practice Review Panel, who agreed to remove the primary issues of concern raised by the CHSCP (that sharing of interview records and other material between learning and conduct processes would be automatic). An 'advisory framework' responding to this issue was subsequently issued by the Panel and IOPC.

The funding for the **IRIS domestic violence service** was a major point of discussion. In 2024, the boards were briefed that Public Health intended to withdraw funding, as they felt it was not an appropriate use of their budget. The potential loss was seen as a significant risk. By March 2025, the risk was mitigated for the short term, as the NHS North East London ICB agreed to take on the full cost for the 2025/26 financial year while a long-term business case was being developed.

GP Patient Access System: A presentation in June 2024 highlighted the new system that gives patients online access to their medical records, including correspondence from children's social care. It was recommended that professionals are reminded of the requirement to redact sensitive data.

Continued overleaf.

EVIDENCE CONTINUED

The City of London pilot of the GCP2 toolkit for identifying neglect was discussed. The tool was found to have a small but positive impact, helping practitioners distinguish low-level neglect. The board decided to continue its use and closed the related action.

The Prevent team in the City of London gave a detailed presentation on their program in March 2025, in light of a national incident. The City board requested a piece of work, through audit or a themed approach, around the increased vulnerability of neurodivergent children to pathways of radicalisation.

The boards regularly received updates on inspection outcomes and was also updated on several new and ongoing projects. Some examples include:

New Children's Homes: An initiative to open two new children's homes in Hackney was presented. These homes are intended to keep children with complex needs in the borough, providing a stable environment and improving care quality while also reducing costs.

School-Based Health Services: A new service was presented, designed to provide flexible, targeted healthcare for schools using a neighbourhood model and digital tools.

- **Immunisation Strategy:** A new strategy was presented to improve vaccination coverage and address inequalities. A key concern was the ad-hoc nature of government funding and the upcoming end of MMR catch-up funding.
- **Trauma-Informed Guidance:** New guidance for child victims of domestic abuse was developed and shared to promote a system-wide trauma-informed response.

Attendance

CHSCP EXECUTIVE

Organisation	Jun 24	Aug 24	Oct 24	Dec 24	Dec 24 (Hackney DSPs)	Jan 2024	Attendance
City of London Corporation	✓	✓	✓	✓	—	✓	100%
Hackney Council	✓	✓	✓	✓	✓	✓	100%
NHS NEL	✗	✓	✓	✓	✓	✗	66.6%
MPS	✗	✓	✗	✓	✗	✓	50%
COL Police	✓	✓	✗	✓	—	✓	80%

HACKNEY SAFEGUARDING CHILDREN PARTNERSHIP BOARD

Organisation	Jun 24	Sep 24	Nov 24	Mar 25	Attendance
CAFCASS	✓	✓	✓	✓	100%
Hackney Education	✗	✓	✓	✓	75%
London Fire Brigade	✗	✓	✗	✗	25%
Hackney Children & Families Service	✓	✓	✓	✓	100%
Hackney Community & Voluntary Service	✗	✗	✗	✗	0%
Homerton Healthcare NHS Foundation Trust	✓	✓	✓	✓	100%
NHS North East London (City & Hackney)	✓	✓	✓	✓	100%
East London NHS Foundation Trust	✓	✓	✓	✓	100%
Hackney Housing Services	✓	✗	✓	✗	50%
Metropolitan Police Service	✓	✓	✓	✓	100%
Probation Service	✗	✓	✓	✗	50%
Public Health	✓	✓	✓	✓	100%

CITY OF LONDON SAFEGUARDING CHILDREN PARTNERSHIP BOARD

Organisation	Jun 24	Sep 24 Ofsted	Nov 24	Mar 25	Attendance
CAFCASS	✗	–	✓	✓	66.6%
City of London Children's Services	✓	–	✓	✓	100%
East London NHS Foundation Trust	✓	–	✓	✓	100%
London Fire Brigade	✓	–	✗	✗	33.3%
Somerton Healthcare NHS Foundation Trust	✓	–	✓	✓	100%
NHS NEL	✓	–	✓	✗	66.6%
City of London Police	✓	–	✓	✓	100%
Probation Service	✓	–	✓	✗	66.6%
Public Health	✗	–	✓	✗	33.3%

Financial Arrangements

IMPACT

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

Expenditure

Reviews	£32,650
Staffing and Travel	£326,282
Training, Learning & Development	£17,322
Printing, Supplies and Equipment	£4,320
Venues & Miscellaneous	£6,874
Total Expenditure	**£387,448**

Income

Hackney Council	£227,317
City of London Corporation (incl. CoL Police)	£29,480
Hackney Education	£24,480
East London NHS Foundation Trust	£24,480
North East London ICB	£12,000
Homerton Healthcare NHS Foundation Trust	£12,000
Metropolitan Police Service	£5,000
Probation Service (London Division)	£3,051
Use of Reserves	£31,517
Total Income	**£419,325**

Communication

CHSCP WEBSITE

Number of unique visitors to the site:
17,720
Increase of 1,553

Monthly average of visitors:
1,477

Visitors from the UK
11,553 (66%)

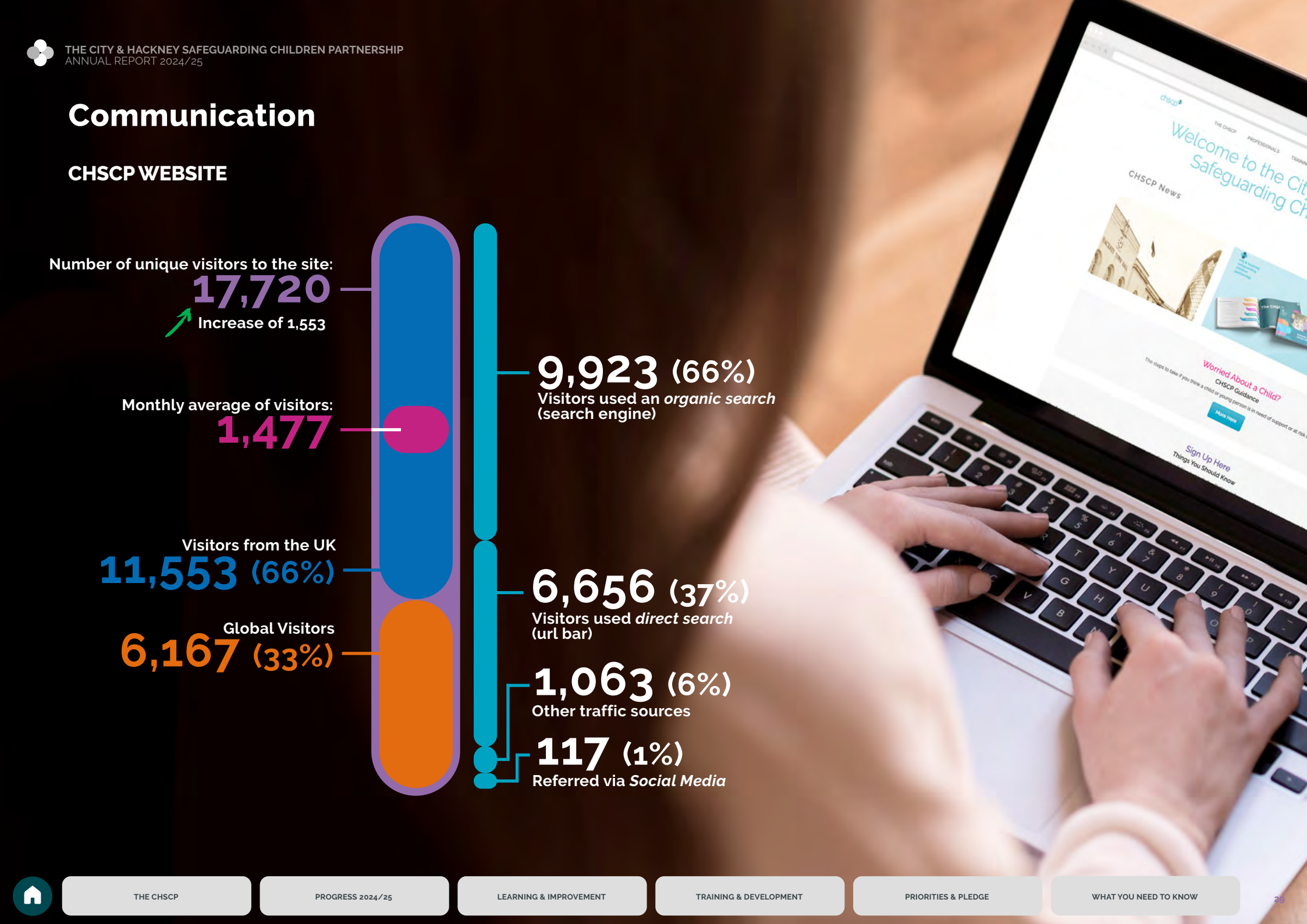
Global Visitors
6,167 (33%)

9,923 (66%)
Visitors used an *organic search* (search engine)

6,656 (37%)
Visitors used *direct search* (url bar)

1,063 (6%)
Other traffic sources

117 (1%)
Referred via *Social Media*



PAGE INTERACTION

10 most popular web pages

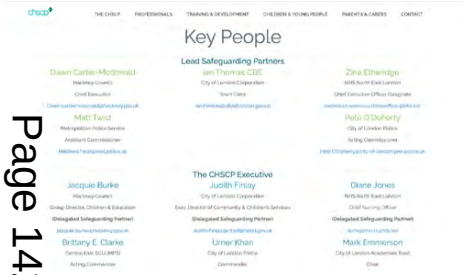
www.chscp.org.uk



Homepage
7,754 views



Case Reviews
2,853 views



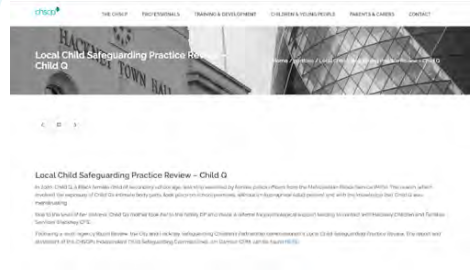
Key People
1,935 views



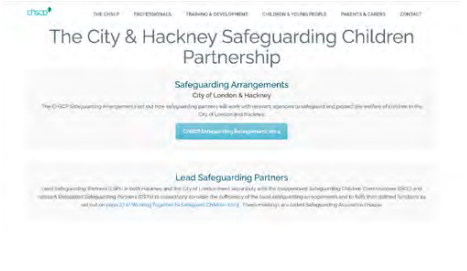
Learning & Improvement
1,851 views



Early Help in Hackney
1,507 views



Child Safeguarding Practice Review – Child Q 1,290 views



Our Arrangements
1118 views



E-Learning
809 views



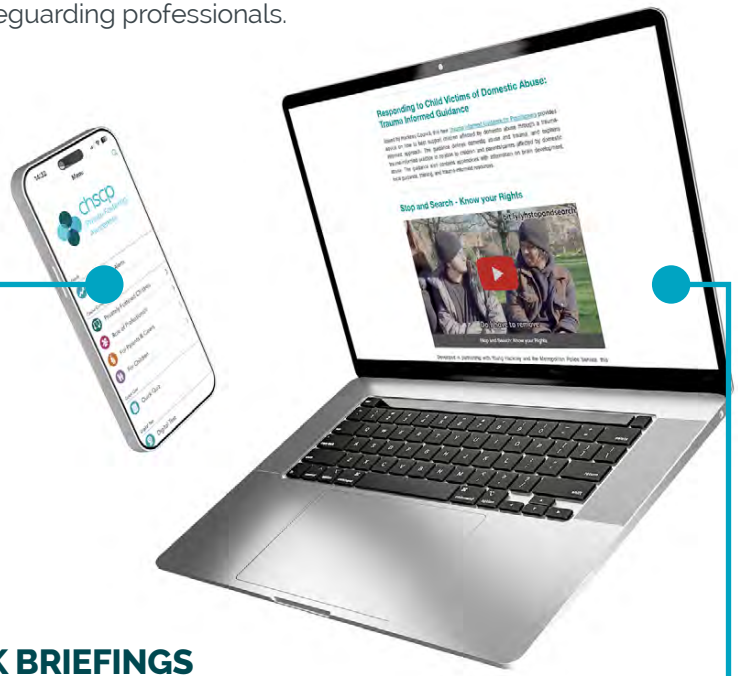
Allegations Against Professionals
762 views



Child Safeguarding Statements
713 views

PRIVATE FOSTERING APP

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



TUSK BRIEFINGS

The CHSCP produces e-briefings called 'TUSK' briefings (Things You Should Know). These are circulated to subscribers and cascaded by safeguarding partners, relevant agencies and named organisations. The number of subscribers to the TUSK fluctuated between 1,416-1,476 subscribers during 2024-2025, with an average of 1,446 each month. This is a drop from the maximum of 1,680 subscribers noted the previous year.

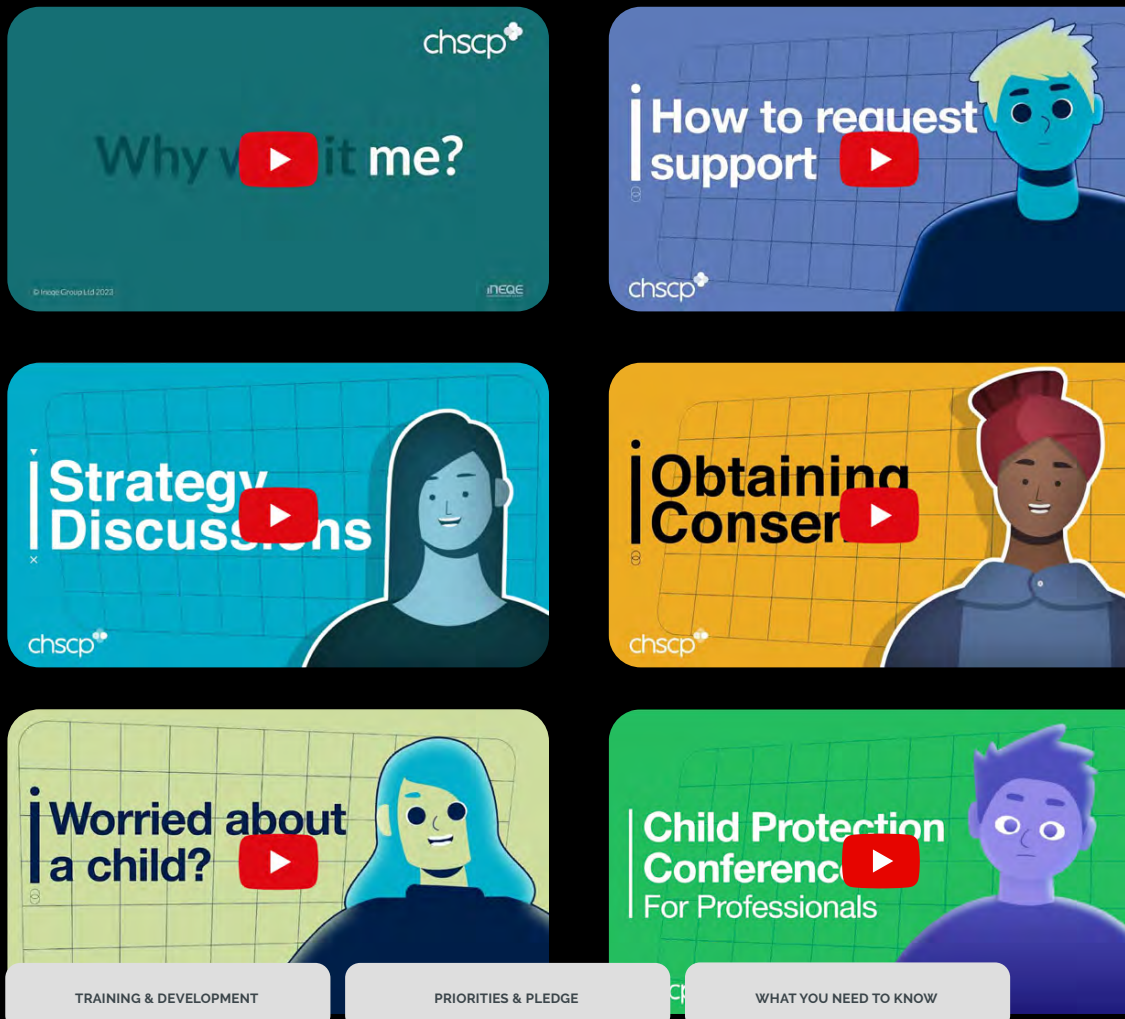
Published TUSK briefings can be found HERE.

YouTube

YOUTUBE

The CHSCP has produced several video guides covering a range of safeguarding topics. These can be viewed HERE.

These have attracted 9,987 views to date, an increase of 4,546 views in comparison to the previous reporting period.



Progress 2024/25



The CHSCP's Priorities

PRIORITY 1

THE HEALTH & STABILITY OF THE SAFEGUARDING WORKFORCE

The CHSCP Executive and both Boards consistently monitors this priority through the CHSCP's risk register, where workforce health and stability remain as a standing risk. Meetings regularly address issues related to workforce stability, capacity, and well-being, particularly in the context of financial pressures and new legislation.

A key concern over 2024/25 was the significant organisational change and restructuring taking place across many organisations. For instance, throughout the reporting period, Hackney Children and Families Service (HCFS) began to implement a flatter management structure aimed at increasing the number of permanent staff and improving stability. This included a restructure of the MASH to reduce social work roles while strengthening early help positions. These financial and structural changes are a direct response to budget constraints. Additionally, the new Families First Partnership Programme, a major government reform, is seen as a potential "seismic shift" for the partnership that will require considerable focus, resources, and effort. Underpinned by changes to statutory guidance and proposals in the Children's Wellbeing and Schools Bill, these reforms—along with new duties, such as those related to children educated at home—introduce a risk of 'organisational churn' and workforce stability concerns.

Financial pressures are indeed prompting many organisations to implement significant cost-saving measures. In relation to the Families First reforms, concerns have been raised that agencies will be competing for a limited pool of qualified professionals. Meetings also highlighted the difficulty in recruiting for roles such as designated nurses for looked after children. The need for updated training and professional development remains crucial in the context of these legislative and policy changes. The new reforms will introduce "differently qualified staff," but clear guidance on their training requirements is not yet available from the Department for Education (DfE). This creates a need for cohesive, joined-up training across all agencies. Inter-agency collaboration and communication remain central to managing these workforce challenges.

PRIORITY 2

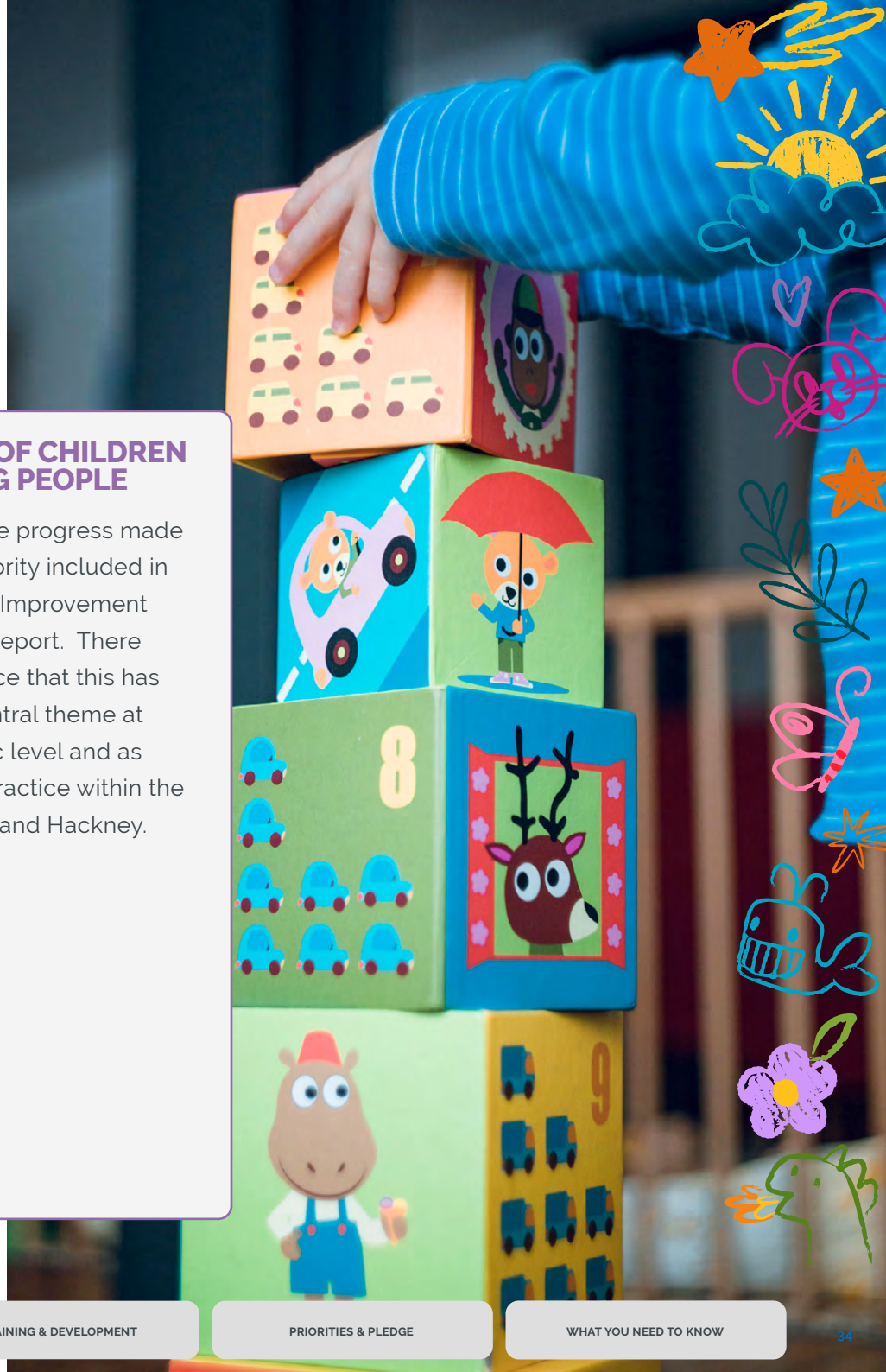
ACTIVE ANTI-RACIST PRACTICE

Partners are continuing to consider and advance their focus on anti-racist practice, with the Executive launching the CHSCP's Active Anti-Racist Charter during 2024/25. The charter is designed as an umbrella document to be used alongside existing organisational policies, guiding the partnership's efforts. The Executive Group decided that the charter's impact would be measured at Board level through partner updates in 2025/26 and via existing scrutiny processes like audits and reviews.

PRIORITY 3

THE VOICE OF CHILDREN AND YOUNG PEOPLE

Examples of the progress made against this priority included in the Learning & Improvement section of this report. There is good evidence that this has remained a central theme at both a strategic level and as part of direct practice within the City of London and Hackney.



PRIORITY 4

GETTING THE BASICS RIGHT

The CHSCP maintained its priority on keeping its local policies and guidance up to date and routinely promoting these via its TUSK briefings. Practice in many areas of safeguarding children is good as reflected in the outcomes of inspection activity.

The City of London Corporation was rated as Outstanding in its 2024 inspection. This highlighted, *'Children living or arriving in the City of London receive excellent services that are making a significant difference to their lives. Starting from the very strong service seen at the last inspection, a highly effective senior leadership team has developed services further and continued to make improvements'*,

In Hackney, its Ofsted inspection undertaken in 2024 identified, *'MASH social workers recognise and understand risk to children living in homes where there is domestic abuse and conflict, substance misuse and alcohol misuse. Workers respond quickly to immediate risks. They exercise professional curiosity and consider the family's history and past incidents in context, involving the multi-agency network when required. Children and their families are quickly directed to the most suitable agency to intervene and support them'.*

In January 2025, the Met Police was assessed as having made improvements and was removed from an enhanced level of monitoring by the police inspectorate. His Majesty's Inspector of Constabulary Lee Freeman said: *"I am pleased with the good progress that the Metropolitan Police Service has made so far. Whilst there is still a significant amount of work to do, I have recommended removing the service from our enhanced level of monitoring, known as Engage, and return it to routine monitoring. I am reassured by the plans that the commissioner has put in place to continue making sustainable improvements. We will continue to monitor the progress of the Metropolitan Police Service to make sure those living and working in the capital are getting the service they deserve from their force."*

In July 2025, the Police Efficiency, Effectiveness and Legitimacy assessment of the City of London Police was published by HMICFRS. This identified: *"The City of London Police is outstanding in how and when it records crime. This improvement is testament to the force's investment of time, effort and resources in crime recording. The force has also significantly improved the timeliness with which it records crime. This means investigations and support for victims begins sooner. I was pleased to find improvements in the management and scrutiny of criminal investigations. The force has invested in governance and performance processes to improve and maintain its investigative standards. This has led to continued performance improvements. Overall, we found that investigations were thorough and well supervised. Investigators look for opportunities to bring offenders to justice, even when victims are unwilling or unable to proceed."*

PRIORITY 5

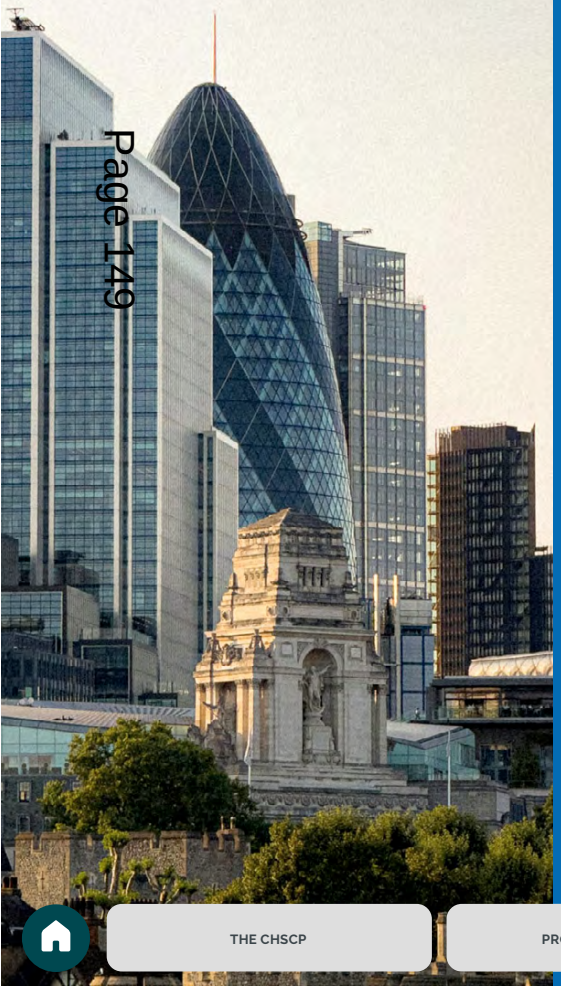
THE APPETITE TO LEARN

Progress against this priority remains strong. Whether through reviews, auditing or other activity, the CHSCP's Learning & Improvement framework continues to identify lessons and drive practice improvement. Our local focus on independent leadership and scrutiny via the ISCC remains a key component in this context. During 2024/25, the Boards tested the effectiveness of how learning was being cascaded to front-line practitioners.

PRIORITY 6

MAKING THE INVISIBLE VISIBLE

During 2024/25, progress in respect of the UES agenda remained slow on a practical level. Changes are awaited from the Children's Wellbeing and Schools Bill. If passed into legislation, there is likely to be a degree of regulatory shape introduced. Whilst welcome, there remain concerns about the impact of the enhanced monitoring regime for children who are electively home educated. There are also concerns about the potential loopholes that could exist by way of UES still being able to operate broadly as they are (with reduced hours) – hence avoiding registration and regulation. In April 2025, the CHSCP's ISCC issued a public statement on this matter. This can be read HERE.



City of London Safeguarding Snapshot 2024/25

The City of London, often referred to as the "Square Mile," is characterized by its small residential population and a significant working population. According to the 2021 Census, the residential population is 8,579, while the daily workforce is almost 615,000 (Office for National Statistics 2022). The residential demographic is notably young, with a large proportion of working-age residents. Only 14% of the population are aged 65 or over, and around 8% are under 18. This youthful trend is complemented by high life expectancy rates; between 2013 and 2017, life expectancy at birth was 88.8 years for males and 90.7 years for females, which is higher than the national average.

The City's demographic composition also reveals interesting patterns in family life, housing, and diversity. There are approximately 430 families with 713 children under 18, residing in 4,900 households, with an average size of 1.7 people. The area is ethnically diverse, with 42% of residents identifying as being from a Black and Global Majority background. There is a large Asian population (16.8% of the population), many of whom live on the east side of the City of London. While a place of great affluence, the Square Mile also has pockets of deprivation, with the Portsoken ward being among the top 20% most deprived areas in the country. To address housing needs, the City Corporation owns 1,923 social rented homes across 12 estates, with two located within the Square Mile and the rest spread across six London boroughs.

Within the City, there is one maintained primary school, four independent schools and several higher educational establishments. It has no maintained secondary schools. Most children attending these schools come from other boroughs and most of the local authority's secondary school age children go to school outside of the City.

Healthcare provision in the City of London is unique due to its dense workforce and small residential base. The Neaman Practice is the only NHS GP practice within the City's boundaries, primarily serving residents in the northwest. Due to proximity and accessibility, approximately 20% of residents, particularly those in the eastern wards like Portsoken, are registered with GP practices in the neighbouring borough of Tower Hamlets.

713
children under 18 (Census 2021)

8.3% of total population (Census 2021)

23.2%
of children in primary schools in receipt of free school meals

24
cases referred / stepped down to the City's Early Help Team

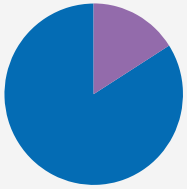
26
Team around the Family (TAF) meetings held

6
children going missing from care during 2024/25

3
children going missing from home during 2024/25

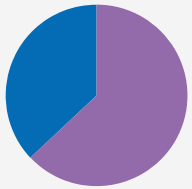
709
contacts to the City Children & Families Team Hub

58
Referrals



16%
re-referrals

8
statutory social work assessments completed by The City Children & Families Team



63%
of assessments completed within 45 days

6
child protection investigations

2
children on a Child Protection Plan as of March 2025

11
Children in Need as of March 2025

5
children looked after as of March 2025

3
MARAC meeting cases involved children

122
contacts to the LADO

0
Private Fostering arrangements as of March 2025

Hackney Safeguarding Snapshot 2023/24

According to the 2021 Census, Hackney's population stood at 259,200, Hackney ranked 68th for total population out of 309 local authority areas in England, which is a fall of two places in a decade. Hackney remains a relatively young borough with almost half of its population between 22-45 years old. That said, overall population sizes for under 19 and under 24 years old have declined slightly from 25.1% and 33.9% respectively since 2011.

Hackney is defined as a super-diverse borough. Almost 40% of the population was born outside of the UK. There is a significant 'Other White', Black and Turkish/Kurdish communities. A large Charedi Jewish community is concentrated in the North East of the borough. 89 different main languages are spoken in Hackney, out of a total across England of 96 main languages. Just over a third of Hackney's residents have stated on the Census they had 'no religion'; followed by the second largest group who are Christian. Hackney has significantly more people of the Jewish and Muslim faiths than England.

Hackney continues to face significant economic and social challenges despite being a hub for creative and tech industries. It has the third highest rate of income deprivation in London. Over 1 in 100 residents were destitute in 2022, equating to almost 1,600 households. Hackney has the 7th highest number of children living in low-income families of any borough in London, with the highest concentration in the North of the borough. With regards to child poverty, this is 25% for children living in income deprived households or 43% when defined as 'children not having enough resources to meet minimum needs, including taking part in society'. This places Hackney as the third highest rate of child poverty in London. There are over 8,500 households on Hackney's housing waiting list, many of whom are living in overcrowded conditions.

Crime levels have fallen between 2019/20 and 2022/23 in Hackney with 1,913 fewer victims. Hackney has recently seen reductions in serious youth violence, gun crime, knife injuries (under 24 years), knife possession, and lethal barrelled discharges. Referrals to the Domestic Violence Intervention Service have reverted to pre-pandemic levels of around 25 referrals a week.

The education system in Hackney is characterized by a mix of primary and secondary schools. The borough has a notable number of "Outstanding" schools rated by Ofsted. In 2024, Hackney ranked 35th of all local authorities on the percentage of pupils achieving a Good Level of Development. Historic attainment gaps persist in 2023. For Key Stage 2 pupils (age 11), Hackney is ranked 6th of all local authorities nationally on the percentage of pupils achieving the expected standard in reading, writing and maths. At KS4 (end of Year 11), Hackney is in the top twenty local authorities nationally. Performance of economically disadvantaged and Special Educational Needs and Disabilities pupils are consistently strong.

Approximately
57,291
children and young people under 18

21% of total population

22.1%
of under 16s live in a low-income family

41.1%
of primary pupils eligible for free school meals

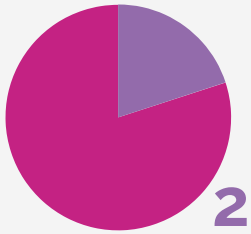
48.9%
of secondary pupils eligible for free school meals

609
families with children under 5 received Early Help MAT intervention

407
new early help cases (families) identified and supported through the MAT process

14,649
contacts to Hackney CFS

3,653
referrals



20%
re-referrals

3,439
assessments completed by Hackney CFS

91%
of assessments were completed within 45 days

1,352
child protection investigations

215
Children on a Child Protection Plan as of March 2024

382
children & young people looked after as of March 2024

296
MARAC meetings involving children and young people living in families with domestic violence

463
contacts to the LADO

15
Private Fostering arrangements as of March 2024

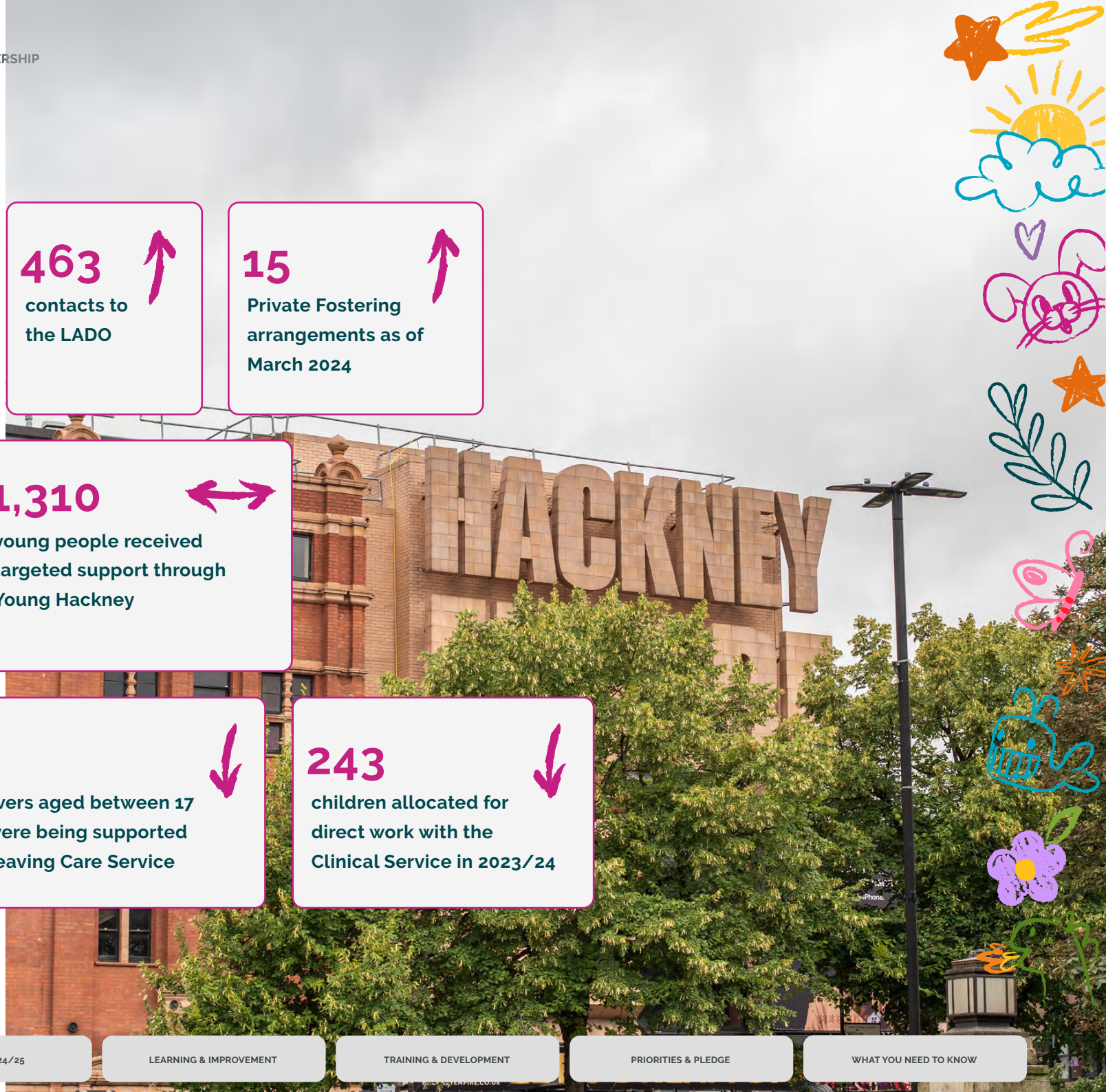
14,290
young people accessed universal services offered through Young Hackney

1,310
young people received targeted support through Young Hackney

133
children entered care during 2023/24

334
care leavers aged between 17 and 21 were being supported by the Leaving Care Service

243
children allocated for direct work with the Clinical Service in 2023/24



Safeguarding Partners & Relevant Agencies

During 2024/25, many agencies focused on strengthening their safeguarding frameworks and improving data management. The Met Police has addressed three causes of concern identified by HMICFRS, including improving its response to missing children and tackling victim-blaming language. They also launched a new "Child First" strategy, which aims to treat those under 18 as children first, identifying their vulnerabilities and understanding their circumstances. Similarly, the City of London Police has recruited new staff and improved processes for child sexual abuse material (CSAM) investigations. The East London Foundation Trust (ELFT) has a robust safeguarding governance framework and has improved its process for reporting referrals to Children's Social Care by mandating staff to complete an incident report form alongside any referral.

Numerous agencies have implemented new training and development initiatives. The City & Hackney Public Health Service has made children and adult level 1 safeguarding training mandatory for all staff. The National Probation Service has delivered updated training on safeguarding children and adults, as well as domestic violence, and has established stronger connections with specialist services.

Agencies are also making progress in service delivery and strategic planning. The City of London Children's Social Care and Early Help received an "Outstanding" Ofsted rating and has a stable workforce. Hackney Children and Families Service (CFS) also received a "Good" rating from its Ofsted inspection. Homerton Healthcare NHS Foundation Trust (HHFT) has developed new integrated pathways for Children's Occupational Therapy to improve patient safety and reduce risks. Additionally, Hackney CFS has opened a Care Leavers Hub and is planning to open internal Children's Homes.

Collaboration and a multi-agency approach are key themes in good practice. NHS NEL and its partners developed **a trauma-informed response** for child victims of domestic abuse, creating a guidance document with relevant resources for professionals. Agencies are also focusing on person-centred and holistic support, such as Homerton's Enhanced Health Visiting Service that is helping to identify early risk among vulnerable families.

Many agencies face **financial constraints** and workforce challenges. The Metropolitan Police Service has a £260 million budget deficit, which will lead to a reduction of approximately 1,700 staff, with the majority being officers. Hackney Council faces a financial challenge, needing to save £52 million over the next three years. Homerton Healthcare NHS Foundation Trust and other provider organisations face financial pressures to meet saving targets and are challenged by the ongoing recruitment difficulties for specialist children's roles.

There is also a growing concern about the **rising complexity of cases** and the gap between concerns and statutory thresholds. ELFT reports a sustained rise in emotional distress and self-harm among children and young people. The City of London Corporation Education and Skills Services noted an increase in children with social, emotional, and mental health (SEMH) issues, which has impacted school attendance. CAMHS teams across ELFT and HHFT are managing more complex cases involving a mix of mental health issues, exploitation, and neglect. Practitioners frequently find that these cases, while high-risk, fall below the thresholds for social care intervention, which creates ethical and clinical dilemmas.

Other challenges include **system-wide issues and new risks**. The loss of borough-wide forums, such as the Complex Case Forum, has led to some fragmentation in multi-agency working, with practitioners relying more on individual relationships to escalate concerns. The City of London Corporation Education and Skills Services highlighted challenges with adultification bias and digital safeguarding, noting that the evolution of digital platforms outstrips current frameworks. The National Probation Service and Hackney CFS also face staffing shortages and high turnover, which puts pressure on capacity and caseloads.

THE CITY OF LONDON CORPORATION - CHILDREN'S SOCIAL CARE AND EARLY HELP

EVIDENCE AND IMPACT

The Children's workforce has remained stable except for natural transitions and breaks such as maternity leave. Recruitment took place in 2024/25 to ensure that a permanent team is now in place. The workforce has now all completed the Achieving Best Evidence and Breakaway training; they have also accessed a range of training specifically around domestic abuse through the Court Trailblazers programme. All workers are supported to access Systemic Training and where required the Practice Educator training programmes. There is a comprehensive training programme in place as well as a well stocked resource library of research and direct work tools to support excellent practice which has positive outcomes for children. This was acknowledged in the 'Outstanding' Ofsted Inspection grading received during 2024/25.

Whilst numbers across the service have stayed relatively stable in relation to number of contacts, Early Help, Child Protection, there has been a reduction of the number of children remaining in care, although an increase in the numbers coming into care across the year. As most children in care in the City are unaccompanied asylum seekers, they arrive are accommodated and then placed on the National Transfer Scheme (NTS). The NTS has been working particularly quickly this year meaning some young people have been moving within 2-3 weeks of arriving. Which is positive for them as they are then able to settle in the Local Authority in which they will remain.

Child in Need numbers have decreased across the year this is in no small part due to the strong Early Help offer which provides a range of support at the earliest opportunity and prevents children and families requiring higher level support, which is positive. Thus, the number of children supported at home with their families overall remained consistent.

A well-developed Care Leaver Offer was launched which is accessible online and in a range of languages (Care Leaver Offer - City of London Family Information Service). Regularly monthly online drop-in sessions are offered to support care leavers to understand their rights and entitlements. Care leavers represent our largest cohort of young people accessing the service, with housing, immigration status, and employment being their top priorities.

We have continued to conduct an independent Annual Feedback Survey with broadly positive feedback received across all service areas. 83% of care leavers felt that their social worker was easy to contact and communicate with and 78% felt that the received the right amount of support. The Early Help received a 100% satisfaction rate. Children in Care and Child Protection numbers were very small with more variation in their views and experiences in terms of satisfaction; however the small cohort makes it difficult to draw definitive conclusions. We completed a 'You Said, We Did' response document to the feedback received and ensured that the feedback informed service development plans.

EVIDENCE AND LEARNING

We have consistently undertaken quality assurance practice reviews during the year, totalling thirty-nine reviews, to monitor the quality of practice and the impact on children and family's day to day experiences. None have been found to be 'Inadequate', 5 (13%) were graded as 'Requires Improvement', 15 (38%) were 'Good' and 19 (49%) were 'Outstanding'. Demonstrating that overall, the service provided is strong, where we have recommendations for improvement these are tracked on a monthly basis until we have implemented these and the impact then measured in future quality assurance activity.

IMPACT

CASE STUDY 1: *We had a baby under 1 years who was not previously known to City service present in an out of hours crisis. Police and out of hours services took immediate steps to ensure the safety of the baby, services then worked quickly to reunite baby and their parent in a safe assessment centre. Long and complex Care Proceedings were initiated, which were a challenge for the family to manage due their diagnosed additional needs and created feelings of hostility towards the social worker and service. However, the social worker and service worked persistently and tirelessly to continue to work with the family and support them to engage in the process. Sadly, the parent and baby were not able to remain together, however extensive work was done to explore extended family members to try and keep the baby within their family network. At times it did not feel like this would necessarily be viable however the social worker and service preserved and recently the baby was able to move to the care of a family member, with a package of support in place. This is the first use of our refreshed Kinship Support Offer (September 2024) which is in line with the best practice outlined in the Care Review. This is a plan that the parent has been able to give their consent to, recognising some of the issues which prevent them from providing sole care for her child. So far this is going well, and we are ensuring support is in place to try and sustain this arrangement.*



IMPACT

CASE STUDY 2: *An 8-year-old boy was referred to Early Help by a community outreach worker. The child had a disability from birth, but the family were not access disability benefits, and he was struggling in school. The family lacked confidence in navigating education or health systems due to language and cultural barriers. Once Early Help were involved they were able to support a referral to an Educational Psychologist for a comprehensive needs assessment, liaised with a specialist teacher to advise the school on appropriate adjustments, provided support for the family to apply for disability benefits, and an EHCP application was submitted to secure appropriate provision and prepare for secondary transition. The child now receives tuition and tailored classroom support, his family has increased financial stability and understanding of their child's condition, and he is more confident in learning and uses his aids consistently to support this.*

CHALLENGES

We have continued to focus on workforce stability and wellbeing, and whilst this has been good, we recognise the toll safeguarding work takes on individuals and teams. We have developed a Wellbeing Support Guide for People's Services which outlines a wide range of ways in which staff can promote their emotional and physical wellbeing.

This year we have started to define our Families in the City programme which will implement the National Social Care Review. Proposals were drafted and accepted by Senior Leaders which will lead to the creation of a Programme Board, under which three workstreams will work to deliver the changes needed. This will be established in 2025-26 and replace the current Senior Leader working group and include multi-agency partners. Whilst City already run a generic social work service there will need to be changes made and this may impact current roles and configurations which could lead to workers leaving or being dissatisfied with the new expectations.

Despite potential change we need to continue to deliver services to a high standard, which improves the daily experience and longer-term outcomes of our children, young people, and families, with minimal disruption. Therefore, communication with children, families, workers, and partners will be key to maintain consistency and limited confusion. The Quality Assurance service will also need to adapt as required to modified systems and ensure the framework meets the need of a newly modelled, multi-agency service. Workforce development will also need to be reviewed to ensure it is able to meet any gaps identified within the Families in the City programme in a timely manner.

THE CITY OF LONDON CORPORATION - EDUCATION AND EARLY YEARS

EVIDENCE AND IMPACT

Over the past academic year, City of London schools have embraced the Working Together to Improve School Attendance statutory guidance, updating policies and adopting a whole-school approach to promoting good attendance. In line with this, the City Code of Conduct was revised and, while no penalty notices were issued, eight 'Notice to Improve' letters were sent to parents. The Code will be reviewed annually, with minor updates planned to improve clarity and referral processes.

The School Attendance Support Team has maintained strong engagement with all schools, conducting regular visits and hosting two successful School Attendance Network meetings. These meetings, including input from DfE Advisor Victoria Franklin, highlighted the shared responsibility for attendance and the vital role of Attendance Officers. The DfE has assessed the City of London's arrangements as 'Green'. A termly newsletter will now keep schools informed of updates, training, and local data.

Using data from the school tracker, which currently monitors City-resident children across 68 schools in 20 local authorities, the team has identified and contacted out-of-borough schools with persistently absent pupils. Schools have been reminded that the team is available to support families in overcoming attendance barriers. To ensure a clear picture of where City children are educated, the school tracker has been updated to include those in alternative provision and with SEND, helping to anticipate needs and guide support.

The restructured Attendance Improvement Group—formerly the Vulnerable Children group—meets termly and includes representatives from education, social care, and the Virtual School. It ensures early identification of concerns and coordinated support for re-engagement with education. Recognising that poor attendance can impact a child's potential and safety, termly Education Safeguarding Forums have provided a platform for schools, the local authority, and CHSCP to share best practices. External services such as Prevent and the City & Hackney Substance Use Service have also contributed. The School Attendance Support Team continues to offer timely signposting and referrals to relevant agencies. For example, following the Inclusive Charter conference, a referral was made to Fight for Peace—a programme using boxing to re-engage a school refuser with SEND. Finally, the newly established Network Attendance Meeting brings together DSLs and attendance leads to share strategies, raise concerns, and collaborate on improving attendance outcomes.

IMPACT

CASE STUDY 1: *A Year 8 pupil with a diagnosis of Autism Spectrum Condition (ASC) came to the attention of the City of London SEND Team due to escalating behavioural concerns in school. Although the pupil had a confirmed diagnosis of ASC, their needs were not being adequately supported, and they were at risk of permanent exclusion. This risk materialised in January 2025, just before the finalisation of their Education, Health and Care (EHC) Plan.*

The SEND Team worked closely with Early Help Support Services to ensure both the pupil's social and special educational needs were identified and addressed. Interim tuition through an alternative provision provided some initial stability while a longer-term solution was sought. Through persistent advocacy and collaboration with a neighbouring borough, a place was secured at an Autism Resource Provision (ARP) within a mainstream secondary school.

A robust transition plan was co-produced by SEND, Early Help, the family, and professionals from both the alternative provision and the ARP. This ensured a phased and well-supported entry into the new setting. Since joining the ARP, the pupil has shown marked improvement in emotional regulation and engagement with learning. While some behaviours linked to anxiety and ASC continue to present, the school is well-equipped and skilled in supporting these needs. The family now has a secure and coordinated network of professionals around them, able to adapt provision as needed to give the pupil every best chance of success. The pupil's progress is being closely monitored to ensure their needs are met holistically. This case highlights the importance of early support following diagnosis, cross-agency collaboration, and the value of specialist provision in enabling pupils with complex needs to re-engage with education and thrive.

IMPACT

CASE STUDY 2: *With reference to one of the City of London schools, concerns were raised by the school of a year 10 pupil arriving persistently late frequently, arriving after registration closure.*
The Education Welfare Manager supported a meeting with parent and the pupil to understand the root cause of poor routine and disengagement with learning. An Early Help referral was made by the Education Welfare Manager, with the consent of parent.
Close parental engagement work was carried out from a Family Practitioner to support the relationship between the young person and their parent.
The school noticed an improvement in punctuality and learning engagement and continues to be supportive through praise and regular check-ins with parent and pupil.

EVIDENCE AND IMPACT

SEND - SEND is always a priority and the Service, along with the area partnership is committed to ensuring that *The City of London is a place where children and young people feel safe, have good mental health and wellbeing, fulfil their potential and are ready for adulthood whilst growing up with a sense of belonging*. We remain committed to high aspirations for all our children and young people, ensuring they receive an education tailored to their individual needs, along with the appropriate support to help them reach their full potential.

In line with national trends, we have continued to experience a rise in the number of Education, Health and Care (EHC) Plans over the past year, leading to increased demands on the SEND team. The SEND Team has increased capacity through an additional EHC Caseworker to support this increased demand. The City of London has also agreed a contract with the Hackney Educational Psychology Service to offer a bespoke package of support for City children and young people with SEND. There has been an increase in need in children coming through in the early years, and an increase in social, emotional and mental health issues in children coming though in KS3. Where there has been an increase in social, emotional and mental health needs, this has impacted on school attendance and one permanent exclusion. The SEND team has worked closely with the Education Welfare Manager and Children's Social Care and Early Help Service to regularly monitor and support these young people.

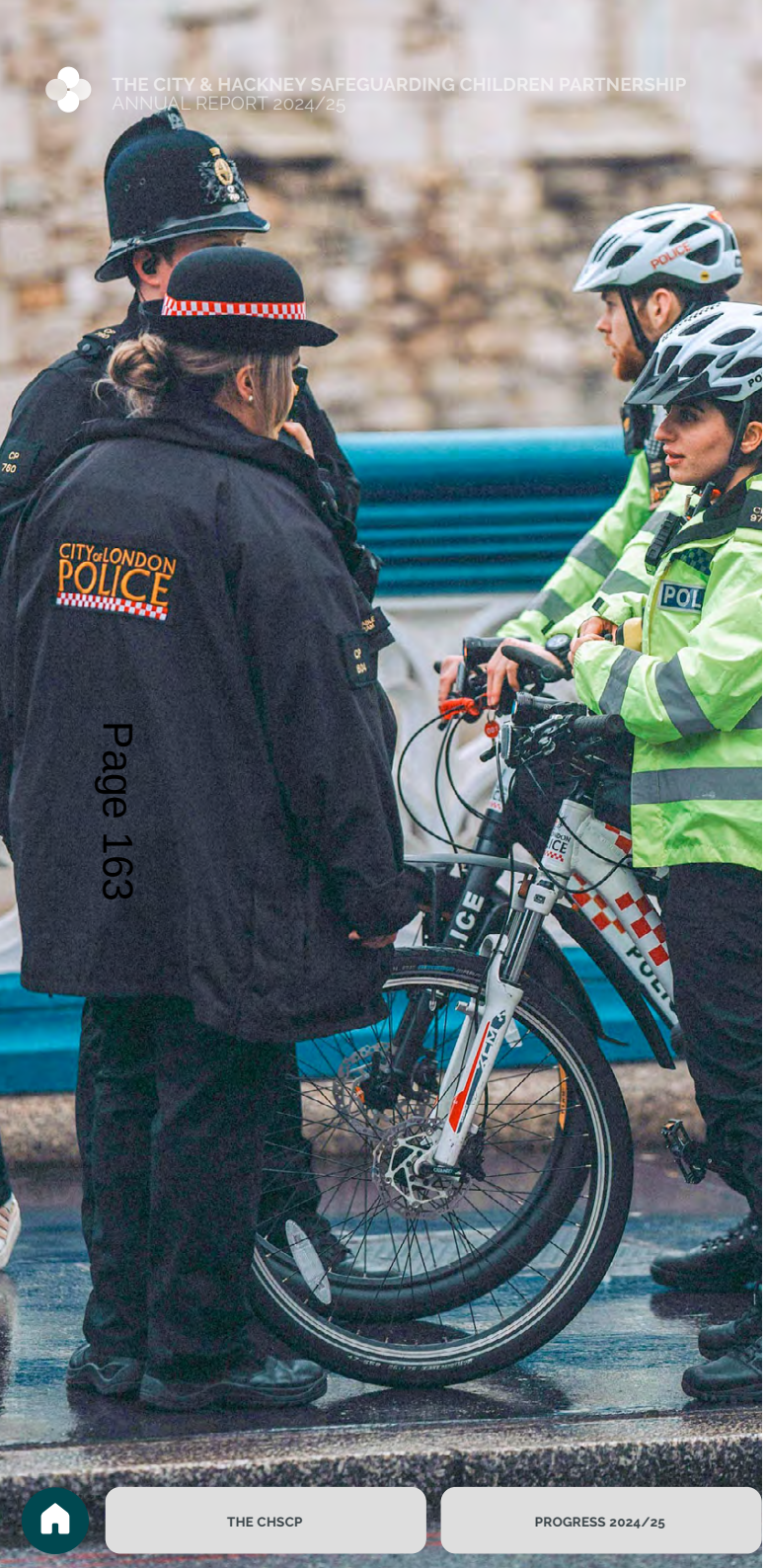
The City of London actively participates in every annual review to maintain oversight of any emerging developments and to ensure families are signposted to relevant services or referred as needed. Several children and young people with EHC Plans are also supported by children's social care and early help services, prompting close collaboration between the SEND team and social workers to ensure a coordinated and integrated approach. The SEND team also attends meetings arranged by the Children's Social Care and Early Help Service such as CIN meetings and TAF meetings to ensure a coordinated approach to meeting these children's needs.

EVIDENCE AND IMPACT

Early Years - The Early Years Advisor undertakes yearly Leadership and Management audits in the Autumn Term. These include key questions on safeguarding and ensure early years settings continue to be compliant with regulations. The Early Years Foundation Stage (EYFS) framework, which outlines safeguarding requirements for children under five, has had some clarifications. Changes include amendments to staff-to-child ratios, clearer guidance on paediatric first aid training and the importance of ensuring adequate supervision, especially when children are eating. Effective from September 2025, the Department for Education (DfE) is implementing significant reforms to the EYFS safeguarding requirements to ensure that early years providers maintain high standards of safety and care for children. These reforms are based on extensive consultations and feedback from stakeholders in the early years sector. The Early Years Team continues to work closely with the Early Help Team, particularly when children with additional needs are concerned as well as on the development of the Start for Life and Family Hub. All City Early Years settings remain Good or Outstanding with Ofsted.

EVIDENCE AND IMPACT

Adult Education and Skills - The adult skills service reviews termly all learners' continued understanding of Safeguarding. Important emphasis is placed on safeguarding themselves and others. 'Good Safeguarding' practice is fully incorporated in the subject course curriculum – it therefore becomes an integral part of teaching and learning. Learners are given an induction on the importance and value of understanding 'good Safeguarding'. All course tutors receive level 2 certificated training in understanding Safeguarding. The Service employs 3 Safeguarding Leads – they also receive certificated training. All learners are regularly/ termly asked about their understanding of Safeguarding. Their responses are recorded, analysed and an action plan is put in place to support any areas for further development. Learners are advised how to report breaches in Safeguarding practices - they are advised on the role of the Safeguarding Leads, and how to report issues and concerns. Monthly meetings are held with the DCCS Safeguarding Lead/ Adviser. Focus on Apprentices.



THE CITY OF LONDON POLICE

EVIDENCE

There have been several *Operation Makesafe* deployments across the City of London designed to test the response of hotels to possible child sexual exploitation and educate them as how to best respond to protect children and young people. The CoLP Public Protection Unit have benefited by the recruitment of an experienced Child Protection Detective Inspector and have created a further Detective Sergeants post to assist with partnership working and coordinating safeguarding across the force. The Public Protection Unit has reviewed and improved the processes around Child Sexual Abuse Material (CSAM) Investigations ensuring compliance with national best practice and welfare support for investigating officers.

EVIDENCE

A recruitment process was held for a new Detective Inspector in the Public Protection Unit. This was extremely competitive, and a new appointment was successful. The post-holder brings a wealth of experience with him as he was previously a DI in a child abuse team. The force is subject to a HMICFRS inspection and as part of this, a review of the PPU was conducted including Child Abuse Investigation and the management of Registered Sex Offenders. Once the feedback is received the CHSCP will be updated in respect relevant findings.

IMPACT

CASE STUDY 1: *PPU have an ongoing case where a young female travelled into the City with a friend and was able to get served alcohol in a licensed premises. She became intoxicated, separated from her friend and was then befriended by a male who subsequently seriously sexually assaulted her. She had no memory of the assault. Detailed forensic work has identified the offender, and he has subsequently been charged. Alongside this, colleagues in licencing are now seeking to prosecute the licenced premise that served the victim alcohol.*

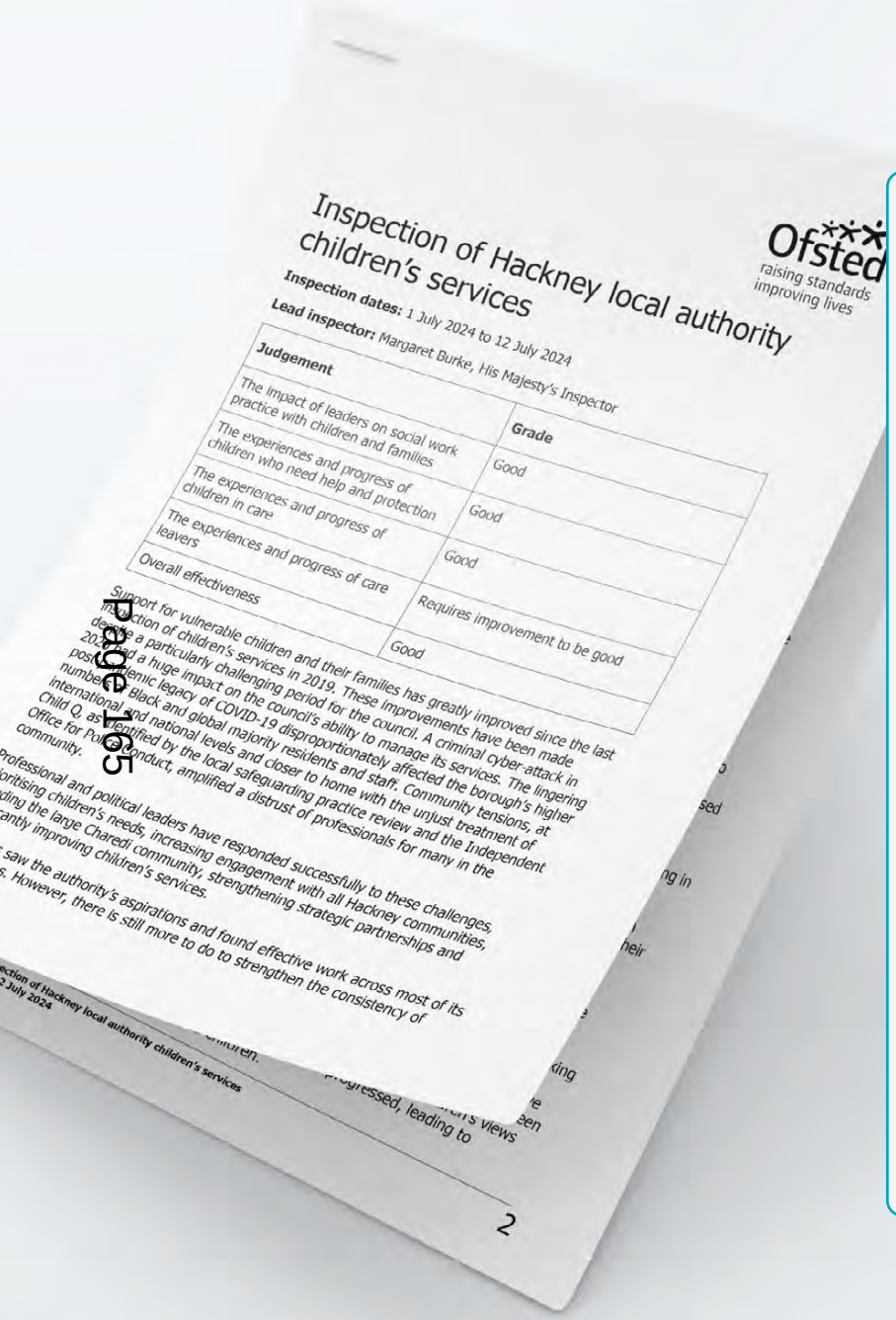
LEARNING

The CoLP have requested that the Vulnerability Knowledge and Practice Programme (VKPP) come and perform an inspection of how the force deals with vulnerability in children and young people. The VKPP is part of the College of Policing which sets out best practice nationally. The review was not requested as the result of any incident or organisational failure but rather as an opportunity to obtain feedback and seek to improve.

IMPACT

Further engagement work was completed by CoLP during the recent County Lines Intensification Week (CLIW) which included Officers attended high-end retailers within the Square Mile to raise awareness of how children exposed to CSE may be bought gifts as part of the grooming process into County Lines. This was also well received and further education was requested. During CLIW, six hotels in the City were also tested. Only one hotel passed by appropriately dealing with a child being checked in with an adult that appeared to be unknown to them. Following this, education pieces will be rolled out to hotel management to upskill staff to spot signs and disrupt where possible.




Inspection of Hackney local authority children's services

Ofsted
raising standards
improving lives

Inspection dates: 1 July 2024 to 12 July 2024

Lead inspector: Margaret Burke, His Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Good
The experiences and progress of children who need help and protection	Good
The experiences and progress of children in care	Good
The experiences and progress of care leavers	Requires improvement to be good
Overall effectiveness	Good

Support for vulnerable children and their families has greatly improved since the last inspection of children's services in 2019. These improvements have been made despite a particularly challenging period for the council. A criminal cyber-attack in 2020 had a huge impact on the council's ability to manage its services. The lingering post-pandemic legacy of COVID-19 disproportionately affected the borough's higher numbers of Black and global majority residents and staff. Community tensions, at international and national levels and closer to home with the unjust treatment of Child Q, as identified by the local safeguarding practice review and the Independent Office for Police Conduct, amplified a distrust of professionals for many in the community.

Professional and political leaders have responded successfully to these challenges, prioritising children's needs, increasing engagement with all Hackney communities, including the large Charedi community, strengthening strategic partnerships and significantly improving children's services.

Inspectors saw the authority's aspirations and found effective work across most of its service areas. However, there is still more to do to strengthen the consistency of

Page 195

2

HACKNEY COUNCIL - CHILDREN & FAMILIES SERVICES

EVIDENCE

The most recent inspection of children's services in Hackney was published in August 2024. This graded the overall effectiveness of the Local Authority as Good. The report can be read HERE.

Inspectors said: "*Support for vulnerable children and their families has greatly improved since the last inspection of children's services in 2019. These improvements have been made despite a particularly challenging period for the council. A criminal cyber-attack in 2020 had a huge impact on the council's ability to manage its services. The lingering post-pandemic legacy of COVID-19 disproportionately affected the borough's higher numbers of Black and global majority residents and staff. Community tensions, at international and national levels and closer to home with the unjust treatment of Child Q, as identified by the local safeguarding practice review and the Independent Office for Police Conduct, amplified a distrust of professionals for many in the community. Professional and political leaders have responded successfully to these challenges, prioritising children's needs, increasing engagement with all Hackney communities, including the large Charedi community, strengthening strategic partnerships and significantly improving children's services. Inspectors saw the authority's aspirations and found effective work across most of its service areas. However, there is still more to do to strengthen the consistency of support to care leavers and to secure good-quality and stable accommodation for them at the time they need it.*" ***Ofsted 2024***

EVIDENCE AND IMPACT

The restructure of the management levels within Children's Social Care concluded in January 2025. The restructure has simplified the service structure, providing clearer management structure and lines of accountability. The new structure includes a move away from the unit model towards a traditional social work team model, with Consultant Social Workers and Practice Development Managers have been replaced by Team Managers and Practice Leads. Separate to the management review - the Multi Agency Safeguarding Hub (MASH) completed a staffing review in the spring of 2025. The MASH has aligned its management structure with the wider CFS, incorporated EDT line management to the structure, and ensured permanency for the MASH Early Help Hub.

Our in-house Clinical Service is undergoing a restructure. The clinical restructure has meant we are no longer delivering clinical interventions that would elsewhere be the responsibility of CAMHS. There is also a Business Support Review which was launched in July 2025, which is looking at the structure of our business support functions. Furthermore, the Young Hackney service has undergone a restructure. The Young Hackney restructure has refocused the age profile of those supported by the service towards adolescents aged 10 – 19 and developed a locality model on a smaller defined geography, including 4 area teams. Further organisational change is likely to occur in areas such as the Family Support Service as the Directorate responds to the Social Care Reforms.

EVIDENCE

Plans are underway to open internal Children's Homes, to promote Children in Care living within our borough. Feedback from the pre-planning application has been received, and planning applications are set to be submitted. A new Commissioning Officer has started as Project Manager adding additional capacity and expertise to drive the programme forward. Work to recruit young people to co-produce the final design and finish of the buildings, as well as procure the expert service partner to run the homes and support commissioners to monitor the quality of the homes when they are set up, is underway.

LEARNING

Learning Conversations: *Between February and April 2025,* a total of 15 learning conversations were carried out on children's files. These conversations focused on Parental Metal Health. 53% of cases were rated as being good, 40%, were found to require improvement, and 1.7% judged to be inadequate. Good practice included inclusion and promotion of children's voices in their plans, good plan progression, good multi agency support for children, good management oversight for children supported by legal proceedings, Looked After Child and Child Protection plans, and good curiosity around children's identity needs.

LEARNING AND IMPACT

Practice Observation Week. In June 2025, Hackney CFS launched a Practice Observation Week, where leaders including Team Managers, Service Managers, Heads of Service, the Director and Group Director completed observations of direct practice. The purpose of this was to provide feedback to practitioners on their practice and to enable managers to experience the quality of practice across our services to children and their families. Highlights included:

> One observer felt that the social worker 'clearly demonstrated an effective use of communication with the child. He was curious about what they had said and their experience, including of having multiple social workers come into their life. He was able to take time to explore what they thought about the situation and what might make things better for their family'.

> One observer commented on swift MASH procedures, 'the decision making is very effective and timely - following the conclusion of the telephone call - [the social worker] is recording and processing the information without delay - and a MASH manager is subsequently making the decision to progress the contact for assessment. The whole process is concluded within 45 minutes of the call coming through'.

> Observing a Young Carers Group, the observer commented that 'the voices of all young people are being heard within session, the communication helps to facilitate learning. The views and suggestions are taken on board. The young people expressed how much they enjoyed being part of this group and the positive experiences that they have had at the Young Carers'.

> One family shared that the social worker 'genuinely listens which is helpful, they haven't always felt listened to by social workers but do with [the social worker]', and another stating the social worker has 'consistently been efficient, communicative, and very easy to work with. Her dedication and professionalism have been evident throughout, and we are genuinely grateful for her continued support over the years.'

IMPROVEMENT

In May 2024, Practice Development Managers reviewed 11 full audits undertaken in HCFS that were initially graded as Inadequate or Requires Improvement. The purpose was to re-evaluate these cases and identify any improvements in practice. The findings showed significant progress, with practice improving to Good in over half (58%) of the reviewed files. Notably, two cases that were previously graded as Requires Improvement were now considered Good. None of the cases remained at the Inadequate level. The review also highlighted improvements in timely and detailed recording, and it was noted that identified actions were either completed or in progress. However, some areas for improvement were still identified, including instances where visits and recordings were outside of set timescales and meeting minutes were missing from two audits.

IMPACT

A parent or carer working with the Family Support Service shared: *"I really want to say a huge thank you for all the support and guidance you've given me. Your help has made such a difference in getting [Child] back on track and I feel so much more confident as a parent because of you".*

A parent or carer working with Young Hackney shared: *"Thank you so much for your work with [Child], it has made a huge difference and you have helped them through a very difficult time and they have come out confident and happy on the other side".*

A parent or carer working with the Multi-Agency Safeguarding Hub shared: *"Your kindness, expertise and sensitivity...made a huge difference to my wellbeing".*



CHALLENGES

Financial Pressures: In Hackney, we are facing ongoing pressures of service demand and tightening of funding. This is due to increasing costs, growing demand and a lack of clarity about long-term funding arrangements. As a council, we have to save £52m over the next 3 years. Therefore, there will be an action plan to reduce expenditure within each Directorate. Due to this, the provisions currently on offer will be under review, and future provisions may change.

As the cost-of-living crisis continues, Hackney families continue to face poverty, homelessness and hunger. Thus, supporting families with the cost of living at the earliest stage possible is of key importance. Hackney Council is undertaking a range of activity in response to this crisis, including the adoption of the Poverty Reduction Strategy 2022-2026.

Workforce: Nationally there continues to be high staff turnover, and challenges in recruiting and retaining social workers, resulting in high caseloads. Where we have recruited staff, they may be less experienced and require increased support from managers to ensure high-quality practice. We have implemented several incentives to recruit and retain staff.

Care Leaver Accommodation: During our 2024 inspection, the key message once again from our young people, echoed by inspectors, was that for care leavers, access to safe, affordable, sustainable housing is their number one priority. We have established a sub-group of the Corporate Parenting Board, Chaired by the Group Director for Climate, Homes and Economy, to track the progress and monitor outcomes of this work over the next year. The most significant development has been the decision - endorsed by Cabinet - that the Housing Register would be amended from April 2024 to enable care leavers to join in a priority band from 18. Work is underway to support all care leavers who wish to do so to join the register. Housing colleagues have backdated all existing application start dates for care leavers to their 18th birthdays. We hope in time that this will mean fewer care leavers experience a 'cliff edge' in their housing options at 21 and more are able to secure social housing tenancies - should they wish to do so - in a timely way.

We were delighted to secure Department for Levelling Up, Housing and Communities' funding early this year for a Housing First project, through which 10 care leavers with the most complex needs will be offered a tenancy alongside intensive, wrap-around support from Centre Point. Through this joint Children's Social Care and Housing project, we hope to learn more about how best to offer post tenancy support to our care leavers. This learning will inform an update of our Joint Protocol, which will include a new focus on post tenancy support, including repairs and maintenance.



HACKNEY EDUCATION

EVIDENCE

Hackney Education's mission is to improve the life chances of every child in Hackney by creating a safe, inclusive, and exciting educational environment. The organisation is aligned with Hackney Council's corporate values, these are: child and learner focused, ambitious, proactive, inclusive, pioneering, open, and proud. These values guide the organisation's approach to its objectives. A significant focus of Hackney Education's Improvement plan is safeguarding children and addressing systemic racism. Priority (A) is dedicated to ensuring that all schools are, and feel, completely safe and free from racism, building on the report into the experience of "Child Q". Key initiatives include:

- Introducing a "Hackney safe and inclusive schools charter".
- Taking rapid action on the presence of police in schools..
- Sustaining action on anti-racism and providing professional development for staff to be anti-racist.
- Ensuring the voices of children, parents, and staff are heard.

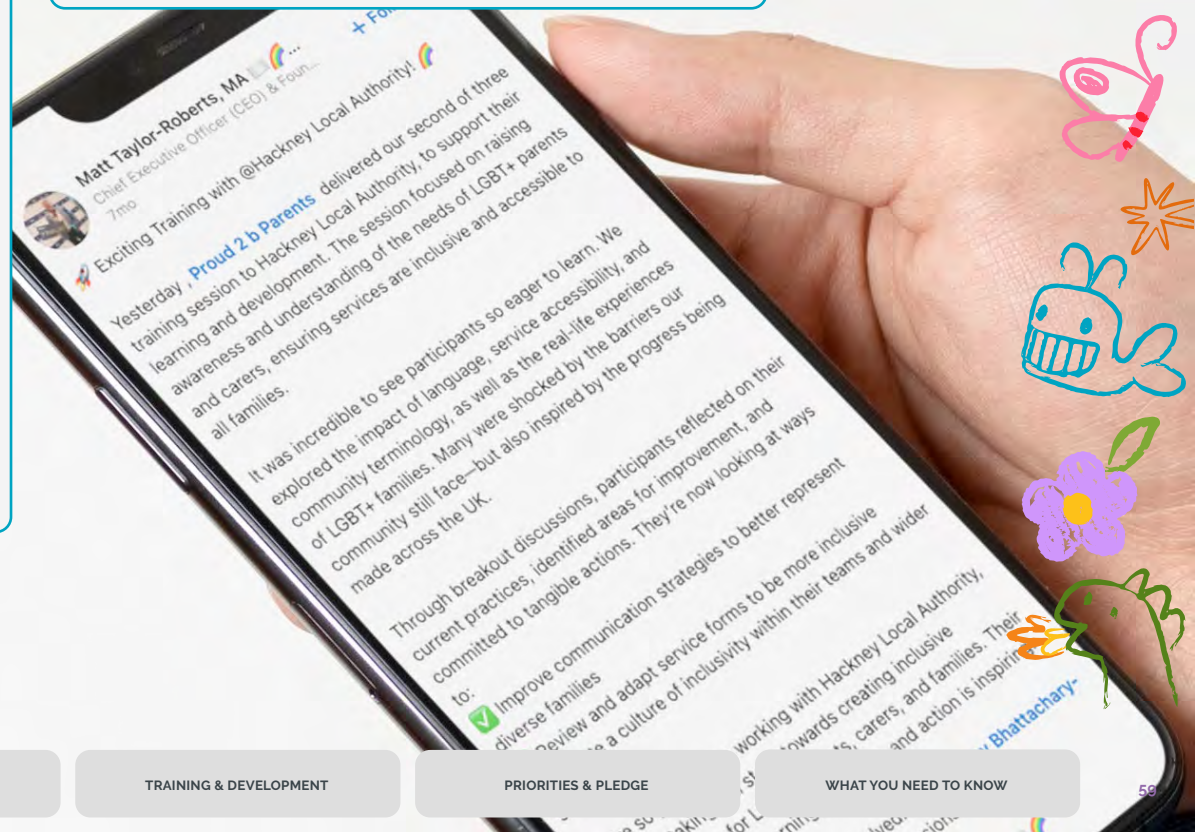
EVIDENCE

During this reporting period, Hackney Education had five main priorities:

- **Priority 1:** Achievement: Working with schools and settings to enable the best possible achievement for every child, with a focus on closing achievement gaps for pupils receiving pupil premium, Turkish Kurdish Cypriot pupils, Caribbean pupils (boys), and Orthodox Jewish pupils.
- **Priority 2:** Wellbeing and Inclusion: Promoting safeguarding, wellbeing, and inclusion, including provision for children with Special Educational Needs and Disabilities (SEND), reducing exclusions, anti-racism, and post-COVID recovery.
- **Priority 3:** Quality Places: Providing quality educational places for every child from age 0 to 19, including implementing a school place strategy and transforming children's centres.
- **Priority 4:** Strong and Sustainable System: Ensuring the Hackney education system remains strong, sustainable, local, and responsive to enable high performance in all schools and settings.
- **Priority 5:** Supporting Parents: Supporting and engaging parents and carers by ensuring their voices are heard and providing support routes for those experiencing difficulties.

EVIDENCE AND IMPROVEMENT

Children and Family Hubs have moved to a neighbourhood model, based on eight primary care neighbourhoods aligned with Children's Centres. SEND Hubs, Super Youth Hubs, Child in Need teams and Family Support teams will also be aligned according to this neighbourhood model. After the final Children and Family Hub was launched at Woodberry Down on 27 February 2025, new programmes have been commissioned, including the WellComm Tool, Proud to B Parents Training, and an Outreach Strategy with HCVS.



EVIDENCE AND IMPROVEMENT

Improving school attendance is a priority nationally in education, and Hackney has developed a School Attendance Support Team to respond to the barriers to education that schools and families are experiencing. As part of this work, we have extended our offer beyond maintained and academised schools, to include the Charedi independent schools operating in Hackney. These schools serve children who identify as Charedi in Hackney, which is a rapidly growing percentage of our overall school-aged population. The work has focused on developing a culturally informed programme of support, and forming positive relationships through which we can jointly leverage change and positive impact for the children we serve. Hackney Education has one attendance officer dedicated to supporting just our Charedi schools around attendance barriers, the consistency of which has really helped to strengthen the relationship and quality of the work undertaken.

We have provided ongoing training to education professionals in the Charedi community that is accessible and culturally informed (for instance, we run face to face sessions as well as online sessions, and attendees can choose between sessions run by either a male colleague or a female one). In order to demonstrate our commitment to understanding and serving our Charedi independent schools, we have broadened our attendance training offer to include all Charedi independent schools in the UK. We have welcomed Charedi education colleagues from Manchester, Salford and Gateshead into our Hackney-based training sessions. One session which we ran online was attended by 86 rabbis. We continue to offer guidance and oversight around attendance policies and approaches and are working with around 70% of our Charedi independent schools, and we look forward to developing this work further and with more settings in the new academic year.

EVIDENCE AND IMPACT

- To help children and families cope with the cost-of-living crisis, the following support is available.
- Free school meals: All children starting school in the reception class, Year 1, or Year 2 will get a free meal at school regardless of income.
- Children and families 0-19: Children receiving free school meals or those identified by local providers in the statutory, voluntary and community sector or Children's Centres (including the Orthodox Jewish community) and in local colleges have been provided with food vouchers. School uniform grants are also available from Hackney Education for families who are struggling to afford this.
- Hackney provides funded 2 year nursery places, now open to families with no recourse to public funds.
- Early Help hub and Multi-Agency Safeguarding hub: Families contacting the Early Help hub or professionals making contact on the MASH consultation line on behalf of families in crisis may be referred to community support, including children's centres, youth hubs or community partners, and families may be provided with food vouchers in an emergency.
- Children and families hubs: Families receiving targeted support via the Multi-agency teams (MAT) receive food vouchers, and all other families who are eligible can access Healthy Start vouchers and Alexander Rose vouchers, redeemable for fruit and veg from Hackney markets.
- Youth hubs and adventure playgrounds/ holiday activities: Free after school and holiday activities are provided to families via youth hubs and adventure playgrounds.
- Voluntary and community sector support for under 5's: Voluntary and community groups who support families in need across the borough have been provided with funds to purchase food vouchers to distribute, and a number of these are accepting referrals from other VCS groups.
- Emergency funds remaining for children in need: emergency funding for food vouchers has been identified to support care leavers, families supported by Child in Need, Child Protection and Family Support plans, and in-house foster carers.
- Section 17 Finance Guidance for CFS Staff: A guidance document produced to assist practitioners in the work they do with and for families when children's identified needs require the provision of financial assistance.

IMPACT

This year also saw 100% of our schools and children's centres receive good or better Ofsted judgements in all of the graded areas of inspection.

Ofsted
raising standards
improving lives

CHALLENGES

It has been a challenging year for many of our communities facing the closure of their schools due to declining pupil numbers. Particularly, it has been painful to see the closure of four wonderful schools who have provided the best possible education for their families: We thank and recognise the staff leaving the following schools which are closing at the end of the academic year 2025.

- Oldhill Community School (whose pupil body is merging with Harrington Hill School)
- St Dominic's RC Primary School
- St Mary's C of E School
- Sir Thomas Abney Primary School (whose pupil body is merging with Holmleigh School and will be located on the Sir Thomas Abney site)

CHALLENGES

A consultation on the Strategic Plan for 25-28 began in the Autumn of 2024. In order to tackle some of these challenges, several key priorities were identified. These were:

Special Educational Needs and Disabilities (SEND) and inclusion: Ensuring efficient and sustainable SEND provision, early identification of needs, and timely support.

Additional and Alternative Learning Provision: Developing a three-tiered support model to promote inclusion, reduce exclusions, and ensure appropriate interventions.

Strength and sustainability: Ensuring schools, children's centers, and settings are strong, sustainable, and financially viable, with a focus on recruitment and retention of staff.

Sustainable school improvement: Delivering a successful, affordable, and sustainable local education system by promoting collaboration, sharing best practices, and supporting innovation.

Equity for children and families: Working to achieve the best outcomes for all children, particularly focusing on ensuring equitable opportunities and targeted support for those who need it most to thrive.

Outreach and engagement activities will continue into the 25/26 period.

YOUNG HACKNEY

EVIDENCE

Young Hackney successfully re-structured in 2024 in response to local savings targets. The new iteration of the service went live in April 2025. The integrated model and approach to service delivery largely remains the same and there have been no changes to play, young carers, health and wellbeing and substance misuse services. However, the service is now operating with a more streamlined and targeted capacity and is focusing the Young Hackney offer at adolescents more specifically. Key changes include; a revised aged criteria for universal youth services and targeted early help of 10-19 (25 with SEND), the introduction of a medium/ high early help need threshold for individual targeted early help, earlier and longer opening hours for teenagers at our youth hubs and the establishment of a dedicated Young Hackney Detached Outreach Team.

Since the re-structure Young Hackney has started to receive fewer 'Requests for Help', this is consistent with expectations as the service manages demand under new arrangements, however patterns regarding type of need, referral source and interventions offered remain consistent.

Health Spot City and Hackney at Forest Road Youth Hub- the young people's health initiative led by the CAMHS Alliance and Young Hackney that brings a broad range of health services to young people and supports access with youth workers continues to grow and develop.

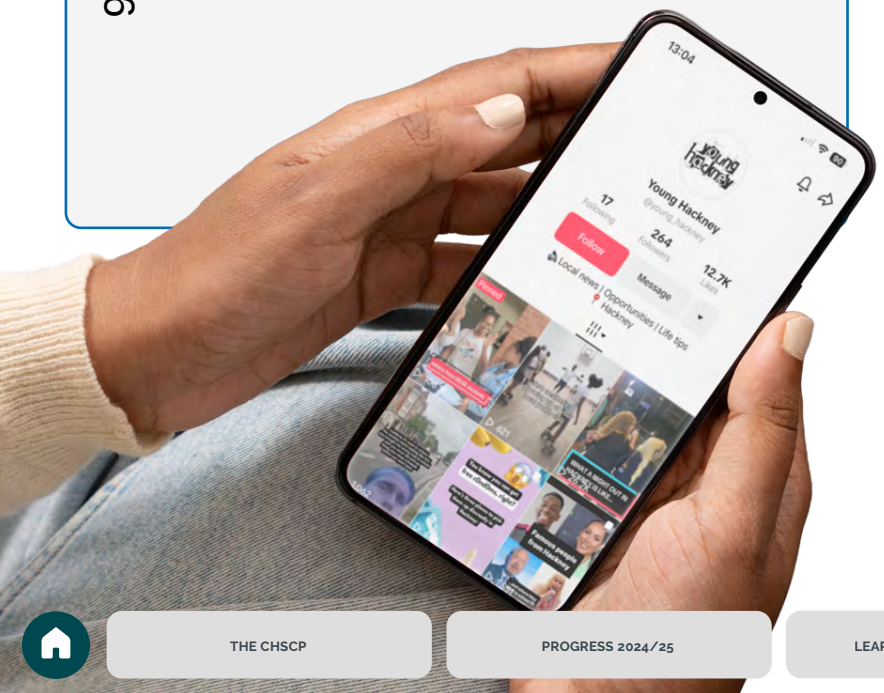


LEARNING

Young Hackney is refreshing some foundational training for its staff and beginning to expand this offer to commissioned VCS youth providers with a first cohort of practitioners recently completing 'An Introduction to Systemic Practice' and Trauma Informed Care training with the Tavistock and Portman NHS and second cohort pending.

EVIDENCE AND IMPROVEMENT

Young Hackney is now on TikTok: @young_hackney. Early indications suggest the social media platform will offer a significantly broader digital communication reach for the service to young people.



IMPACT

Referred by school to Young Hackney's Young Carers Service in December 2024. Mum has Type 1 Diabetes and her health had deteriorated in recent years resulting in a period of hospitalisation. IS-L was providing practical, personal and emotional care for mum. School were concerned about the impact IS-L's caring responsibilities were having on his emotional wellbeing and difficulties in school. The family were isolated, both mum and IS-L had little support beyond each other. The YH Young Carers Team quickly engaged the family, forming strong relationships with both IS-L and his mum. IS-L was offered six individual support sessions and access to a range of activities for young carers. Mum was anxious about IS-L leaving the home and engaging in extracurricular activities but was reassured with support to allow IS-L to start attending young carers swimming lessons which eventually lead to mum attending her own fitness classes on the same site. Soon the family were taking part in a range of leisure and fitness activities independently and together helping to address their isolation and mum's health needs.

During the course of the intervention IS-L disclosed experiences of racism in school by a teacher. The Young Carers Team addressed this with school who responded appropriately, IS-L and Mum reported a significant change in IS-L's experience in school thereafter. Mum is better managing her health needs now, her independence and confidence is returning and IS-L's caring responsibilities have become more manageable. Mum said *'The service has helped us in many ways. I feel like it's an extended family that I can rely on. With so much support it's brought balance and security'... 'After the 1:1 sessions IS-L comes back feeling 'full', it's like a reset for him'...'It's provided hope of getting back to normal'*

IMPACT

A young person was referred to Young Hackney for Targeted Early Help by the police via the MASH in February 2025 following a missing episode after getting in trouble at school. At the point of referral parents also shared concerns that they had found a knife under the young person's pillow, and that the young person was worried that peers had threatened to attack them in their home. Whilst doing academically well, the young person experienced bullying and had no friends.

The allocated Young Hackney worker formed a trusted relationship with both the young person and family and quickly hypothesised that they may have an undiagnosed/ unmet learning need that was affecting social skills, interactions and experiences. This was a very sensitive matter for the young person and family who were reluctant to engage in this discussion. The Young Hackney worker tactfully addressed the matter enabling the family to eventually disclose that the young person has a lifelong neurological condition that would explain their difficulties. Due to mistrust, the family had never wanted to share this diagnosis with school or other professionals, had been managing this on their own for most of their child's life and they thought that because they were doing well academically, their condition was not the cause of her current difficulties. The Young Hackney worker helped the family to understand the impact of the condition on social skills and relationships and with reassurance they consented to this information being shared with a trusted adult in school so that the appropriate support could be put in place. The school was supportive and despite there still being some difficulties the family have reported significant improvements in circumstances.

CHALLENGES

Young Hackney has been through considerable change this year, there may be challenges as these changes continue to take effect and we begin to see possible consequences- managing demand for individual targeted early help or school-based interventions for example. It will be important that we continue to work closely with partners- particularly school and health and the MASH to collaboratively meet early help need.

HACKNEY YOUTH JUSTICE SERVICE

EVIDENCE

The new 2025-2028 Youth Justice Service Strategic Partnership Plan was approved by Full Council in July 2025, as required as a condition of our YJB grant. To develop the Youth Justice plan 2025-28 the Safer Young Hackney Board came together in a facilitated workshop to consider our local performance data, the outcomes we achieve for children, the challenges we are now facing, feedback from children and families and the progress made. Collectively the Board agreed our shared practice principles and approaches and the shared key objectives for the next three years.

The plan outlines Hackney's partnership vision for children who are engaged with, or at risk of entering the Youth Justice System. It emphasises safeguarding, prevention, early intervention, and responding to local needs. It highlights the partnership's shared commitment to a "child first" and strength-based approach which is aligned with our Hackney STAR-R model (Systemic, Trauma Informed, Anti Racist and Restorative). The document includes the partnership's anti-racism position statement, acknowledging systemic racism and committing to practice which is anti-racist and actively champions social justice.

EVIDENCE AND IMPROVEMENT

Safer Young Hackney Board continues to be well attended and effective.

The Youth Justice Integrated Health Team (Health Huddle) continues to be embedded as part of the Hackney Youth Justice Service. This health team includes the Youth Justice Service Lead Nurse, Speech and Language Therapy Service, Clinical Team, Specialist CAMHS, Substance Misuse Service, and Sexual Health Nursing Service.

Our SALT team have been commended for their work in court with positive feedback from magistrates, defence solicitors and parents.

ETE - Recruitment for an additional Virtual School member to support children on both Out of Court Disposals and Bail Support is now complete - This was required as an outcome of inspection.

P&D/ MPS Stop & Search information initiative (QR code) with a video developed by young people which brought the information to life.

IMPACT

Parent: *Felt fully involved in her child's YJS work noting her child was "challenged" by his YJS practitioner in a way that prompted her to reassess her parenting and professional interactions. The parent noted that the YJS involvement was the most positive event for her child and their family.*

Child: *Practitioner, "if it wasn't for you I would not have gone back to school, I mean that. You have helped me more than I even thought you would, when nobody was listening and even my own family didn't believe what I was saying, you believed me. I'm in a different place now and I'm moving on with my life." (Prevention & Diversion Team Feedback).*

Victim: *"You're the first person to reach out to me since the incident happened 3 years ago, and I truly appreciate you checking in and updating me on the progress of the court case. You took the time to listen to me, which really meant a lot, and you made sure I knew what support was available. Without your contact I would have missed the chance to have my voice heard in Court and the opportunity to attend. Thank you for making sure I didn't go through this alone."*

Child: *"Victim awareness sessions went very well, she (RJ Worker) was easy to speak to and I was able to see myself like I have never done before, to be more open minded and reflective. I was able to put myself in the shoes of the victim, realise the impact of doing so and what could have gone wrong or even worse if the scenario was different."*

CHALLENGES

Challenge regarding the quality of the secure estate - An urgent notification was issued for Oak Hill on 31 July 2025, following a failed inspection. Oak Hill management and staff are currently developing an action plan to address the issues. Options for relocating children from Oak Hill are severely limited. Hackney's YJS has therefore increased contact with Hackney children who are either current or recent residents of Oak Hill. Of note, whilst Oak Hill has its issues, the "lived experience" of children there is generally not as poor as that of children in Feltham Young Offender Institution (YOI), where feedback on safety and staff access is universally negative, despite Feltham not being subject to an urgent notification.

Discussions are underway with ELFT about how to better engage CAMHS practitioners in Hackney's Prevent/ Channel processes. Furthermore, there remains a degree of uncertainty regarding the MPS reorganisation and the implications this will have on Youth Justice police officers & MASH.

HACKNEY HOUSING

EVIDENCE

In 2024-25, Hackney's housing strategy focused on creating genuinely affordable homes and improving housing services, though affordability remained a major challenge, with a housing strategy position statement approved in December 2024 and a new 5-year plan expected in late 2025. Key initiatives included building 1,000 new council homes and implementing schemes like Hackney Living Rent to offer homes below market rates. The borough also saw rising private rents and a growing housing register, with ongoing efforts to improve standards in the private rental sector and enhance safety compliance in council housing.

EVIDENCE

The Housing service continues to operate in a challenging borough context. As of June 2024, the average house price in Hackney was £590,000, which is 18.5 times the average household income of £31,580. Private rents increased to an average of £2,361 per month in July 2024. There are 8,500 households on the Council's housing register and 3,400 homeless households are in temporary accommodation. Approximately 4000 children were living in temporary accommodation. The Council has a significant challenge with the supply of social housing, with only 570 lets available between April 2022 and March 2023. Hackney is experiencing a significant increase in homelessness, with an 8% increase in temporary accommodation required year on year.

IMPROVEMENT

The Council has implemented a housing improvement plan to address issues around mould and dampness. The plan focuses on four key themes: response to regulation, workforce development, resident focus, and systems and data. A full stock condition survey is underway to identify issues and this information will be used to create an updated asset management strategy.

CHALLENGES

While Hackney has made notable progress in its 2024-25 housing strategy, significant challenges persist, particularly concerning affordability and supply. The Council's proactive measures, such as the commitment to deliver 1,000 new social rent homes and the implementation of a Housing Improvement Plan, demonstrate a clear focus on enhancing both the quantity and quality of housing. Moving forward, the forthcoming 5-year housing strategy in 2025 will be critical in consolidating these efforts and building upon the foundation laid by the 2024-25 position statement to create a more equitable and sustainable housing future for all Hackney residents.

THE METROPOLITAN POLICE SERVICE

EVIDENCE AND LEARNING

The MPS is no longer in ENGAGE phase as specific causes of concerns have been addressed. This is positive. In June 2023, the Mayor's Office for Policing and Crime in London commissioned HMICFRS to inspect how well the Metropolitan Police Service handled the sexual and criminal exploitation of children. HMICFRS carried out the inspection in September 2023 and issued three causes of concern and made 11 recommendations.

The causes of concern were as follows:

- **The force needs to improve how it identifies and assesses risks, and how it responds, when children are reported missing.**
- **The force should improve its investigations when children are at risk of, or harmed by, criminal or sexual exploitation.**
- **The force needs to make sure its officers and staff, at all ranks and grades, understand what victim blaming is and how it affects the service they provide.**

HMICFRS revisited the force between 30 September and 18 October 2024 to review its progress and found:

- **Senior leadership response to above issues had been positive and the cause for concerns were closed.**
- **The MPS children's strategy sets out the commissioner's ambition to adopt a child first approach.**
- **Through renewed focus on child exploitation, its links to missing children and the language officers and staff use has made positive progress.**
- **The changes (policy/guidance, training, uplift in officers) introduced by the MPS are also providing better outcomes for children in London.**

EVIDENCE

The Central East BCU received an uplift in officers during the reporting period to support Public Protection investigations. The officers arrived on BCU came with diverse range of policing experiences and added value. Our teams continue to provide business as usual in the areas of child safeguarding. Going forward the MPS like many partner organisations will face financial challenges and will need to make tough choices. Tough choices work is underway across the organisation.

IMPROVEMENT

Children reported missing:

- MPS has improved its policy and guidance and provided additional training including best way to improve its practice when children are reported missing.
- Saw an improvement in MPS's response when children are reported missing.
- MPS is better at planning for when children at risk of exploitation are reported missing and will strive to get better.
- MPS uses innovative methods to help find children.
- MPS has better oversight when children are reported missing.
- The MPS has improved how it shares information with its partners.

IMPROVEMENT

Child Exploitation:

- MPS is focusing more on safeguarding children.
- Tackling exploitation of children is a higher priority.
- More investigators have been trained in child exploitation.
- Number of officers working in exploitation teams has increased.
- More frontline officers and staff have been trained in child exploitation.
- Fewer delays in starting investigations.

IMPROVEMENT

Victim Blaming Language

- MPS has carried out substantial work to try and stop victim blaming language
- MPS encourages its officers and staff to challenge victim blaming language
- Most officers and staff recognise victim blaming language and understand its negative effect

EVIDENCE, LEARNING, IMPROVEMENT

On 26 September 2024, the MPS launched its new Children's Strategy to keep children in London safe, build their trust and bring to justice those who abuse and exploit children. This is a 5 year strategy. Around 2 million children live in London and the policing challenges they present are wide ranging from exploitation, to growing up among domestic abuse, to child abuse to a child carrying a knife. In 2023, there were approximately 61,000 child victims of crime and 51,000 children who were suspected of committing a crime.

Child first is an approach that has been developed using evidence of what works to reduce children engaging in criminal behaviour, achieving positive outcomes and create safer communities. Child first recognises that children are different to adults, they have different needs and vulnerabilities. Child first seeks to treat children as individuals and for professionals to understand the wider context of their lives. Child first ensures that work with children acknowledges their status as a child rather than treating them as adults.

What Child First Means for policing

- Those below 18 should be treated as children first.
- The vulnerability of children should be identified and responded to effectively in order to protect them from harm.
- Full understanding of children's circumstances should be sought.
- Every interaction is both an intervention and an opportunity. This is an opportunity to enhance relationships.
- The voice of children must be heard and their opinions respected.



EVIDENCE

While not formally evaluated, collaboration between Safer Neighbourhood Teams and schools has established 'safer corridors' and adjusted school detention times to protect children from becoming victims of crime on their way home.

IMPACT

CASE STUDY 1: *Six children obtained ABH level injuries whilst in a nursery and an employee was witnessed to have assaulted babies on two occasions. These concerns were shared with police via NHS colleagues post attendance at a hospital. An urgent referral resulted in joint working with LADO, OFSTED as well as statutory partners to plan investigation. This resulted in OFSTED suspending the licence to provide nursery provision. Communication took place with parents which resulted in multiple parents coming forward with concerns. Joint working and cooperation with parents and a child centred investigation resulted in the obtaining of witness testimonies. Post evidence being secured, police focused on enforcement, resulting in the arrest and interview of two persons who have now been charged with multiple offences (cruelty and neglect). A trial date is set for 2027.*

CHALLENGES

The MPS faces a £260 million budget deficit. This is a significant challenge for our organisation. To reduce the funding gap, work has been completed to make savings. Despite this the MPS needs to make 'tough choices'. This in essence means that our workforce size will shrink to match our budget. In total, the size of our workforce will be reducing by c1700 and majority of this will be officer numbers. Finer detail is being worked on and we will know the detail and impact in due course.

NHS NORTH EAST LONDON INTEGRATED CARE BOARD

EVIDENCE, LEARNING AND IMPACT

Hackney Trauma Informed Multi-Agency Practice: Responding to Child Victims of Domestic Abuse: A Partnership Steering Group was established to review and identify good practice already happening within services across the partnership, and to develop a whole-system trauma informed response across universal and targeted services to child victims of domestic abuse. A Guidance Doc for Trauma Informed Support for Children and Young People was developed which provides organisations and professionals with approaches and resources relevant to their agencies to advise and support child victims of domestic abuse.

Sudden Unexpected Death in Infancy (SUDI): Work has continued following the SUDI Conference in March 2024 utilising a NEL wide approach to review and focus on SUDI reduction. This work is ongoing and involves a number of key partners and CDOP colleagues to engage in quality improvement work with identification of key data interrogation.

The Tree of Life: For the past three years, the Tree of Life in Schools Programme in City and Hackney has been providing African, Caribbean, and mixed heritage young people with a unique form of culturally attuned mental health support.in collaborative partnership between local schools, NHS Mental Health Support Teams, and voluntary sector organisations. Partners included Child and Adolescent Mental Health Services (CAMHS) East London NHS Foundation Trust, Hackney CVS, NHS North East London ICB, Wellbeing and Mental Health in Schools Service (WAMHS), Hackney Council and the City of London Corporation.

City and Hackney Childhood Adversity, Trauma and Resilience Programme (ChATR): ACEs and Trauma-informed Practice Training is now available on the City and Hackney Children Safeguarding Partnership (CHSCP) Training Platform. In collaboration with the Trauma Services Lead at Tavistock & Portman FT, a Train the Trainer model for training of facilitators was developed to deliver the ChATR ACEs & TIP Training. The ChATR Online Resource Portal has been relaunched to align it with the ACEs and TIP Training. The ChATR portal includes a range of practice tools, academic research and video resources.

The Named GP in City and Hackney: Has effectively supported and represented GPs at partnership and strategic events. This has included GP participation in multi-agency audits, rapid reviews, safeguarding partnership meetings and the Child Death Overview Process (CDOP). This allows a GP voice to scrutinise local child deaths and identify system gaps for improvement in general practice. Over 150 GPs, practice nurses, and physician assistants have received level 3 safeguarding training, with over 80% of attendees rating the content as very useful and relevant. Participants praised the engaging presentations, with real-life scenarios and Mentimeter interactivity. Additionally, reflective safeguarding sessions have been well attended by GP safeguarding leads, providing opportunities increased training and opening channels for feedback directly into the partnership from GP's.

HOMERTON HEALTHCARE NHS FOUNDATION TRUST

CHALLENGES

The **national reconfiguration** of ICBs will mean challenge in meeting the required 50% reduction in operating costs. Whilst the statutory requirements for safeguarding will need to be met it is currently unclear what this will look like locally.

Identification and Referral to Improve Safety (IRIS) - Public health have withdrawn 50k of funding as part of cost saving and the service cannot continue on a reduced financial envelope. NHS NEL ICB have provided extra financial funding to continue the service for another year. Alternative funding / options being explored. IRIS has been running in C&H since 2007.

EVIDENCE

Overall, there has been no reduction in the growth of the contemporary safeguarding children's agenda which the Homerton has had to respond to. Nevertheless, staff have access to expert safeguarding advice, support, training, and supervision. The Homerton SCT and related staff have continued to contribute to the development and ongoing scrutiny of the multiagency safeguarding arrangements primarily through the work of the CHSCP. Homerton ED continues to see growth in the cohort of vulnerable children with disabilities and additional needs who present in mental health and behavior crisis some require in patient care. This reinforces the need for a paediatric Learning Disability Nurse who can support this vulnerable group of children as well to enable staff to work effectively with these children and their families. There have been ongoing discussions with the commissioners regarding this issue. Recruiting to specialist children posts such as health visiting, paediatric nursing is a challenge locally and nationally.

Overall, whilst innovation and good practice is ongoing, the workforce challenges in specialist children roles persist, there are internal pressures to meet saving targets, continued increases in the safeguarding agenda at a national level (which include the implementation of the Families First Partnership Programme), the unknown must do's from the Children's Wellbeing and Schools Bill, coupled with the changes in NHSE which will impact on the statutory safeguarding responsibilities of ICBs. This means that there are challenging times ahead for provider healthcare organisations.

EVIDENCE AND IMPACT

Enhanced Health Visiting Service (EHVS) is key in the early identification of safeguarding risk and need, particularly among families who may not otherwise be visible to services. As a non-stigmatising, universal service, health visitors uniquely engage with all families with children under five, regardless of explicit health needs. This universal access enables early intervention and the provision of targeted, intensive support to vulnerable families.

EVIDENCE AND IMPACT

CAMHS - An Executive group for WAMHS has been created with the Head of Community CAMHS and Specialist CAMHS, Directors of Education and SEND. To look across Hackney school at strategic joint pathways, role of CAMHS in to safeguard children from increased exclusion and to scrutinise practice and learnings from exclusions to change practice. Recent changes to autism and co-occurring ADHD for new referrals using the hub and spoke model, meaning access to diagnosis whilst in treatment, cutting out secondary long wait hopefully eliminating further referrals and distress. This has come about following a QI and pilot project collecting feedback for parent and CYP on the effects of the new model. All resoundingly positive benefits for clinicians too, in terms of ethical practice.

EVIDENCE AND IMPACT

Children Therapy Services - As one of the outcomes from Child V child safeguarding practice review therapists and the Named Professionals are developing resources to identify neglect and the evidence base for non-engagement with health appointments in non-verbal CYP with profound physical disability. Children's OT have made considerable progress in developing and embedding integrated pathways that enhance patient safety and reduce risks for vulnerable children. These have focused on four key areas:

- **Fire Safety Risk Assessment:** A holistic approach has been implemented to balance fire safety legislation with a child's abilities and the risk of absconding, creating safer environments compared to other boroughs that rely heavily on 1:1 care packages through co-production of an updated fire safety risk assessment.
- **Safer Spaces Pathway:** Designed for children with self-harming or challenging behaviours, this pathway ensures MDT collaboration and considers developmental needs, deprivation of liberty, and psychological factors.
- **Reducing Delays in Assessments:** New systems were established to track, assess, and expedite high-risk cases, ensuring timely interventions. A 'fast-track' pathway was co-developed with the LBH Adaptations Team to address urgent cases efficiently.
- **Integrated Problem-Solving:** Monthly risk management meetings have been introduced to ensure collaborative decision-making across health, social care, and housing teams, providing coordinated solutions for complex cases.

These integrated pathways have significantly improved patient safety, with key outcomes such as reduced waiting times for assessments—decreasing from an average of 5.5 weeks to 3 weeks despite an increase in referrals. Additionally, formal complaints have been eliminated in the current period, compared to three in the previous year, further demonstrating the effectiveness of the service.

EVIDENCE

Midwifery - Maternity safeguarding is launching the HOPE Box project. In summer 2025. This work brings together midwifery, social care, health visiting and charity organisations including Birth Companions for an MDT approach in supporting women and families at risk of separation from their babies.

IMPACT

School Based Health Service - The SBHS continues to offer assessments to all children entering child protection plans, with over 90% of CYP seen. The service has updated the contract variation to clarify responsibilities for children in local authority settings and City and Hackney residents.

EVIDENCE AND IMPACT

Talking Therapies - City and Hackney Talking Therapies is a primary care mental health service delivering short term, mostly Cognitive Behavioural Therapy oriented therapy, to adults with common mental health problems. The service has worked closely relationship with City and Hackney community CAMHS to provide a small bespoke treatment pathway for over 16-year-old patients who CAMHS determine to be suitable for therapeutic interventions. Within the last year an additional treatment pathway that prioritises the assessment and treatment of parents who have a child who is being seen within a CAMHS service. Although cases are small in number, this pathway supports the family unit receiving mental health intervention as they manage their challenging circumstances.

In addition, an internal child safeguarding support role was created which offers specific support to all our clinicians regarding the development of greater confidence in assessing and managing child safeguarding concerns. Such concerns may arise in any communication with a patient, and this role seeks to support staff in sensitively having such conversations with patients and holding more accurate knowledge around the role and function of child social care services. Additionally, from time to time our clinicians are requested to attend various child protection meetings and having this extra specialist support will also advise on the expectations and engagement in such.

This role has not been created to replace the function of the SCT who continue to advise our staff on child safeguarding concerns and recommended actions. This new role is primarily intended to provide our staff with skills and knowledge to feel more confident in child safeguarding assessment, and in having accurate child social care information to support such patient conversations.



EVIDENCE AND LEARNING

City & Hackney CAMHS Alliance & Partners Learning Disabilities/Neurodevelopmental Conditions Working Group. Homerton has been part this multi-agency group which is looking at developing joint working approaches to meet the needs of neurodiverse children.

CHALLENGES

CAMHS - Huge financial pressure on the workforce e.g. lack of drawdown of SEND funding from 2024 meaning good staff who were training have left. Pressures from ICB for integration for neuro disability and significant increase in neurodisability and complexity coming into CAMHS.

Closure of Children Social Care CAMHS provision affecting CAMHS case work, meaning changes picked up in Specialist CAMHS and consequently Tier2/getting help increasing complexity and length of time needed for cases to remain open (closure of Quick Steps Autism due to no funding).

EAST LONDON NHS FOUNDATION TRUST

EVIDENCE

ELFT maintains a robust safeguarding governance framework, ensuring effective leadership, accountability, and multi-agency collaboration across all services and boroughs. Safeguarding is a core responsibility embedded at all organisational levels, reflecting the Trust's values. The Trust contributes strategically and operationally through participation in various safeguarding partnership boards, subgroups, and local assurance meetings. This includes engagement in local audits, multi-agency training, and strategic reviews such as Safeguarding Adult Reviews (SARs), Child Safeguarding Practice Reviews (CSPRs), Domestic Abuse Related Death Reviews (DARDR), Channel Panels, and PREVENT/CONTEST Boards. The Trust Safeguarding Committee meets quarterly to provide challenge and assurance regarding safeguarding arrangements and monitors compliance. Quarterly reports are submitted, providing assurance against responsibilities outlined in CQC Regulation 13, Contractual Safeguarding requirements, the Children Act (1989/2004), and the Care Act 2014.

EVIDENCE AND IMPROVEMENT

The Trust has implemented an improved reporting process for CSC referrals. From 1 April 2025, all staff are mandated to complete an InPhase incident report form concurrently with any child protection referral to CSC. This measure will enable timely and accurate data capture, effective oversight by the safeguarding team and prompt, effective intervention.

EVIDENCE AND LEARNING

The Trust has demonstrated strong improvement in safeguarding training compliance across both children and adult safeguarding in 2024/25. Level 3 Safeguarding Children training compliance rose to 89%, up from 83% in 2023/24 – a 6.7% increase year-on-year.

EVIDENCE AND IMPACT

Mental Health Support Team and Wellbeing and Mental Health in Schools: The launch of the Low-Level Concerns guidance was supported through two CAMHS in Schools Forums, where staff explored its application and received input from safeguarding leads across the partnership. We collaborated with Educational Psychology, Public Health, and Hackney Education on responses to school-based trauma, such as sudden deaths and community incidents. We also continue to support suicide prevention through staff training and policy development in schools.

Child A was referred to social care after risk of grooming and county lines emerged. The clinician supported the parent, ensured police involvement, and maintained confidentiality safeguards at school. The child is no longer considered at risk.

Child B came from a previously unknown family of five. The clinician identified safeguarding concerns, made trauma-informed referrals to Early Help and the Children's Centre, enabling broader family support.

Child C, showing extreme aggression, was supported through coordinated agency input (including YOT and social care). A full risk and mental health formulation was documented, supporting a timely response.

Emotional & Behavioural Team (E&B): The E&B team maintains regular safeguarding supervision and utilises MASH and trust safeguarding consultations to inform safe and timely care planning. Weekly MDTs support risk-based decision-making, and a new consultation pilot is helping clarify CAMHS involvement while families await assessment. The team works closely with schools and Local Authority services, referring complex joint CAMHS/CSC cases to the Complex Case Forum and ensuring smooth service transitions.

Case 1: A family with domestic abuse, parental mental health issues, and neurodiverse needs was supported collaboratively by CAMHS and Family Support, with effective TAC coordination leading to improved engagement.

Case 2: After Early Help initially closed a case, a joint MASH referral by CAMHS and school led to reallocation to a senior Early Help social worker. A robust package of support was arranged, and the father expressed gratitude for the collaborative care.

Continued overleaf.

EVIDENCE AND IMPACT CONTINUED

Behaviour Support and Outreach (BS&O): **BS&O's proactive, no-waitlist** model enables swift risk response and family stabilisation. Strong links with MACE, EFRP, MASH, and local authority partners support contextual safeguarding work.

A referral for ADHD assessment led to a broader safeguarding concern being uncovered. MDT discussion led to MASH referral due to serious neglect and physical harm between siblings. All three children were placed on Child Protection Plans. Despite parental criticism over the non-diagnosis of ADHD, the case exemplified strong safeguarding vigilance and thorough clinical assessment

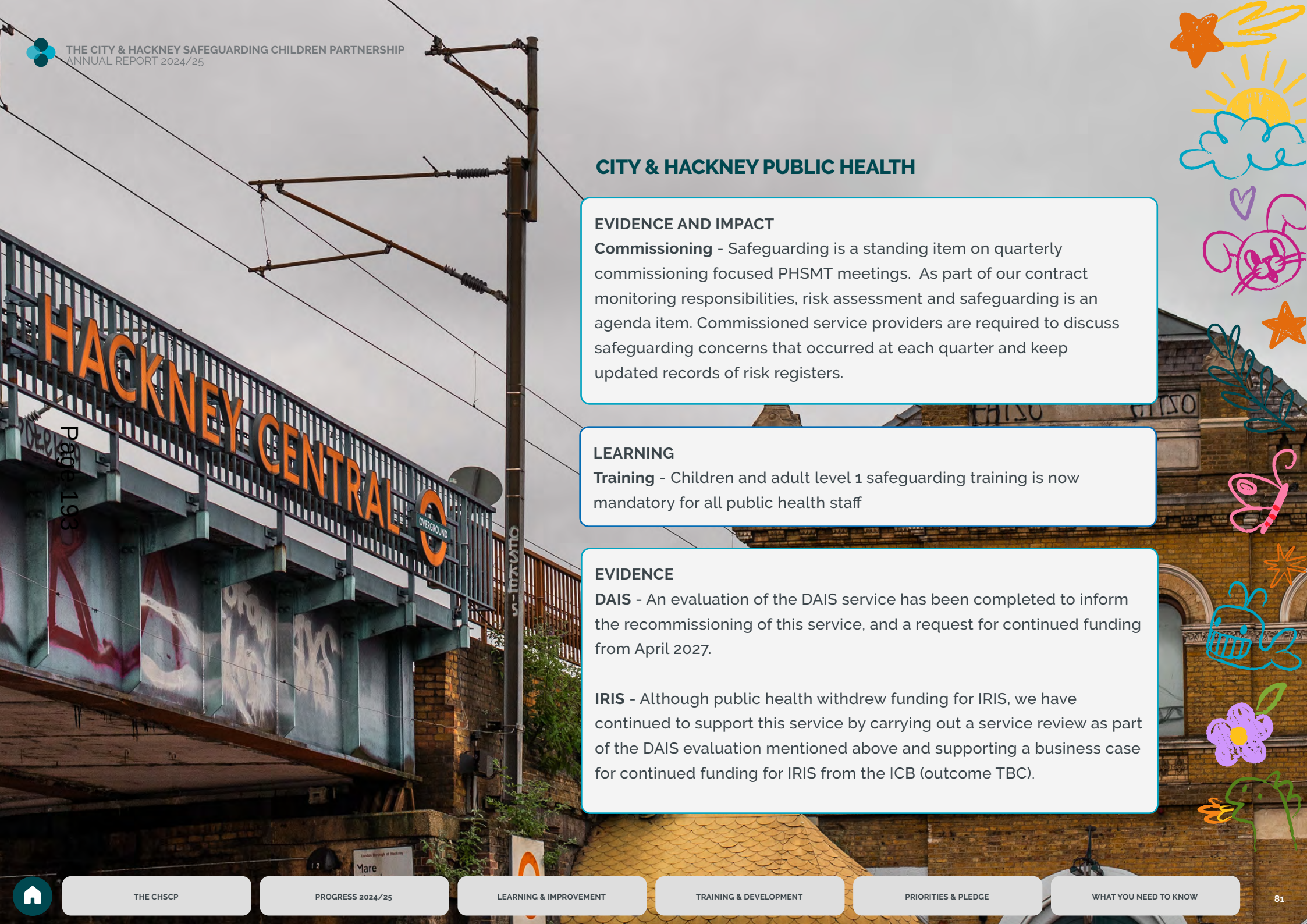
Adolescent Mental Health Team (AMHT): AMHT engages in early consultation with MASH and works jointly with social care, Early Help, education, and other agencies. Clinicians attend multi-agency meetings and reflect on complex cases in MDTs. Joint visits and care planning are common, with attention paid to addressing environmental factors affecting young people's mental health.

Neurodevelopmental Team (NDT): NDT contributes to multi-agency risk and planning forums such as the Dynamic Support Register (DSR) and LDA subgroup, focusing on young people with Learning Disabilities and Autism. Safeguarding consultations are regularly sought, and all cases with risk of admission are reviewed via LAEP meetings to prevent unnecessary inpatient stays. The team also contributes to service improvement work around Fetal Alcohol Spectrum Disorder (FASD), and has responded to a recent Serious Incident with enhanced risk recording and TAC documentation processes.

CHALLENGES

This year, our safeguarding work has reflected a deep commitment to integrated, trauma-informed, and child-centred care, despite the mounting pressures across health, education, and social care. We have responded to complex and evolving risks, strengthened frontline practice, and maintained a focus on vulnerable groups, including those affected by contextual harm, neurodevelopmental needs, and digital exploitation.

Looking ahead, our priorities will include improving the quality and consistency of multi-agency collaboration, especially in the absence of some previously established forums; enhancing digital safeguarding approaches in response to emerging online risks; and supporting workforce capacity in light of system-wide financial pressures. In alignment with City & Hackney's wider priorities, particularly around early intervention, equity of access, and coordinated care, we will continue to drive safe, responsive, and relational safeguarding practice across CAMHS.



CITY & HACKNEY PUBLIC HEALTH

EVIDENCE AND IMPACT

Commissioning - Safeguarding is a standing item on quarterly commissioning focused PHSMT meetings. As part of our contract monitoring responsibilities, risk assessment and safeguarding is an agenda item. Commissioned service providers are required to discuss safeguarding concerns that occurred at each quarter and keep updated records of risk registers.

LEARNING

Training - Children and adult level 1 safeguarding training is now mandatory for all public health staff

EVIDENCE

DAIS - An evaluation of the DAIS service has been completed to inform the recommissioning of this service, and a request for continued funding from April 2027.

IRIS - Although public health withdrew funding for IRIS, we have continued to support this service by carrying out a service review as part of the DAIS evaluation mentioned above and supporting a business case for continued funding for IRIS from the ICB (outcome TBC).

EVIDENCE AND IMPACT

System leadership - Public health led the completion of a review of the health and social needs, and inequalities, faced by Families in Temporary Accommodation. This review includes an overview of the evidence base, local insights and local support / provision and will inform system work to support the needs of this vulnerable cohort.

EVIDENCE, IMPACT AND LEARNING

Identified from service that Public Health commissions:

Health Visitors supporting caseloads of the most vulnerable families receive additional supervision from a Parent-Infant Psychotherapist and an Integrative Child Psychotherapist monthly in the form of reflective practice, to ensure that they receive the appropriate support required to safely and effectively manage complex cases.

The **Schools Based Health Service** conducted an audit of safeguarding assessments, ensuring adherence to quality and compliance standards. The audit revealed a high level of compliance with child-centred practices; however, it also identified areas for improvement, such as inconsistent documentation following handovers and variability in the care packages provided. The audit served as an opportunity to address these gaps promptly, leading to the implementation of digital monitoring for safeguarding sessions and regular reviews of documentation during both school nursing team meetings and supervision sessions.

CHALLENGES

Meeting the needs of socially vulnerable pregnant women and new mothers is a key priority. We are focused on strengthening our services to ensure they receive the support they need. The Community Peer Mentoring Service, which began in November 2022, has not fully delivered on its intended outcomes and so the service will come to an end earlier than planned, in December 2025. We are also working with the Enhanced Health Visiting Service, commissioned in September 2023 to evaluate the impact of this service on this vulnerable cohort and are actively collaborating with the provider to improve the performance of these services.

CAFCASS

EVIDENCE

Between April 2024 and March 2025 Cafcass received a total of 16,195 children's public law cases.

Between April 2024 and March 2025 Cafcass received a total of 11,430 care applications. This figure is 0.4% lower than the previous financial year.

The average for 2024-25 was 41 calendar weeks, which is 3 weeks lower than the previous year.

Between April 2024 and March 2025 Cafcass received a total of 39,182 children's private law cases. This figure is 0.7% lower than the previous financial year.

PROBATION

EVIDENCE, IMPACT AND LEARNING

Over the past year, we have placed significant emphasis on learning and development, with updated training courses delivered on safeguarding children and adults, as well as domestic violence. These efforts have strengthened staff awareness and confidence in managing complex safeguarding concerns.

In addition, we have established stronger connections with specialist services within the borough, helping to clarify the support available and enhance our child-centred approach to risk management. This collaborative work ensures that interventions are informed, responsive, and aligned with best practice. We have also driven forward improvements in the quality of assessments. This has been achieved through case dip-sampling, which ensures safeguarding concerns are being addressed in line with our statutory duties.

A continued focus has been placed on the accurate recording of safeguarding checks and responses across the PDU. This enables us to evidence the work being undertaken, particularly in relation to child safeguarding, and supports a culture of accountability and continuous improvement.

IMPACT

CASE STUDY 1: *The removal of a Registered Sexual Offender (RSO) from a residence where unsupervised contact with children was taking place led to a disclosure of offending behaviour. This decisive action eliminated the immediate risk posed to children and ensured the RSO was relocated to suitable accommodation, aligned with safeguarding protocols. This case exemplifies the importance of proactive risk management, multi-agency collaboration, and the effective use of assessment tools in protecting vulnerable individuals and upholding public safety.*

IMPACT

CASE STUDY 2: *During a routine home visit, professionals observed damage to the door of the property, which prompted further professional curiosity. This observation was escalated to the allocated social worker, enabling additional assessments to be carried out. As a result, risk mitigation strategies were implemented to ensure the overall safety and wellbeing of the child. This case highlights the importance of frontline staff remaining vigilant and responsive to environmental cues, and how such actions can lead to timely safeguarding interventions.*

CHALLENGES

Staffing and Capacity: Recruitment remains a key focus, with a plan in place and ongoing efforts to increase staffing levels. While numbers are improving, we are not yet at full complement and continue to experience capacity pressures, which are being monitored and actively managed.

New entrants require comprehensive training and time to build experience, particularly given the complexity of cases across the caseload. Senior Probation Officers (SPOs) are allocating cases based on skills and experience, while also providing mentoring from experienced staff, themed case discussions and workshops and enhanced oversight for complex cases.

Safer Workforce

Despite all efforts to recruit safely there will be occasions when allegations are made against staff or volunteers working with children. Organisations should have clear procedures in place that explain what should happen when such allegations are raised. These should include the requirement to appoint a Designated Safeguarding Lead (DSL) to whom these allegations are reported. It is ordinarily the responsibility of the DSL to report allegations to, and otherwise liaise with, the Designated Officer in the local authority (referred to as the LADO). The LADO has the responsibility to manage and have oversight of allegations against people who work with children. In line with paragraph 2.1 of the London Safeguarding Children Procedures, the LADO should always be contacted when there is an allegation that any person who works with children has:

- Behaved in a way that has harmed a child or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children.
- Behaved in a manner that discriminates against a child on the basis of one or more of their protected characteristics as defined by the Equalities Act 2010.

Further criteria (paragraph 2.2.) relates to allegations that can be made in relation to physical chastisement and restraint but can also relate to inappropriate relationships between members of staff and children or young people, for example:

- Having a sexual relationship with a child under 18 if in a position of trust in respect of that child, even if consensual (see s16-19 Sexual Offences Act 2003).
- 'Grooming', i.e. meeting a child under 16 with intent to commit a relevant offence (see s15 Sexual Offences Act 2003).
- Other 'grooming' behaviour giving rise to concerns of a broader child protection nature e.g. inappropriate text/e-mail messages or images, gifts, socialising etc.
- Possession of indecent photographs/pseudo-photographs of children.

Paragraph 2.3 of the procedures define were these should be applied when there is an allegation that any person who works with children:

- Has behaved in a way in their personal life that raises safeguarding concerns. These concerns do not have to directly relate to a child but could, for example, include arrest for possession of a weapon.
- As a parent or carer, has become subject to child protection procedures.
- Is closely associated with someone in their personal lives (e.g. partner, member of the family or other household member) who may present a risk of harm to child/ren for whom the member of staff is responsible in their employment/volunteering.

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

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

The City of London

EVIDENCE

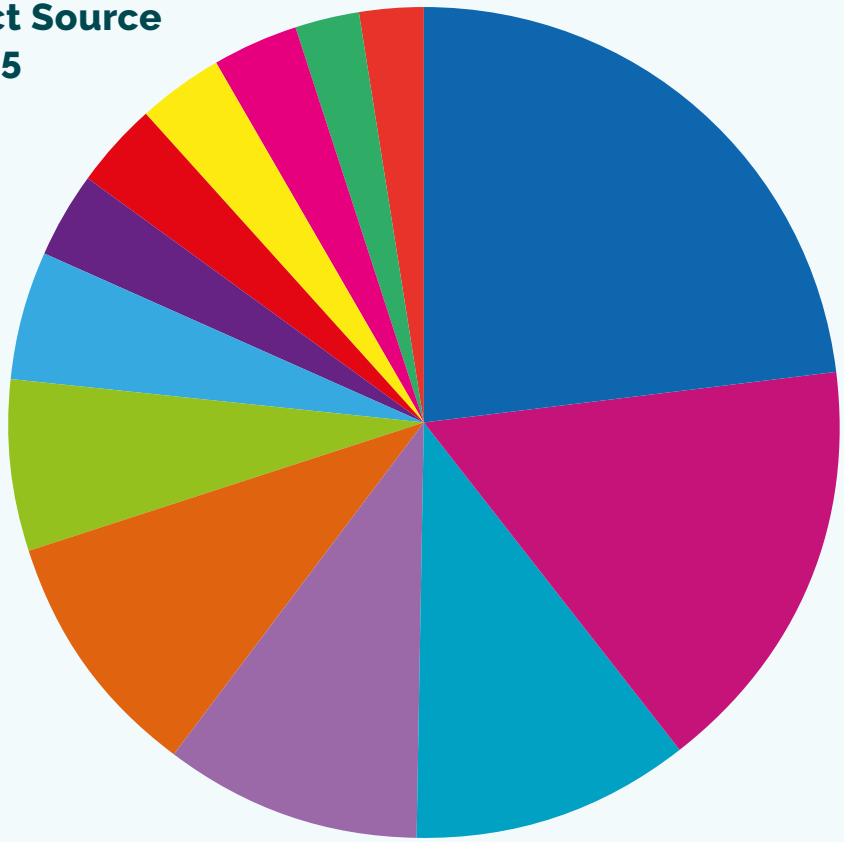
'There are effective arrangements in place to oversee and manage allegations against professionals. Work is completed in a timely way. The local authority designated officer (LADO) provides effective guidance, support and training to external agencies.' **City of London Ofsted, 2024**

EVIDENCE

This year there have been 122 contacts to the LADO Service, this is an increase of 48 from the previous reporting year, which is a 65% increase of contacts to the service. The increase in contacts is in line with London and National trends as is the fact that the vast majority of these, do not meet the LADO threshold. The increase in numbers is also attributable to improved recording methods. There has also been a change to the categories of contacts recorded to include guidance and advice. Contacts recorded as consultations generally require a one-off conversation to ensure that all aspects of the situation have been considered, and that appropriate action is taken to reduce any risk and improve conduct. Those instances where guidance and advice is provided often results in further action by the employer, such as an internal investigation with oversight from the LADO, rather than requiring an Allegation against Staff and Volunteers Meeting which would be recorded as a referral.



Contact Source 2024-25



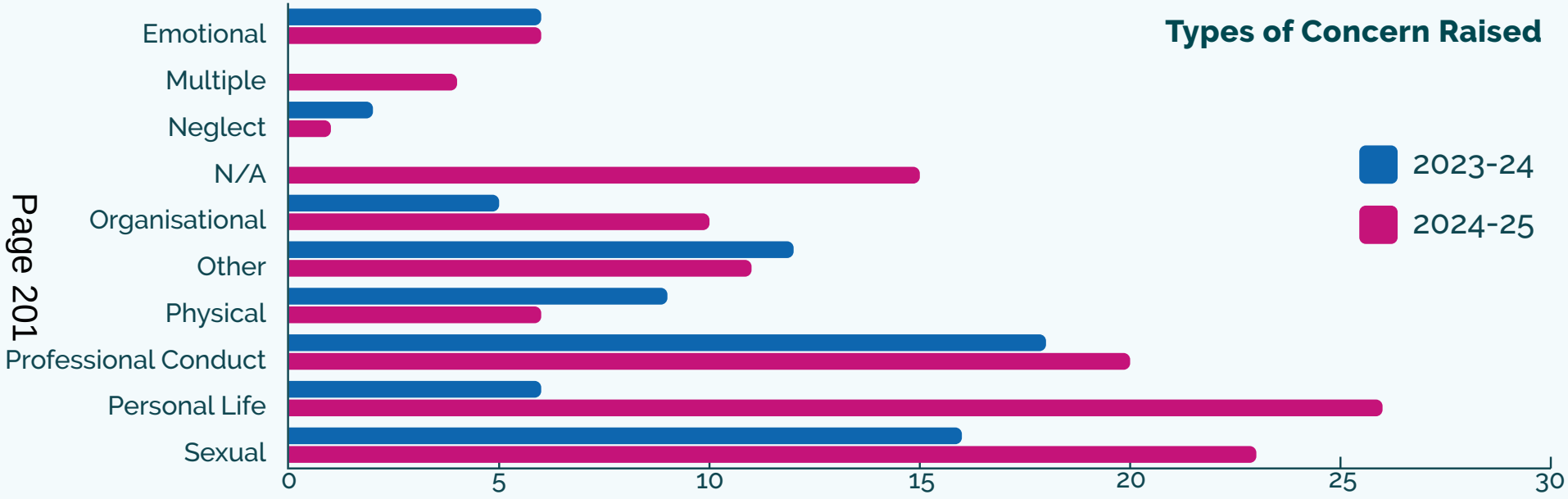
- Other LA/LADO (28)
- Other (20)
- Education Primary (13)
- CVS (12)
- Education Secondary (12)
- Police (8)
- Inspectorate (6)
- Adoption Agency (4)
- CoL Corporation (4)
- Health (4)
- Religious Agency (4)
- CoL Police (3)
- Early Years (3)

EVIDENCE

There continues to be a wide range of agencies contacting the LADO, which demonstrates that the process is known and understood across a broad range of partners. The sectors with the highest level of contacts are 'Other LA/LADO' (23%) which is likely to relate to and the cross over with multiple Local Authorities in terms of where jurisdiction and responsibility may fall. The Head Offices of several agencies are also located in the City, so whilst professionals may not physically work in the City, their agency 'employer' is based here. Such cases are responded to in a timely and effective manner by the LADO, to ensure risk is managed by the appropriate area. The ongoing good level of contact between the City of London Police and LADO (as well as other area Police forces) remains positive.

EVIDENCE

In relation to the types of concerns being reported to the LADO Service, the four categories of harm (as per child protection procedures) are used alongside types of concerns relating to an individual's personal life that could present transferable risk factors to their employment or work with children. The categories are recorded in line with the presenting issue identified during the initial contact with the LADO.



	Emotional	Multiple	Neglect	N/A	Organisational	Other	Physical	Professional Conduct	Personal Life	Sexual
2023-24	6	0	2	0	5	12	9	18	6	16
2024-25	6	4	1	15	10	11	6	20	26	23

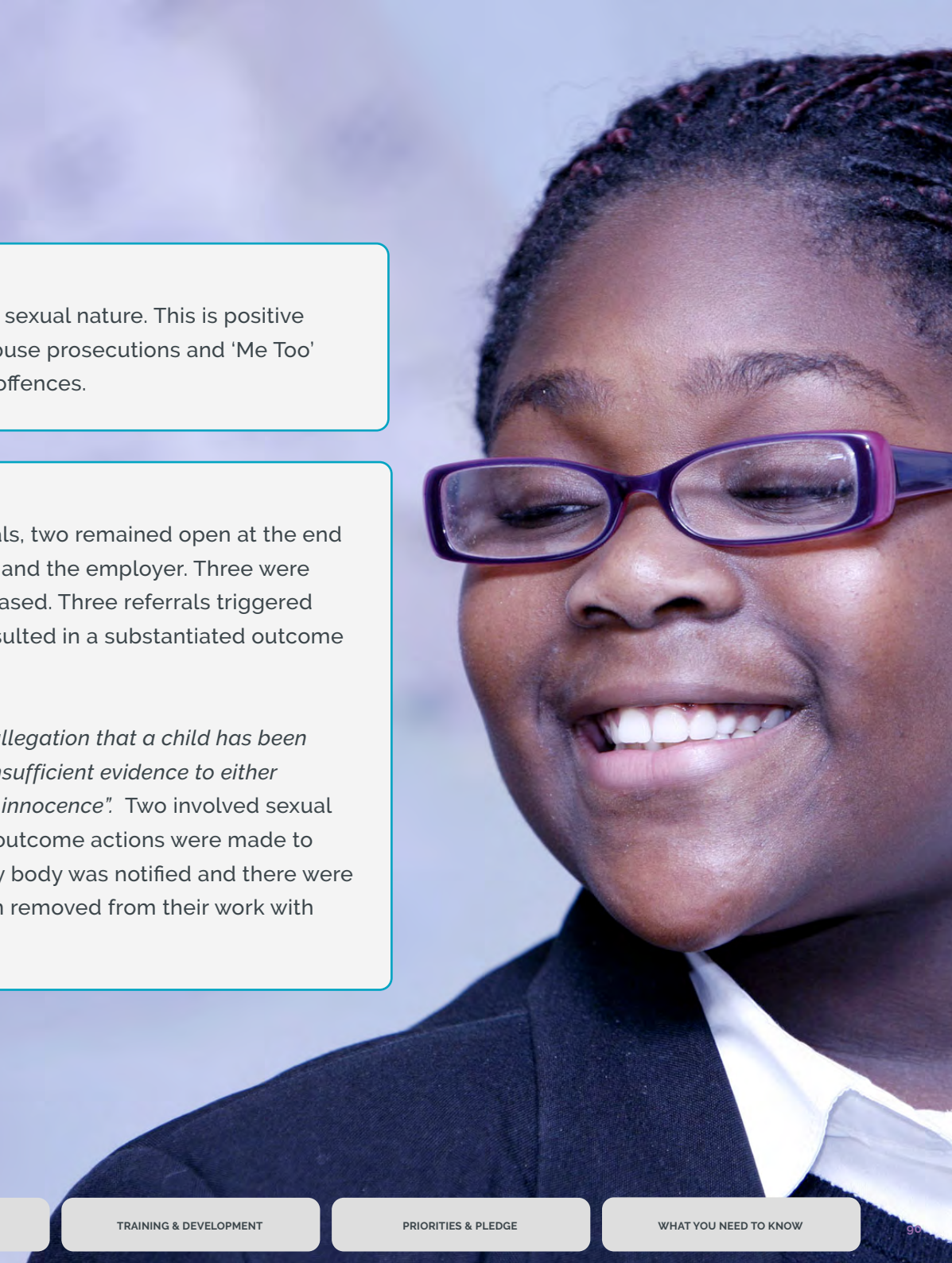
EVIDENCE

There continues to be a high level of reporting in relation to concerns of a sexual nature. This is positive and continues to demonstrate the impact of several high-profile sexual abuse prosecutions and 'Me Too' movement. This is a mix on non-recent and recent incidences and online offences.

EVIDENCE AND IMPACT

Of the 10 contacts that met LADO threshold and were classified as referrals, two remained open at the end of the reporting year as further information was being sought from Police and the employer. Three were transferred to other Local Authorities as this is where the employer was based. Three referrals triggered Allegations against Staff and Volunteers (ASV) Meetings. Two of these resulted in a substantiated outcome and one in an unsubstantiated outcome.

A substantiated outcome means *"there is sufficient evidence to prove the allegation that a child has been harmed or there is a risk of harm"* whilst unsubstantiated means *"there is insufficient evidence to either prove or disprove the allegation. The term, therefore, does not imply guilt or innocence".* Two involved sexual concerns whilst the third was physical. Where there was a substantiated outcome actions were made to refer to DBS, which is a legal duty for employers. In one case the statutory body was notified and there were ongoing internal HR processes initiated. In all cases individuals have been removed from their work with children in a timely way.



LEARNING

LADO training continues to be provided through the CHSCP facilitated jointly by the Hackney LADO and the City LADO. It also continues to be well attended with positive feedback. Bespoke training requests for specific settings or teams can be provided as needed. The LADO also attends and contributes to the Safeguarding in Education Forum on a quarterly basis. The overview of the LADO continues to be part of bi-annual People's Directorate Inductions which last took place on 15/11/2024. A LADO podcast has also been recorded for Early Years workers who often struggle to attend day time training sessions, this can be found on the Family Information Service website; Training, forums and continued professional development - City of London Family Information Service.

EVIDENCE

This year there has been continued focus on developing support tools to aid consistency and clarity in relation to LADO and employment processes. A LADO Referral Form has been developed and now sits on the CHSCP website as well as a guide for parents/carers who are considering engaging a private tutor or similar. An overview LADO leaflet has been updated and distributed. Also in train is the development of some guidance for employers around making referrals to the DBS, this is being produced in conjunction with the DBS Regional Outreach Advisor for London.

IMPROVEMENT

Priorities for the next 12 months include continuing to refine and develop the LADO training offer, to update website information and to refine recording systems to ensure that data and performance can be easily analysed and extrapolated. Significantly, concerted efforts to be made to reach out to religious institutions in the City to raise awareness of the LADO arrangements and offer of training.

Hackney

EVIDENCE AND IMPACT

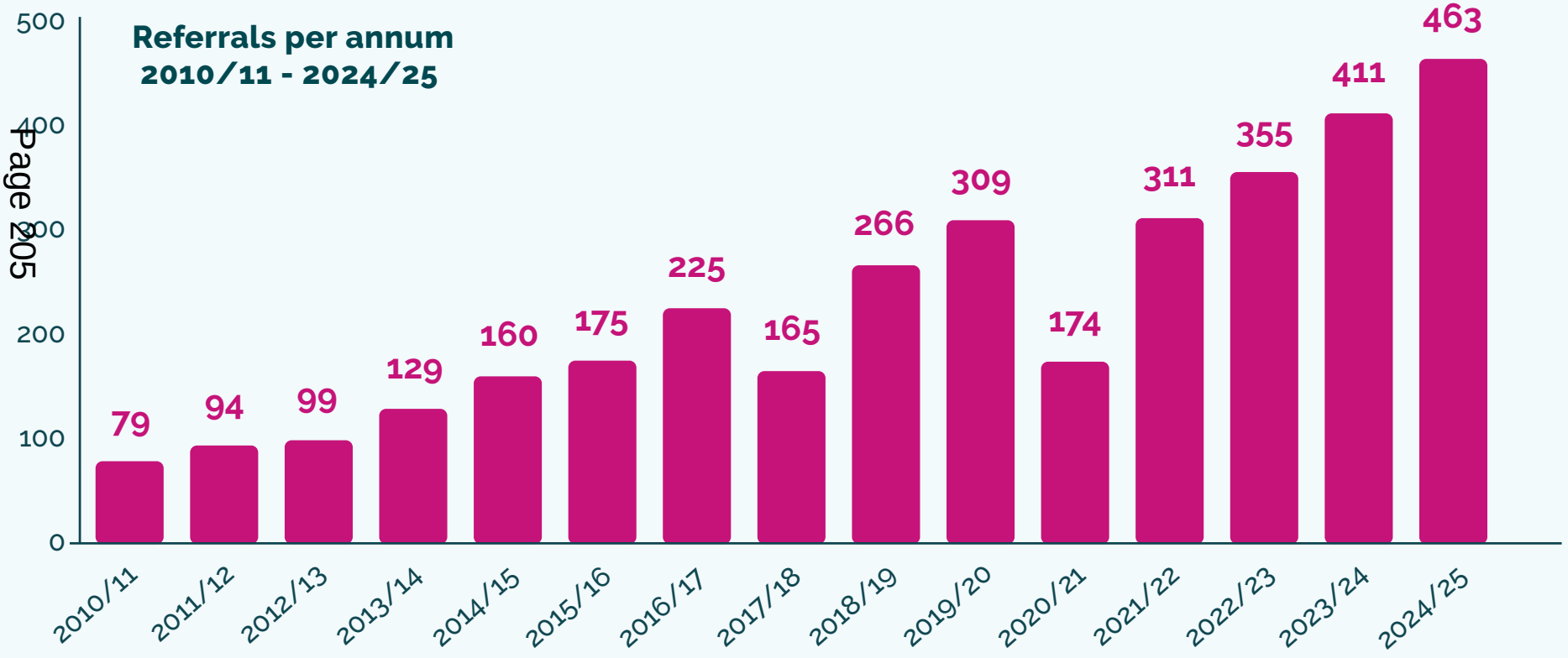
An effective local authority designated officer (LADO) service operates with clear systems in place to ensure timely responses to allegations against professionals. Partnership working is strong, and managers are ably assisted by the LADO to carry out their responsibilities. Training is relevant and routinely provided to partners to increase surety of their safeguarding practice' **Hackney Ofsted, 2024**

EVIDENCE, IMPACT AND LEARNING

A Peer Review was completed 31 May 2024 by the Islington LADO Service. It covered a strategic overview, operational functions, data collection and case file standards. As part of this process, a self-audit was also undertaken. Findings included: *The Hackney LADO service provides an efficient service in delivering management oversight of allegations against staff and volunteers who work with children. Thresholds are applied fairly and proportionally with clear management rationale. The range of referral sources suggests that the training delivered across the partnership has been successful in embedding the LADO role and ensuring employers understand their statutory duty in this area of work. The partnership has provided overwhelmingly positive feedback in this peer review in terms of scrutiny, decision making and containing the anxiety this area of work can raise. The safety of the workforce and the children they serve is clearly at the core of the service. Recording of contacts to LADO and the outcomes are clear. Further discussion around recording on Mosaic will be important to ensure potential patterns of behaviour of staff are picked up. Succession planning and management oversight will be important to ensure this high-quality service continues in [the LADOs] absence. The Hackney LADO is seen as an exponent of good practice across the London LADO network and a supportive member of the team.*

EVIDENCE

The LADO service received 463 contacts during the period of 1st April 2024 to 31st March 2025 which is an increase of 52 (12%) on the previous year (411 contacts). Other than during the COVID-19 pandemic, the trajectory of year-on-year increases in LADO contacts continues.

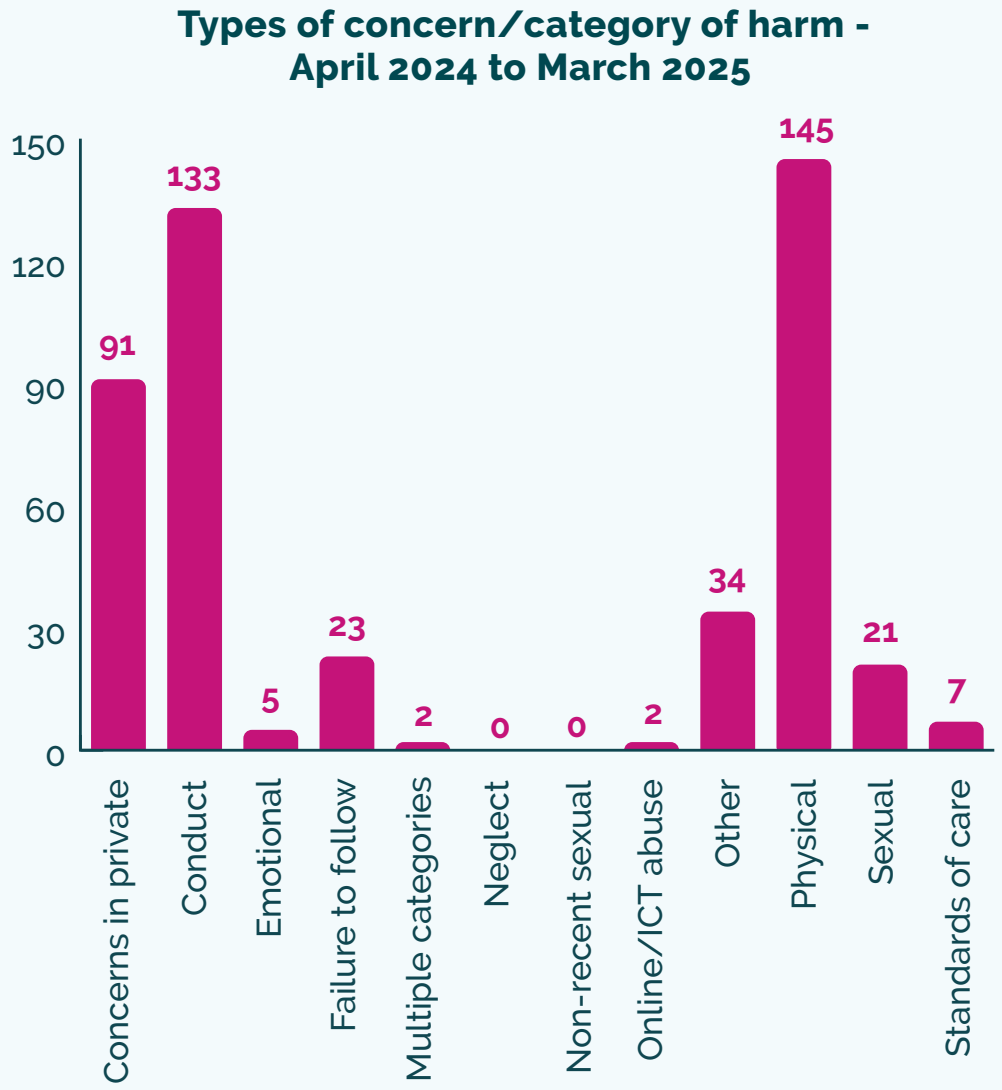


EVIDENCE

The occupations with the highest number of contacts were school support staff (23.6%), teachers (22.4%) and nursery workers (14.4%) which remains consistent with 2022/23 figures of 26.5%, 25.6% and 11.8% respectively. This is likely attributable to the higher ratio of children to staff given schools and day care provisions have higher numbers of children accessing services compared with health or leisure facilities for example.

EVIDENCE

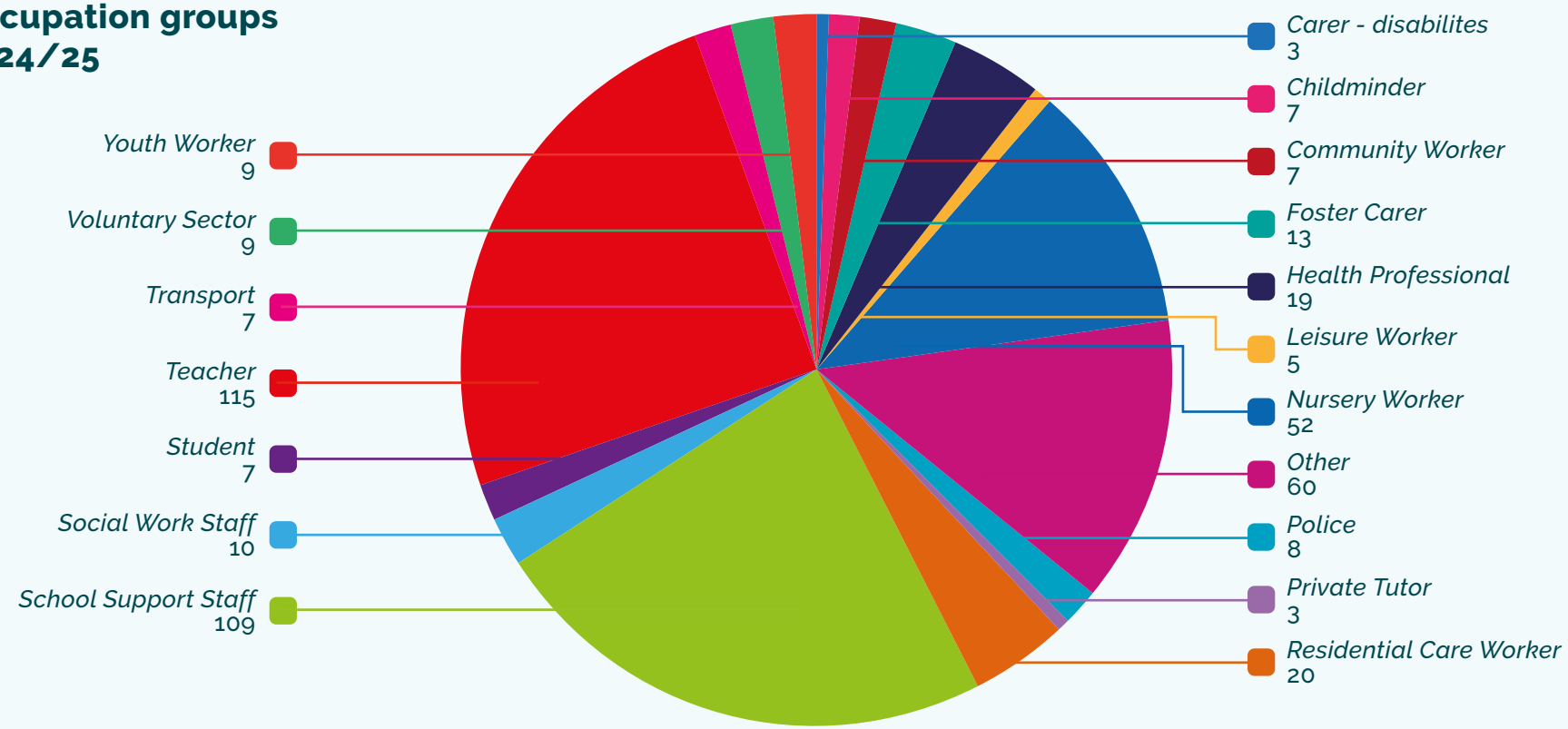
In 2024/25 the category with the highest number of contacts related to physical harm (31.3%) with conduct (28.7%) being the second highest. Concerns in private life had the third highest number of contacts (19.6%). These categories mirror those of previous years. 'Other' types of concerns set out in the table below are for those matters that do not fall under the defined categories of harm. It includes, for example, notification of unregistered educational settings, seeking advice regarding the behaviour of students, information requests for references, Ofsted contact seeking information prior to inspections.



EVIDENCE

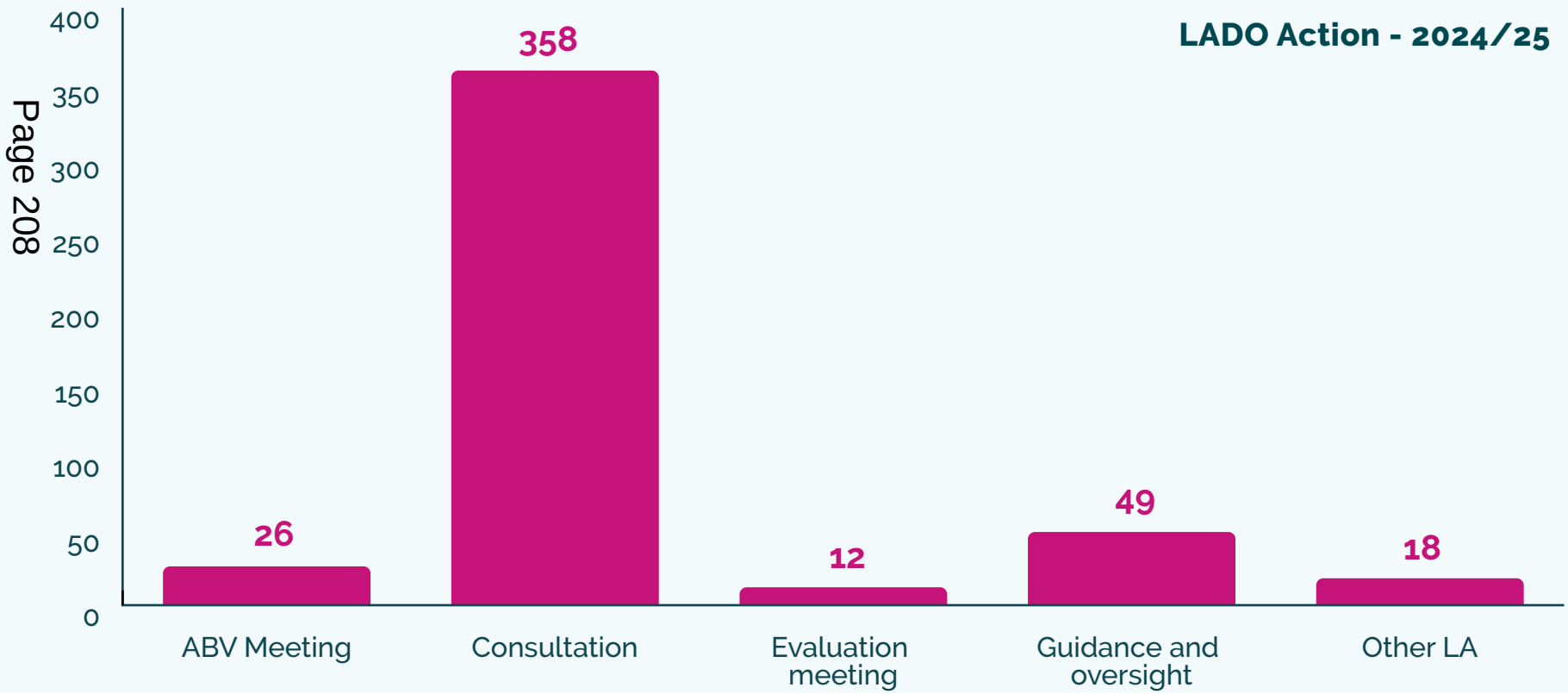
The occupations with the highest number of contacts related to teachers (24.8%), school support staff (23.5%), and nursery workers (11.2%) which remains consistent with 2023/24 figures. This consistency is likely attributable to the higher ratio of children to staff within the education sector.

Occupation groups 2024/25



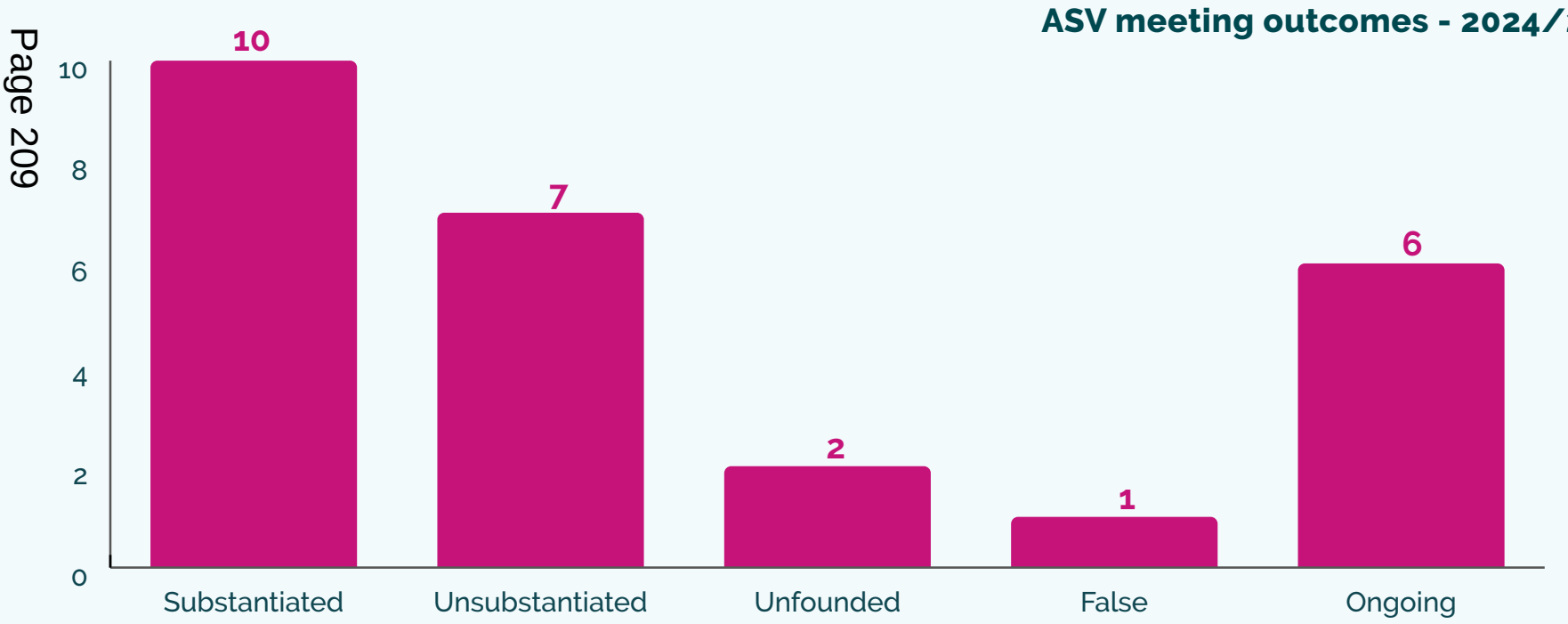
EVIDENCE

Consultations remained the highest demand for the LADO service in 2024/25 accounting for 81%, which is an increase of 23% compared with 2023/24. This could in part be attributable to the overall increase in contacts, but also to DSLs and Headteachers becoming more familiar with the LADO process - requiring less guidance when notifying of a concern or allegation. There has been a slight increase in Evaluation meetings being held (7) and the increase in 'Guidance and Oversight' and 'Other Local Authority' could all be attributed to the overall increase in contacts.



IMPACT

Most cases considered at ASV meetings during 2024/2025 resulted in a 'substantiated' outcome. Seven out of the 20 concluded cases resulted in an 'unsubstantiated' outcome. The fact that the concern/allegation was not substantiated does not suggest that these matters did not need consideration under the LADO procedures. It only indicated that evidence was lacking to support the allegation/concern or could not disprove it. Only one case resulted in a 'false' outcome. The cases that are 'ongoing' refers to awaited outcomes of Police investigations, some of which relate to suspicion of possession/distribution of indecent images of children which involves long waiting times due to the forensic analysis of electronic devices required and delays owing to the volume of such cases.



EVIDENCE

In terms of LADO outcomes, internal investigations completed by settings/employers made up 44.27% (42.09% for 2023/24) of the total outcomes with the second highest being information sharing at 16.41% (15.57% for 2023/24). Similar to 2023/24, for the period of 2024/25 'advice only' was the third highest outcome at 9.93% (12.16% for 2023/24). Again, a strong statistical consistency exists year on year with the outcome of LADO contacts remaining unchanged.

LEARNING

The Hackney Education (HE) Safeguarding in Education team runs an extensive training programme throughout the year including Safeguarding and Child Protection training for HE staff, Designated Safeguarding Leads for schools, colleges and early years, school and college staff, governors, early years and childminders. Their training covers safe practice and the procedures for dealing with allegations against adults who work with children and young people. They continue to run specific training dealing with managing allegations for managers in the early years and school sector, once every academic year for schools and twice for early years managers.

LEARNING

The Hackney LADO actively participates in peer discussions with colleagues to share knowledge, trends, and best practices to promote continued learning and development of the service in line with peers. The LADO is also a regular attendee at the London LADO Network to keep abreast of themes and practice dilemmas, to contribute to policy and guidance development, and to be part of the collective voice when challenges are needed to partner agencies.

IMPROVEMENT

Every year, the Local Authority Designated Officer (LADO) will attend the Headteachers' Termly Briefing to share key statistics and insights from this report. The aim is to keep school leaders informed and up to date on safeguarding and the LADO process. A clear need for better understanding of the LADO's role and procedures has been identified among Children's Services staff. To address this, the LADO will provide training sessions for these teams and will also continue to offer tailored training to individual settings as needed. The LADO's internal recording strategy is currently under review, with the goal of finalising a policy that ensures all records are kept accurately and efficiently. Finally, the LADO will continue to work in partnership with the London LADO Network, helping to develop Professional Standards and finalise drafted procedures that are awaiting approval.

Learning & Improvement



Key Messages for Practice

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

SAFEGUARDING FIRST

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

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

Children have said they need...



Vigilance
to have adults notice when things are troubling them

Understanding and Action
to understand what is happening; to be heard and understood; and to have that understanding acted upon

Stability
to be able to develop an ongoing stable relationship of trust with those helping them



Respect
to be treated with the expectation that they are competent rather than not

Information and Engagement
to be informed about and involved in procedures, decisions, concerns and plans

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

Support
to be provided with support in their own right as well as a member of their family



Advocacy
to be provided with advocacy to assist them in putting forward their views

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

CONTEXT

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

CURIOSITY

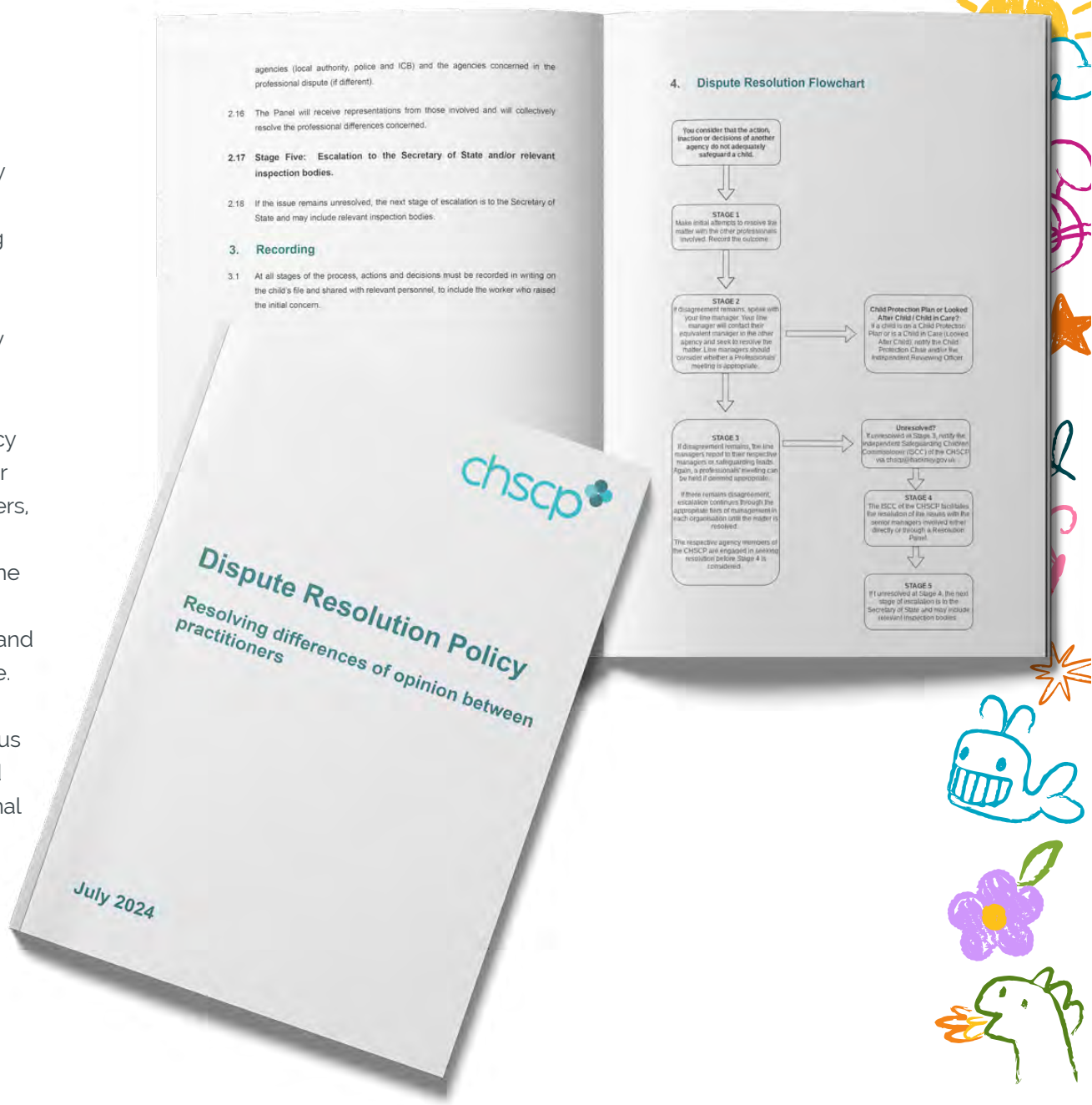
Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This has been described at the need for practitioners to practice 'respectful uncertainty' – applying critical evaluation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

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

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

CHALLENGE

Differences in professional opinion, concerns and issues can arise for practitioners at work and it is important they are resolved as effectively and swiftly as possible. Having different professional perspectives within safeguarding practice is a sign of a healthy and well-functioning partnership. These differences of opinion are usually resolved by discussion and negotiation between the practitioners concerned. It is essential that where differences of opinion arise, they do not adversely affect the outcomes for children, young people or adults and are resolved in a constructive and timely manner. Differences could arise in several areas of multi-agency working as well as within single agency working. Differences are most likely to arise in relation to the criteria for referrals, outcomes of assessments, roles and responsibilities of workers, service provision, timeliness of interventions, information sharing and communication. Safeguarding is everyone's responsibility and front-line staff need confidence in talking with each other about decisions that have been made, discussing any concerns regarding those decisions and where there isn't agreement; escalating those concerns as appropriate. Remember, equally important is the culture of how we work; and it is vital that front-line staff are encouraged to remain professionally curious and to raise issues where they feel that their concerns for children and young people aren't being addressed. To help staff resolve professional differences, the CHSCP has issued a Dispute Resolution Policy.



SAFER - The Golden Rules of Safeguarding

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



Sharing Information

Good information sharing is vital when professionals are worried about people and want to help them. Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Learning from Serious Case Reviews reinforces the fact that both children and adults can suffer significant harm or death when professionals fail to share information or fail to share it in a timely way. Good communication and appropriate information sharing between professionals is therefore a critical element of effective safeguarding practice.



Assessing (& Managing) Risk

When safeguarding children, practitioners working in the City of London and Hackney need to know what to look for and what to do if they think they've seen it. This means practitioners having a good understanding of the signs and symptoms of abuse and neglect and a working knowledge of the local threshold tool. It also means practitioners knowing where to seek help (for example, from their DSL) and how to report any concerns. Importantly, practitioners from both children and adult services need to engage in our multi-agency arrangements, and when needed, contribute to any multi-agency meetings or processes tasked with helping and protecting children.



Focus on the Child

Maintaining a focus on the child and hearing their voices is paramount to our local arrangements. In all our work, we need to listen and think carefully about what children are saying and what meaning this has for them. We need to try and understand their lived experience and what life is like through their eyes.



Escalation

Differences of opinion, concerns and issues can arise for practitioners at work, and it is important they are resolved as effectively and swiftly as possible. Having different professional perspectives within safeguarding practice is a sign of a healthy and well-functioning partnership. Don't be afraid to voice them. These differences of opinion are usually resolved by discussion and negotiation between the practitioners concerned. It is essential that where differences of opinion arise, they do not adversely affect the outcomes for children, young people or adults and are resolved in a constructive and timely manner.



Recording

We should all recognise the importance of good recording. The ability to maintain records that are focused, accurate and evidence professional judgement is a key skill we expect all practitioners to have. Good recording can help spot themes, patterns and trends in a child's care (such a neglect). They are a record for the child and an audit trail of your practice.

Reviews of Practice

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

EVIDENCE

- During 2024/25, two Serious Incident Notifications were made to the Child Safeguarding Practice Review Panel, both of which were subject to a Rapid Review by the CHSCP. From the notified cases, no Local Child Safeguarding Practice Reviews (LCSPRs) were commissioned.
- No Serious Incident Notifications were made relating to cases in the City of London.
- Three other Hackney cases (not meeting the criteria for notification) were also considered by the Case Review Sub-Group.
- Two of these cases resulted in a Rapid Review and one LCSPR was instigated.
- In line with revisions made to Working Together to Safeguard Children 2023, one notification was made following the death of a Care Leaver. Whilst a Rapid Review was held this did not result in a LCSPR.
- Two LCSPRs (Case A and Child V) were published during the reporting period.
- Full details of all the reviews published by the CHSCP are available HERE.

Statement (3) by Jim Gamble QPM - Mossbourne Victoria Park Academy

Terms of Reference - Mossbourne Victoria Park Academy

Statement (2) by Jim Gamble QPM - Mossbourne Victoria Park Academy

Statement (1) by Jim Gamble QPM - Mossbourne Victoria Park Academy

Child V Audio Summary

Child V Summary

Local Child Safeguarding Practice Review - Child V

Case A Audio Summary

Case A Summary

Rapid Reviews

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

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

Once complete, the outcome of a Rapid Review and the CHSCP's decision about whether a review is appropriate is shared with the Panel. The CHSCP's analysis will include whether it thinks the case raises issues which are complex or of national importance such that a national review may be appropriate. Where an incident has not been notified and does not meet the criteria for notification, there is no requirement to send a Rapid Review to the Panel. For all Rapid Reviews, whilst reports of these are not generally published, any actions arising from them will be developed and tracked by the Case review Sub Group.

IMPACT

For the first Rapid Review undertaken in 2024/25, TUSK briefings and video guidance previously produced by the CHSCP were disseminated focussing on information sharing, the DfE's updated guidance and the issue of consent. An action to reintroduce "Difficult Conversations" training is being taken forward by the TLD Sub Group. A themed session to discuss the threshold for triggering an LCSPR was placed on the agenda of the Case Review Sub Group.

IMPACT

Following the second Rapid Review, to enhance practitioner awareness, the CHSCP developed a Partnership Briefing on child protection enquiries, detailing what they involve and differentiating between single and joint agency investigations under section 47 Children Act 1989. Additionally, CHSCP material on strategy discussions has been relaunched to clarify their purpose, attendees, and information sharing standards.

A key focus has been integrating anti-racism into practice, with the strategy discussion template having been reviewed and amended to strengthen its section on anti-racist practice and considerations. To improve understanding of neurodiversity and its impact on children and parents, the CHSCP has explored options for including relevant training courses within its program.

The CHSCP has also committed to identifying and supporting young carers by promoting awareness of Young Carers and relevant policies, procedures, and guidance via its website and TUSK briefings (newsletter). Finally, to ensure practitioners operate within their legal authority, available guidance issued under Working Together to Safeguard Children 2023, the London procedures, and local guidance has been reviewed to confirm sufficient description of respective duties and powers.

Alongside these multi-agency recommendations, individual agencies have also progressed a range of learning. For example, Homerton Healthcare NHS Foundation Trust has focused on enhancing awareness and teaching on caring for neurodiverse clients by sharing further learning and resources. They also aim to embed a trauma-informed approach in service delivery, which involves working with staff to provide trauma-informed care, considering specialist teaching sessions, and holding webinars on Trauma-Informed Care (TIC).

Furthermore, the Trust is improving awareness of police escalation pathways. This has involved establishing regular meetings with the police, developing tips for health and police staff on information sharing in safeguarding cases, and holding a learning event in September 2024. They have also been working to improve understanding of the purpose of Strategy Meetings and the roles and responsibilities of multidisciplinary teams (MDTs), including the impact of information sharing and language used by different agencies, through developing scenarios for simulation exercises.

IMPACT

For the third Rapid Review, a short briefing note about the change in policy and process for reporting care leaver deaths was produced and sent as a letter from the ISCC to partner agencies. An action covering how care leaver information can be integrated into the CPIS system is being pursued.

EVIDENCE

The fourth Rapid Review process involved the concerns raised about Mossbourne Victoria Park Academy. The LCSPR into this case remains ongoing at the time of writing. The review's terms of reference and statements issued by the ISCC can be found HERE.

Local Child Safeguarding Practice Reviews

One Local Child Safeguarding Practice Review was triggered in 2024/25 involving Mossbourne Victoria Park Academy. Two LCSPRs were published (Child A and Child V). Two others were ongoing (Child F and Child W). Published reviews are available on the CHSCP website HERE.

With regards to the Child W review, a final report has been completed by the independent author, and this has been shared with the Child Safeguarding Practice Review Panel. The CHSCP has determined this report shouldn't be published and discussions continue with the Panel on this issue. Our intention remains to release a summary of this case. A final draft of the Child F has also been completed by the independent author, and this will be published shortly. Whilst Case A was referenced in the 2023/24 report, it is included again in this year's report.

CASE A

In 2023, Mr A pleaded guilty to over 30 sexual offences involving both children and adults. He was given a custodial sentence, made subject to notification requirements and issued with a court-imposed Sexual Harm Prevention Order. His crimes included sexual assault, engaging in sexual activity in the presence of a child, making indecent photographs of a child, voyeurism, exposure and up-skirting. Without question, the nature and scale of Mr A's offences are both shocking and deeply disturbing. However, they weren't his first. In 2014, Mr A was found guilty of possessing indecent images of children and given a suspended sentence. At the time, notification requirements were put into place alongside a five-year Sexual Offences Prevention Order. Mr A participated in an internet sex offender programme, unpaid work and was monitored by a local Jigsaw team from the Metropolitan Police Service. Whilst subject to this supervision, Mr A became the father of two children. However, there was no record of him telling the police or the Probation service about their births. Furthermore, despite ongoing monitoring and there being intelligence that Mr A had a child, it was not until late 2018 that a referral was made to children's social care. By this time, the eldest child was two and a half years old, and the youngest, five months. A statutory social work assessment was subsequently triggered by children's social care, although this resulted in no further action and the case was closed. Supervision of Mr A remained with the police until the ending of his notification requirements in 2021.

The LCSPR into this case was commissioned to examine how local agencies managed and mitigated the risks posed by Mr A to his children, other family members and the wider public. It was undertaken by the CHSCP's ISCC (Jim Gamble QPM) and its Senior Professional Advisor (Rory McCallum). It makes five findings and five recommendations for improving practice.

The full report can be read HERE.

A Short Audio Briefing is available HERE.

LEARNING

Finding 1: The management of Mr A via the Level 1 MAPPA arrangements was insufficiently robust in terms of professional curiosity, rigour and authority. Ineffective investigation resulted in missed opportunities to identify risk and intervention lacked any clear focus on the paramountcy of the child.

Finding 2: Practitioners in children's social care were too optimistic when engaging the family. There was little evidence of thoroughness, reflection or an understanding about the risks posed by child sex offenders, and too much emphasis was placed on the police assessment of risk. Opportunities were missed to bring the partnership together to develop clear safety planning and to ensure that everyone was sighted on this family's circumstances.

Finding 3: There was evidence of good practice by the health visitor and nursery manager. Both showed initiative through the health visitor working directly with Ms R on strategies for safety and the nursery manager seeking out further information.

Finding 4: Practitioners responsible for Level 1 MAPPA cases are potential single points of failure. The absence of the need for formal multi-agency meetings, the reliance on professional judgement and the operational pressures on both the police and probation, means it is sensible to consider widening the cohort of practitioners who are automatically alerted to RSOs (i.e. beyond those agencies with access to ViSOR). Whilst not advocating for unfettered information sharing, engaging key partners could help with monitoring and the identification of risk.

Finding 5: Practitioners need to be mindful of the range of research findings about viewers of indecent images of children. Overreliance on messages about low recidivism rates or offending trajectory can lead to superficial conclusions, risk being misinterpreted and false reassurance. In all circumstances, individualised assessments are required that engage those with sufficient expertise in this field of work.

IMPROVEMENT

Recommendation 1: In all cases where known child sex offenders are having contact with children, the MPS (specifically MASH police officers (or equivalent)) should ensure that referrals are always made to children's social care.

Recommendation 2: Both the MPS and the London Safeguarding Children Partnership should review their guidance on the risk management of known offenders and as required, strengthen the clarity on triggering a Section 47 enquiry when known child sex offenders are believed to be in contact with children.

Recommendation 3: The MPS should consider the sufficiency of its arrangements covering the disclosure of an offender's details to third parties. Where necessary, guidance should be updated to specify who is responsible for making third-party disclosures and who is expected to attend relevant multi-agency meetings where disclosures might need to be considered (such as strategy discussions). The MPS should seek reassurance that its processes neither delay nor inhibit its duty to protect children from potential harm.

Recommendation 4: As part of its national review into Child Sexual Abuse in the family, the Child Safeguarding Practice Review should form a view on the potential for the secure and routine information sharing of Level 1 MAPPA Offenders with other key agencies, particularly General Practitioners.

Recommendation 5: The CHSCP should commission context specific training on child sex offenders and include this as part of its annual programme open to all practitioners within the City and Hackney.

IMPACT

The CHSCP Multi-Agency Action Plan for LCSPR Case A has made progress across several recommendations, which are rated using a RAG (Red, Amber, Green) system. Learning on this case has been disseminated via the CHSCP's TUSK briefing.

With regards to Recommendation 1, which requires the MPS to ensure that referrals are always made to children's social care in cases where known child sex offenders have contact with children, the status is "GREEN - Complete". Reassurance has been sought from the CE BCU in this respect and followed up through communication from the ISCC.

Regarding Recommendations 2 and 3, which involve the MPS and the London Safeguarding Children Partnership (SCP) reviewing their guidance on the risk management of known offenders and the arrangements for disclosure, both are marked "AMBER – In progress". Letters were sent to both organisations by the ISCC. The London SCP has acknowledged the proposals and is considering them through its editorial board.

With regard to Recommendation 4, which asks the Child Safeguarding Practice Review Panel to consider the potential for routine information sharing of Level 1 MAPPA Offenders with other agencies, this is rated as "GREEN – Complete". At a meeting between the ISCC, the SPA, the Chair of the national Child Safeguarding Practice Review Panel and a Panel member, a briefing was given on a national review being published, with reassurance provided that the focus on information sharing and the functions of MAPPA would be considered within this piece of work.

For Recommendation 5, which tasked the CHSCP with commissioning context-specific training on child sex offenders, the status is "GREEN - Complete & Ongoing". The CHSCP commissioned a specialist provider to deliver bespoke training to social workers and police officers, alongside a more general course. More training is being commissioned in 2025/26.

Finally, regarding the dissemination of learning, the CHSCP has completed several actions, including publishing the LCSPR report on its website, highlighting the learning in a "Things You Should Know" briefing, disseminating learning to the CHSCP Training, Learning and Development Sub-Group, and adding the report to the NSPCC repository. These actions were all listed as "Complete" as of July 2024.

CHILD V

Child V, a White female child, died in January 2023 at the age of seven. She had a range of complex health needs and multiple diagnoses. In the years preceding Child V's death, there had been significant contact with practitioners from health and children's social care due long-standing concerns about neglect and Child V's health and wellbeing. The review was authored by Sophie Humphreys OBE. It made five findings and four recommendations for improving practice.

The full report can be read HERE.

A short Audio Briefing is available HERE.

LEARNING

Finding 1: An insufficient focus on the cumulative harm that Child V was being exposed to meant that risk was never fully understood or agreed across the multi-agency network. This resulted in practice lacking both the authority and timeliness to ensure that Child V was effectively helped and protected.

Finding 2: Insufficient management grip, knowledge deficits and the significant number of services involved with Child V meant there was an ambiguity about risk, case ownership, roles, responsibilities and communication. The multi-agency processes in place to help practitioners coordinate intervention were largely ineffective in this complex case.

Finding 3: The main inhibitor to effective engagement in this case was Child V's father. Despite substantial efforts by the many practitioners involved, his entrenched views on the treatment and care for Child V meant that cooperation and change was unlikely. Given the implications for Child V, this should have prompted a more robust response to ensure Child V's needs were met and risk mitigated.

Finding 4: Notwithstanding the significant efforts of many practitioners, the priority afforded to Child V's needs was diluted by repeated attempts to influence a change in parental behaviours. This approach continued even when the evidence showed this was unlikely to be successful. Whilst safeguarding practice should always be characterised by empathy and a sensitivity, the safety and welfare of children must always be the primary drivers of decision making and action.

Finding 5: Notwithstanding the complexity of this case, care proceedings were neither timely nor effective in bringing about a material change for Child V.

IMPROVEMENT

Recommendation 1: Safeguarding partners should seek to strengthen their arrangements for how neglect is understood, identified, assessed and planned for across the partnership. Alongside ensuring that practitioners are alert to the cumulative impact and wide-ranging sources of neglect, there should be a specific focus on children with disabilities and complex health needs as part of this work.

Recommendation 2: The Local Authority and NEL NHS ICB should review the effectiveness of its arrangements governing multi-agency practice with children with disabilities and complex health needs. Reassurance should be sought that these arrangements are explicit about roles and responsibilities as they relate to the assessment, planning and review of risk. The frequency and focus of multi-agency meetings that bring the network together should be sufficiently robust to ensure drift and delay in casework is avoided.

Recommendation 3: The CHSCP should issue practice guidance and review its offer on delivering local multi-agency training aimed at working with parents / carers where their engagement is reluctant or sporadic.

Recommendation 4: The Local Authority should review the existing arrangements for how independent expert reports are commissioned. Whether commissioned as part of ongoing proceedings or in other circumstances, the Local Authority should seek reassurance that these arrangements are sufficiently robust to ensure these reports are properly scrutinised and challenged.

IMPACT

The CHSCP Multi-Agency Action Plan for LCSPR Child V has made progress across several recommendations, which are rated using a RAG (Red, Amber, Green) system. Learning on this case has been disseminated via the CHSCP's TUSK briefing and included in a podcast from RISE.

With regards to Recommendation 1, the status is "GREEN - COMPLETE". The CHSCP already has guidance in place, a range of tools available for practitioners and a rolling training program on neglect continues. The team plans to engage with the London Safeguarding Children Partnership's neglect workstream (this is a London priority for 25/26) to see if any further learning or initiatives can be accrued.

Regarding Recommendation 2, this action is rated as "GREEN - action closed". Significantly, clarity around the roles and responsibilities of practitioners helping and supporting families will be addressed as part of the wider reforms being implemented through the Families First Partnership Programme.

In terms of Recommendation 3, concerning the development of practice guidance and training for working with families where engagement is reluctant or sporadic, this is also "GREEN - COMPLETE". A specific Partnership Briefing has been developed and communicated, and the TLD Sub-Group is actively planning to reintroduce training on "Difficult conversations".

With regard to Recommendation 4, the Local Authority has clear arrangements in place for commissioning independent expert reports. Furthermore, the learning from this review has been cascaded, with a focus on ensuring ongoing professional curiosity and challenge takes place where such reports do not align with the plans of the LA. Whilst 'expert' reports are often requested by the LA itself or instructed (at Court), they should never be judged as 'superior' to the expertise held internally or accepted automatically where there are differences of opinion.

CHILD Q

The CHSCP's multi-agency action plan in response to the Local Child Safeguarding Practice Review and the Update Report for Child Q was last updated in August 2025. As with other action plans, this is being overseen by the CHSCP's Case review Sub Group. By way of summary, several key recommendations remain in progress / awaiting updates.

PACE Code Revisions: Several recommendations depend on the outcome of a statutory consultation on revisions to the Police and Criminal Evidence Act 1984 (PACE) Code of Practice. These include updating police guidance on the engagement of appropriate adults and defining the safeguarding needs of children during strip searches. The consultation response to the Home Office was drafted in June 2024, but the actions remain in progress pending the outcome of this consultation.

CHSCP Surveys and Engagement: The CHSCP was tasked with launching borough-wide, age-appropriate surveys to gather children's views on safeguarding, with a focus on themes from the Child Q review, such as feeling safe in school. Whilst some of this activity is being reflected in the LCSPR involving Mossbourne Victoria Park Academy, work will be taken forward in 2025/26. Progress has been hampered by capacity limitations within the CHSCP team.

DfE Guidance on Strip Searching: The Department for Education (DfE) previously confirmed with the CHSCP it was reviewing its guidance on strip searching in schools following a request by the CHSCP that it better emphasises the "very exceptional circumstances" in which such an action would be appropriate. This work was reported as being considered alongside the Home Office and is still in progress.

BCU Commander Recruitment: This recommendation was for the MPS to develop mechanisms for local representatives to be included in the recruitment processes for BCU Commanders across London. This recommendation is aimed at strengthening accountability and improving community relationships. As of August 2025, there has been no further update on this action.

Auditing

CHILD SAFEGUARDING STATEMENTS

Developed from a model in operation in Ireland, Child Safeguarding Statements are intended to enhance an organisation's ability to identify potential risks, develop policies and procedures and review whether adequate precautions have been taken to eliminate or reduce these risks. They require sign off from Chief Executives / the most senior person within an organisation. This reinforces the need for these key roles to be directly engaged in and sighted on their organisation's strengths and weaknesses. Following a successful pilot and reflecting on feedback from participating agencies, a wider programme engaging all Relevant Agencies and Named Organisations in City and Hackney was agreed and in progress across 2024/25. Capacity issues in the CHSCP Team have meant this initiative has been temporarily paused.

Full details of the Child Safeguarding Statement programme can be found within the Learning and Improvement section of the CHSCP website. This webpage contains a live index of organisations and their completed Child Safeguarding Statements. Whilst not an official accreditation, this will provide a public directory of agencies that have cooperated with the CHSCP's written safeguarding arrangements.

MULTI-AGENCY CASE AUDITS

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

In 2024, the CHSCP undertook a multi-agency case audit of cases involving 'Tier 3.5' cases of children with mental health needs. The cohort included children with ASD. The following provides a summary of the audit's findings. By way of context, the audits identified known demand pressures and the impact on aspects such as timeliness and waiting lists. These pressures fully recognised by our local system, with children's mental health remaining on the CHSCP's risk register. That said, a good range of mitigations are in place and there is ongoing focus, effort and innovation across the partnership.

EVIDENCE

Practitioners are generally alive to issues of risk and need and use internal pathways to escalate and report concerns. There is a focus on identifying and addressing the lack of appropriate educational provision for vulnerable children. Efforts continue to be made to understand the challenges of exclusions and the work of the REU. The audit also highlighted thoughtful approaches by practitioners in capturing the voice of children and young people and integrating it into plans. There is a focus on engaging the wider family and family network in planning. Good practice was seen in giving children and young people the space to be seen by themselves and picking up on nonverbal signs of communication. Schools continue to provide substantial in-and-out-of-school support for children. Agencies are actively trying to make a difference and support children.

EVIDENCE

Mental health issues in children can often be misunderstood or minimised, leading to delayed identification and intervention. There can also be the added complexity involving stigma – that can discourage some families from seeking help or acknowledging their child's needs. Early signs of mental health issues may also be misinterpreted as behavioural issues or dismissed as developmental phases – and responded to as such. This results in need being unmet, ineffective support and ultimately, poorer outcomes for children.

Positively, in the context of the cases audited by the CHSCP, there was good evidence that staff were alive to the issues and risk and need which present for children requiring mental health support. There was also evidence of internal and external pathways being used effectively by staff to report concerns and access support for children and families. Notwithstanding ongoing challenges, local support via the CAMHS Alliance and initiatives such as the Wellbeing and Mental Health Service in Schools initiative are making a difference.

The CAMHS Alliance facilitates better partnership working between different organisations and services, and ensures we deliver integrated pathways that can effectively reach more children, young people, families, schools and the wider community. The Alliance is formed by different services and partners that work across City & Hackney and deal with a range of issues, of levels of need and with specific groups of population. In this directory you can find a description of each of the services that are part of the Alliance, what they do and who is eligible to access them, as well as how to refer a young person who might need their services.

EVIDENCE

The audits showed good practice with two 'pilot' schools engaging multi-disciplinary teams (MDTs). These schools are identifying challenges for children early, putting in school interventions, with the pathways to the MDTs resulting in wrap around provision for children and families. Screening at the front-door of children's services is also focusing on mental health needs in the context of early help.

The Hackney Child Wellbeing Framework and the City of London Threshold of Needs tool continue to help guide practitioners on the most appropriate response for presenting levels of need. Needs relating to the emotional health, wellbeing and behaviour of children are explicitly articulated.

EVIDENCE

The audits evidenced that practitioners from key agencies, including schools, were attending regular multi-agency meetings for these children. More broadly, there is evidence of ongoing scrutiny on issues relating to attendance that continue to help shape policy and support for children. That said, there is a need to better understand the challenges that children face in this context and the sufficiency and efficacy of interventions.

EVIDENCE

The audits demonstrated a thoughtful approach to gathering the voice of children and young people and ensuring these were being integrated into any plans. Older young people had been given the space to be seen by themselves or with a parent / carer if they were particularly anxious. There was also evidence that the wider family network was engaged during the planning process. A training package is being developed by Homerton Healthcare to support professionals in documenting the voice of the child and really understanding what this means and looks like. The training is intended to be open access and could be further developed with a multi-agency focus in future.

EVIDENCE

Effective support requires collaboration among multiple agencies and stakeholders, including parents, teachers, healthcare providers, and children's social care. Poor communication and fragmented systems make coordination challenging. Children in foster care or those experiencing family instability face unique difficulties due to frequent transitions between caregivers and providers. Whilst noting the ongoing challenges around waiting lists, provision and demand, the audits demonstrated that good support is being made available, including that within schools. There was good evidence of the commitment of agencies trying to make a difference and support individual children with mental health needs.

Hackney's Re-Engagement Unit (the REU) is a service that supports families and schools if a child is finding engaging in school difficult. The aim of the service is to enable all children to be happy and to achieve. The REU is made up of workers from many different professional backgrounds: teachers; learning mentors; family support workers amongst others. The REU is also supported by a clinician from the Child and Adolescent Mental Health Service (CAMHS). Find out more information here.

EVIDENCE

The audits identified recent changes in the template for strategy discussions are helping ensure anti-racist practice is better considered as part of this process.

EVIDENCE

Transition periods are known for being a risky period with escalating issues. The audits highlighted the importance of persistent practitioners who keep a focus on the child and can professionally challenge colleagues and the system to advocate for the needs of the child. From a health perspective - as the holders of central health records, GPs were noted as being very important in the transition process. Of note, one of the audits reviewed demonstrated excellent practice in expediting a child's assessment for ADHD during a period of transition.

LEARNING AND IMPROVEMENT

Information sharing was identified as an issue in several areas, with concerns about timeliness, clarity of consent, and lack of follow-up. There can be confusion or anxiety among frontline professionals about expectations around information sharing. Issues were also raised about timeliness and waiting lists for access to services, particularly for appropriate residential and educational provision. There is a need for better joint working and a more integrated approach, especially for children who do not neatly fall into CP, LAC, or CIN categories. The audit highlighted a lack of clarity around the remit and responsibilities of each agency, particularly concerning exclusion processes and pathways.

LEARNING AND IMPROVEMENT

Practice issues were identified about the regularity of reviews and meetings, and agencies being kept in the loop. The audit identified a gap in the system for children with complex needs and families who struggle, with a lack of structure for routine and regular multi-agency working. There is a need for greater consideration of child and family identity, including ethnicity, sexuality, and gender. While some agencies have grasped this well, others have not, highlighting a need for greater awareness and training. Transitions, such as moving from primary to secondary school or changes in social workers, were identified as risky times with potential for escalating problems. The audit highlighted a need for greater attention to transitions and ensuring continuity of support during these times.

LEARNING AND IMPROVEMENT

Ongoing challenges with language barriers and accessing interpreters with the right dialect were identified. This can impact the timeliness of meetings and the ability to engage parents effectively. Overall, there is a need for greater understanding and awareness of the health architecture and system among partners. The audit highlighted a need for a more robust and comfortable system for professionals working with children and families. There is a lack of awareness on what is happening in the space of attendance issues and their link to other risks.

LEARNING AND IMPROVEMENT

Identification and Assessment or Risk and Need: The audits evidenced increased confidence is needed at an individual and agency level around the sharing of information. They noted improvements can be made where agencies are being asked for information by statutory agencies – such as children's social care. On occasions, agencies are not being advised of the outcome of a referral, and this is not being followed up by them. Previous audit rounds have also noted that agencies had sometimes not been provided the context of concerns when being asked to share information. This meant they were unable to make a rational judgement on exactly what information should be shared.

The Department for Education has released updated guidance which is much sharper at emphasising the lawful basis for sharing information when there are safeguarding concerns.

The audits practitioners need for practitioners to remain alert to the different agencies involved with a child / family and who else might need to be engaged in the assessment of need and planning for support.

The audits also found that there can be variability in practice as it relates to the identification of lead professionals and how activity is coordinated for children within this cohort – particularly where support is not part of any statutory intervention. In these circumstances (i.e. early help), cases can become more reliant on individual capacity and judgment as opposed to systems and processes. There can also be a lack of understanding and assumptions made about which agency is 'leading' and has 'responsibility' for a case. The issues relating to lead professionals have featured in previous reviews undertaken by the CHSCP and are subject to ongoing consideration both locally and nationally.

The audits evidenced a need to further consider exclusions in the context of children who might not be able to access services rapidly and who go on to exhibit challenging behaviours in school. Due to the nexus of exclusion with missing children and the escalation of risk, this is an aspect that requires ongoing scrutiny via the CHSCP's arrangements.

The importance of using interpreters was recognised in the audits, although it was noted that a lack of translators who both have the right dialect and also understand mental health, vulnerability and additional needs, could inhibit the ability to practice as well or as timely as needed.

SINGLE AGENCY AUDITING

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

EVIDENCE AND LEARNING

In April, the **City of London Corporation's** Quality Assurance template, process and review quality was scrutinised by the East London Peer Audit Group. The group review the most recent round of 14 reviews completed within the Practice Assurance Review and commented on the strengths and areas for development in relation to the tools used and process. This was a helpful exercise which has led to an updating of the practice review template and questions, informing a more consistent and robust moderation process, and supported the updating of the QA framework. The monthly Quality Assurance Recommendation Tracking and Impact meetings continue to ensure that the learning loop is complete, and we can be assured that recommendations have been completed and measure the impact of these on improving outcomes for children and families.

EVIDENCE, LEARNING AND IMPROVEMENT

Across **Hackney Children and Families Service**, an impressive 85% of learning conversations on special educational needs and disabilities (SEND) were rated as either Good or Outstanding. This positive trend was also evident in a follow-up review by Practice Development Managers, where 58% of files had improved to a Good rating, and two cases specifically moved from Requires Improvement to Good, demonstrating that audit actions are effectively driving change for children.

Positive practice was seen in several other areas as well. The Multi-Agency Safeguarding Hub (MASH) received strong ratings for its feedback to referrers, with 39% of dip samples rated Outstanding and 43% rated as Good. Practice with Children in Need was rated 88% Good or Outstanding, while practice for Looked After children was rated 100% Good. Furthermore, audits of DAIS (Domestic Abuse Intervention Service) practice were 100% Good, highlighting that client history and vulnerabilities were consistently being considered.

A collaborative audit with the Children and Families Division also yielded positive results. The audit of Child and Adolescent Mental Health Services (CAMHS) found that 93% of assessments **clearly identified and captured children's needs**. Similarly, audits of Young Hackney highlighted the **clarity of pathways** and **access to services** as a particular strength. However, within Youth Justice audits, while **family engagement, the child's voice, and identity** were identified as strengths, there is a clear need for improvement in the areas of planning and reviewing.

EVIDENCE, LEARNING AND IMPROVEMENT

During the 2024-25 period, the safeguarding team at the East **London NHS Foundation Trust (ELFT)** carried out a series of multi-agency and Trust-wide audits. These audits were prompted by key learnings from both local and national case reviews. The findings, insights, and recommendations were shared with individual staff, managers, and the Trust Safeguarding Committee. The primary goal was to provide assurance and ensure that valuable lessons were disseminated throughout all directorates to improve practice. The audits focused on several key areas, including a "Think Family" approach, the "Voice of the Child" in adult services, domestic abuse practice and reporting, and child neglect. Across all these audits, several key themes emerged. There was a strong emphasis on **training and supervision** to improve safeguarding skills and compliance throughout the Trust. To enhance the accuracy and clarity of data, new reporting and audit tools were introduced, focusing on **data quality**. A significant finding was the need for a renewed focus on **child-centred practice**, specifically ensuring that the voice and lived experiences of children are captured effectively. Furthermore, the Trust's safeguarding policies were updated to better align with the "Think Family" and domestic abuse guidance. Finally, the use of repeat audits, supervision, and newsletters was identified as a continuous learning strategy to drive ongoing quality improvement.

EVIDENCE, LEARNING AND IMPROVEMENT

The Metropolitan Police conducted an audit of ten cases focusing on children who were witnesses to or involved in domestic abuse (DA) offences. The audit identified key lessons and has led to several changes aimed at improving practice.

One major finding was the **delay in actioning tasks** from Multi-Agency Risk Assessment Conferences (MARAC) when children were involved. To address this, any actions set at MARAC will now be sent via email not only to the Officer in Charge (OIC) and their supervisor but also to the Children's Advice and Information Team (CAIT) referral mailbox. The Connect system will also be updated. This new process aims to prevent delays caused by staff absence or leave. A second issue identified was that Connect triage cards were not consistently being completed with full information, which hindered Children's Social Care (CSC) from taking appropriate action. In response, all frontline officers will now receive **training on how to complete these cards** correctly and on the importance of professional curiosity in their work. Additionally, training on how to refer cases to MARAC has been provided to all frontline officers, with presentation slides being circulated to ensure the information is widely accessible.

EVIDENCE, LEARNING AND IMPROVEMENT

An audit was conducted by **Homerton Healthcare NHS Foundation Trust** on initial health assessments (IHA) in City and Hackney, reviewing five reports from the City and ten from Hackney. The audit's recommendations focus on improving the IHA process, from referrals and documentation to the assessments themselves. To ensure ongoing quality, the audit recommends a re-audit in 18 months and the continuation of the current caseload approach. Several recommendations address the referral and administrative processes, including the **ongoing use of existing escalation processes** for delayed IHA referrals from the Local Authority (LA). It is also advised that the consent process is clarified with the LA to ensure consistency and that **documentation of key dates** for IHA bookings is made more consistent by liaising with Looked After Children (LAC) administrative staff. The recommendations also focus on improving the quality of the assessments. It is a priority to hold **face-to-face health assessments** and to liaise with the LA to ensure relevant background information is shared before appointments. The audit also stressed the importance of having the **named social worker**, or a colleague, present at all IHAs. Finally, it was recommended that the named General Practitioner (GP) prioritises the sharing of GP and immunisation records, and that **part C of the assessment form be adapted** to reflect whether children and young people (CYP) and their carers were offered the opportunity to be seen alone and whether consent was taken for those over 16 years of age during the appointment.

EVIDENCE, LEARNING AND IMPROVEMENT

Probation continues to prioritise safeguarding through ongoing review and monitoring of safeguarding training across the region, case dip-sampling to ensure concerns are identified and addressed in line with statutory duties and a continued focus on accurate recording of safeguarding checks and responses across the PDU. These measures are essential to ensure we can evidence the safeguarding work being undertaken, maintain compliance, and uphold the safety of children and vulnerable adults.

The Voice of the Child, Family & Community

Throughout the year, agencies have demonstrated their ongoing commitment to capturing the voices of children, families, and the community as part of casework and wider engagement activity. Listening and responding to the diverse voices of the community helps to create a more supportive and responsive environment for children and families. Whilst impossible to set out all this activity within the CHSCP's annual report, this aspect was scrutinised by the Quality Assurance Sub Group early in the year. Some examples of activity are set out below:

EVIDENCE AND IMPACT

A key initiative was the establishment of the City of London Children and Families Team's Children in Care Council supper club, which began at the beginning of the year. Born from feedback about isolation among care leavers, these monthly gatherings provide a relaxed, informal setting for young people to connect, build friendships, and support one another. The positive impact is already evident, with a consistent core group of 8-10 attendees who are developing strong peer networks. This sense of community has boosted their confidence, encouraging new members to join subsequent events and reducing anxiety by sharing experiences and hearing consistent messages from professionals.

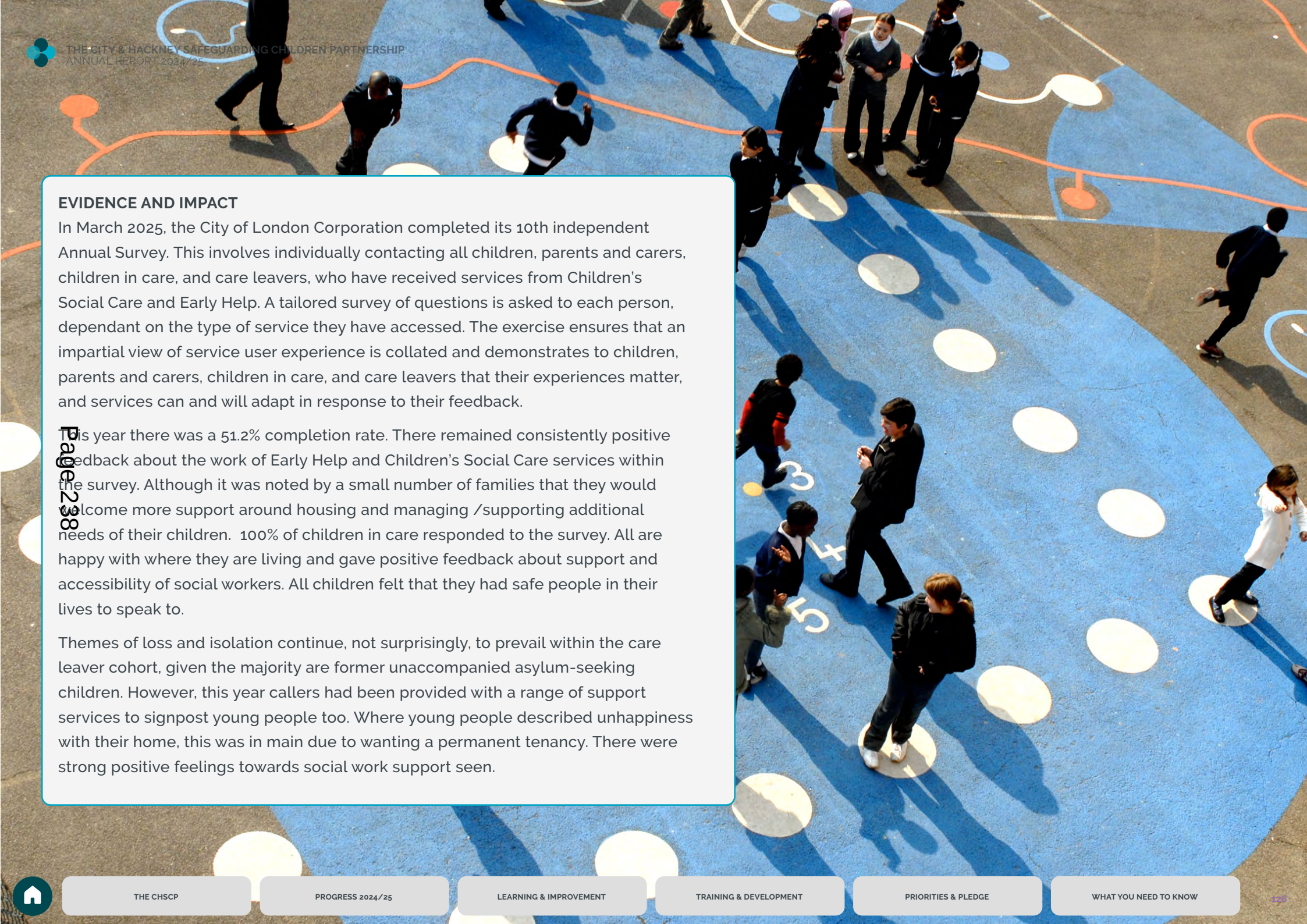
The supper clubs also revealed a need for more specific support, leading to the creation of monthly online information sessions. These sessions, facilitated by a participation worker and attended by senior staff and subject matter experts, address topics like bus passes and housing processes. This direct access to personalised information has been well received, giving young people a reliable space to get answers to their questions and feel more informed about their entitlements. In addition, we facilitated a theatre trip for our young people to see *"For Black Boys Who Have Considered Suicide When The Hue Gets Too Heavy,"* which sparked important conversations about mental health and well-being, allowing them to share coping strategies with each other.

EVIDENCE AND IMPACT

The WAMHS conference provided a platform for educators and mental health workers to hear from young people directly, with a standout performance from Haggerston School drama students and a poignant speech from a young person on the autism spectrum. This highlighted the importance of compassion-focused approaches in schooling.

EVIDENCE AND IMPACT

Hackney Education actively consulted with fathers and male carers to inform the development of Children and Family Hubs.



EVIDENCE AND IMPACT

In March 2025, the City of London Corporation completed its 10th independent Annual Survey. This involves individually contacting all children, parents and carers, children in care, and care leavers, who have received services from Children's Social Care and Early Help. A tailored survey of questions is asked to each person, dependant on the type of service they have accessed. The exercise ensures that an impartial view of service user experience is collated and demonstrates to children, parents and carers, children in care, and care leavers that their experiences matter, and services can and will adapt in response to their feedback.

This year there was a 51.2% completion rate. There remained consistently positive feedback about the work of Early Help and Children's Social Care services within the survey. Although it was noted by a small number of families that they would welcome more support around housing and managing /supporting additional needs of their children. 100% of children in care responded to the survey. All are happy with where they are living and gave positive feedback about support and accessibility of social workers. All children felt that they had safe people in their lives to speak to.

Themes of loss and isolation continue, not surprisingly, to prevail within the care leaver cohort, given the majority are former unaccompanied asylum-seeking children. However, this year callers had been provided with a range of support services to signpost young people too. Where young people described unhappiness with their home, this was in main due to wanting a permanent tenancy. There were strong positive feelings towards social work support seen.

EVIDENCE AND IMPACT

This case study explores the engagement strategies adopted by the City of London Corporatiopn's Education Welfare Manager, in supporting a secondary school student with significant health challenges. The student has been experiencing recurrent health issues, leading to chronic fatigue and significant absences from school. The Education Welfare Manager conducted a home visit to understand the young person's health challenges and gather detailed information from his family. A follow-up letter was sent to parent outlining what was discussed during the home visit and noted actions agreed during the visit. Consent forms were also agreed for the education welfare manager to make contact with health professionals to ensure transparent sharing of information and implementation of prompt and appropriate support. Regular communication was then maintained with the family. This included offering tuition during the summer holidays and exploring flexible schooling arrangements to accommodate the young person's health needs. To ensure the effective implementation of support, the education welfare manager worked closely with the young person's school, to ensure they were aware of his health challenges and could provide appropriate support, including the creation of an Individual Education Plan (IEP). Community resources were explored to ensure comprehensive support for the young person. The education welfare manager actively collaborated with health professionals to ensure a comprehensive understanding of the young person's medical condition and to coordinate support. Regular communication took place with the Head of Year and Safeguarding Lead on several occasions and has extended to the broader community, including liaising with external tutoring providers to arrange educational support for the young person. The education welfare manager has also explored support options from community organisations, such as Young Carers, to provide additional resources for the young person and his family. There is now a more comprehensive plan in place to support this young person as we move into the new academic year.

EVIDENCE AND IMPACT

Clinical Service 2024 Focus Groups: In 2024, the Hackney CFS Clinical Service engaged with children and families who had previously received support from the Surge team. The Surge team has since discontinued but previously offered support for young people presenting in mental health crises and those at risk of Tier 4 (specialised day and inpatient units) admission. Focus groups and telephone discussions were held to understand their experiences of seeking support for their child's mental health and what improvements could be made. The feedback has contributed to the ongoing informing and improving children and families services.

EVIDENCE AND IMPACT

Children's Rights Service SHOUT survey: In November 2024, Hackney CFS asked children and young people who are currently looked after or are care experienced, to tell us about their recent experience of receiving support from their Children's Rights Officers (CROs). An online, child-focused survey was used and 16 responses were received. The responses highlighted positive experiences with Children's Rights Officers (CROs), who are seen as supportive, accessible, and effective in helping young people understand their rights and have their voices heard. Responders appreciated the CRO's ability to listen, provide guidance, and ensure they felt supported during important processes. There were suggestions for improvement, such as quicker responses and better communication. The feedback emphasised the importance of CRO's building trusting relationships, creating a safe environment, and avoiding judgment.

EVIDENCE AND IMPACT

Special Guardian Support Group Questionnaire: Between January 2025 and February 2025 a questionnaire was sent to Hackney's Special Guardians mailing list to understand the challenges Special Guardian's face in their roles, areas of advice and support they may most benefit from and the structure and content of the regular Special Guardian Support Groups. 31 responses to the questionnaire were received, which is 23% of the total mailing list. Those who responded identified some of the main challenges they currently face include dealing with educational challenges for their child, finances, supporting the emotional wellbeing and mental health of their child and managing their child's behaviour. Responders also suggested improvements to the support, information and guidance they are offered. The survey results will be used to inform the support provided for special guardians going forward.

EVIDENCE AND IMPACT

Compliment about Hackney CFS from a parent or carer: *"I wanted to express how deeply appreciative I am of [Social Worker]'s support. [Social Worker]'s ability to understand and motivate [child] has made a lasting difference in their life"*

Compliment about Hackney CFS from a parent / carer: *"Thank you so much for your work with [Child], it has made a huge difference, and you have helped them through a very difficult time and they have come out confident and happy the other side"*

EVIDENCE AND IMPACT

The WAMHS conference provided a platform for educators and mental health workers to hear from young people directly, with a standout performance from Haggerston School drama students and a poignant speech from a young person on the autism spectrum. This highlighted the importance of compassion-focused approaches in schooling.

EVIDENCE AND IMPACT

Hackney Education actively consulted with fathers and male carers to inform the development of Children and Family Hubs.

EVIDENCE AND IMPACT

Working with local schools and their communities, the Met Police further developed the concept of Safer Corridors. This involved the Safer Neighbourhood Teams and schools working together to prevent children becoming victims of crime on their way home from school. The overall aim has been to provide 'safe routes' using crime data and feedback from children around where they feel less safe. Patrols are on foot and on pedal bikes whilst engaging with schoolchildren. Collaboration with one secondary school (Haggerston) resulted in a change in how detentions were issued (from after school to lunch time) to make it less likely children would become victims of crime on their way home.

EVIDENCE AND IMPACT

In 2024, Hackney Council and City and Hackney Safeguarding Children Partnership held a series of meetings with AFRUCA Safeguarding Children to discuss the over-representation of African and Caribbean families in the child protection system as a result of physical chastisement. The local authority was aware that parenting of children in most of these families is good and the incidents of physical chastisement relate more to parenting understanding of what is acceptable or not in terms of chastisement, as opposed to there being any underlying abusive intent. Hackney and AFRUCA agreed to collaborate to deliver a series of three safeguarding training events for faith leaders and workers in Black faith organisations so they can better understand the law and expectations surrounding physical chastisement and how to talk to parents about keeping their children safe. 65 participants from 30 churches attended three events facilitated by AFRUCA. The participants contained a mix of Pastors and leaders in the church. These were the right people who could go back and make a difference to safeguarding decisions in their organisations.



Performance Data

Whilst the CHSCP maintained two area-based datasets which captured a range of safeguarding metrics across the local partnership, with the loss of personnel, the increased use of AI and a focus on avoiding duplication, new arrangements are being introduced to collate and interpret multi-agency safeguarding data for 2025/26. These new arrangements will enhance the focus on any key data shifts, and importantly, what the data might be telling us about performance and the quality of practice.

Front-Line Intelligence

The CHSCP did not issue a staff survey in 2024/25 as planned, primarily because of capacity issues within the CHSCP team. The ongoing focus on the CHSCP's priority on the Health and Wellbeing of the workforce facilitated ongoing insight into the views of front-line practitioners, as did the engagement of some within the CHSCP's reviewing and auditing processes.

External Learning

The CHSCP is a learning organisation and is constantly looking outwards to identify relevant learning opportunities that may help assist in its role of coordinating and ensuring the effectiveness of the safeguarding systems across the City of London and Hackney. Where relevant, national reviews and inspection reports are considered by the CHSCP. Links to NSPCC thematic briefings and wider learning from other local areas continued to be disseminated to front-line staff via CHSCP training and TUSK briefings.





Focus on CSA and CSE

In March 2025, the Home Secretary wrote to Local Authority Chief Executives, outlining the Government's commitment to doing all it can to tackle the horrific crimes of child sexual abuse (CSA) and child sexual exploitation (CSE). As part of this letter, the Home Secretary expressed an interest in receiving an update on how local areas were prioritising their response child sexual abuse and exploitation, and the specific actions being taken to tackle this issue. The following sets out the basis of this response from the CHSCP Executive covering both the City of London and Hackney:

EVIDENCE AND IMPACT

The CHSCP has undertaken a wide range of actions and activities in both Hackney and the City of London to combat Child Sexual Abuse (CSA) and Child Sexual Exploitation (CSE). Our efforts are consistently guided by our "Safeguarding First" approach and our commitment to ensuring children are seen, heard, and helped. Our approach has been multifaceted, encompassing prevention, early intervention, disruption of offending, and victim support, as detailed in our annual reports for 2020/21, 2021/22, 2022/23, and 2023/24.

EVIDENCE AND IMPACT

Learning from Reviews: The CHSCP appropriately conducts Local Child Safeguarding Practice Reviews (LCSPRs) to learn lessons from serious child safeguarding cases and improve multi-agency working. In terms of CSA, the recent CSPR on Case A examined how local agencies managed and mitigated risks posed by a known child sex offender, identifying a lack of robust professional curiosity and insufficient focus on the child's paramountcy. Recommendations from this review aim to improve referrals to children's social care, strengthen guidance on risk management of offenders, and enhance information sharing with key agencies. One recommendation arising from this review links to Multi-Agency Public Protection Arrangements (MAPPA) and we have been engaged with the Child Safeguarding Practice Review Panel on how best to progress improvements at a national level. Another relevant LCSPR (Child W) has recently been finalised. A defined CSA task group has been set up to collate and drive the recommendations arising from this review, Case A, and the national panel's review on CSA.

EVIDENCE AND IMPACT

Auditing and Quality Assurance: The CHSCP implements multi-agency case auditing programmes focusing on specific areas such as intra-familial CSA. these audits lead to outcome-focused action plans and inform briefings for frontline professionals.

EVIDENCE AND IMPACT

Staff Training and Development: The CHSCP provides a comprehensive training programme covering various safeguarding topics, including child sexual abuse, exploitation, and online safety. Training content incorporates learning from local and national case reviews. For instance, specialist training has been commissioned to increase understanding of child sex offenders, all City social workers are now ABE trained and there is ongoing focus on broadening the cohort of trained social workers in Hackney. The CHSCP routinely seeks assurance and evidence from healthcare providers and other agencies that CSE/CSA is included in mandatory training.

EVIDENCE, IMPROVEMENT AND IMPACT

The City of London - Identification and Response:

The City of London experiences a low number of cases, with most contacts related to non-residents. Relevant crimes recorded by City Police included rape, sexual activity, and possession of indecent images, as well as grooming via the internet/social media. The City Multi-Agency Sexual Exploitation (MASE) panel was changed to the Multi-Agency Child Exploitation (MACE) panel to encompass all forms of child exploitation and abuse that adolescents are at increased risk of.

The City of London's location as a major transport hub is significant for intelligence sharing among partner agencies. The City maintains an "it could happen here" stance despite relatively lower risks compared to neighbouring Local Authorities.

The City Police lead on all children missing from home or care, with a coordinated response involving the City Children and Families team. Numbers of missing children in the City of London are very low. Coram Voice conducts independent return home interviews within 72 hours, with therapeutic support offered based on outcomes to address risk-taking behaviour. These interviews are reviewed by the partnership to inform strategy and service delivery. Workers use a range of tools, which they regularly update when children's circumstances change, including risk of exploitation and going missing.

The City of London's MACE panel uses quarterly data and intelligence to understand and identify risk indicators related to all forms of child exploitation. The City of London Police has restructured its public protection department to have specialist officers available out of office hours and seven days a week.

"Operation Makesafe" is ongoing and involves plainclothes police officers attempting to book hotel rooms with a child not related to them, providing feedback and advice to hotels on identifying and disrupting CSAE.

"Operation Reframe" targets the night-time economy to create safer environments for vulnerable people, including test purchases at licensed premises to identify and address alcohol sales to children.

EVIDENCE, IMPROVEMENT AND IMPACT

Hackney - Identification and Response:

In Hackney, children at high risk of extra-familial harm benefit from effective interventions. Professionals work across service areas and through multi-agency panels to robustly explore risks and vulnerabilities for children. Actions are identified to help reduce risk, harm and offending, and to increase children's safety. Children are seen within the context of their own needs as well as within their family, community, and peers. Progress is evident for some children; risks have reduced through successful interventions and the trusting relationships built with key practitioners. If risks increase, children's cases are appropriately escalated through child protection processes to coordinate the multi-agency response.

Analytical research has highlighted three broad CSE profiles: peer-on-peer abuse (sexual offences/exploitation in a group setting), adult perpetrator exploitation (young person believing they are in a relationship with an adult through vulnerable friends or online contact), and exploitation via social media (inciting explicit image sharing).

In Hackney, contacts identifying Child Sexual Exploitation as a potential concern were received for 37 children during 2023/24. There were 1,301 missing episodes reported over the same time period, involving 265 children. The most prominent reason for children going missing was "difficulties at home or school," with overcrowding also noted. Mental health, emotional wellbeing, and learning needs were also precipitating factors. Contacts for 167 children identified Criminal Exploitation (CE) as a potential concern, and 145 children had statutory social work assessments where CE was a factor.

Most CE referrals related to male children from Black and Global Majority backgrounds. Contacts for 185 children identified Serious Youth Violence and Weapons as a potential concern.

The Youth Justice Service reported a 19% decrease in first-time entrants to the youth justice system in 2022/23, with 91% of triaged young people successfully diverted. An Extra-Familial Risk Panel continues to oversee and plan for cases where young people are at risk of harmful behaviours outside the home, with strong multi-agency attendance from Police, Education, Health, Youth Offending Team, Young Hackney, and the Community Gangs Team.

The Metropolitan Police Service's handling of sexual and criminal exploitation of children has improved. The force's children's strategy now sets out the commissioner's ambition to adopt a 'child first' approach. This aims to make sure officers and staff recognise that children are different from adults and should be treated differently because they have different needs and vulnerabilities.

Continued overleaf

EVIDENCE, IMPROVEMENT AND IMPACT continued

Through a renewed focus on child exploitation, its links to missing children and the language the force's officers and staff use, the force has made positive progress. The changes the force has implemented are also now providing better outcomes for children in London.

The Metropolitan Police Service's Safer Schools and Youth Engagement Teams regularly deliver presentations on various safeguarding issues, including youth-produced sexual imagery (YPSI), exploitation, and gangs.

In terms of managing offenders, Probation and Jigsaw staff in Hackney are co-located which has been reported to assist in better collaboration locally. There is now greater emphasis on joint working, home visits, risk assessment, and information sharing.

Children's social care in Hackney has taken significant steps to strengthen its practice in response to child sexual abuse. Alongside identifying dedicated practice leads to develop expertise and be available for consultation, practitioners have access to much clearer guidance and there are defined processes in place such as the following:

- To ensure leadership focus, service managers are informed about any disclosures of child sexual abuse.
- Multi-agency strategy meetings under Section 47 of the Children Act 1989 are convened to discuss risk, develop safety plans, and determine the approach to investigation. There is an expectation that a safety plan is coproduced with the protective care giver, recorded on the case management system, and shared with the family and professionals.
- Importantly, there is defined guidance covering how to issue instructions for specialist risk assessments. This includes the following narrative about how Jigsaw risk assessments should be considered: 'Risk judgement offered by the Jigsaw team engaged with convicted sexual offenders - This judgement of risk is given based on a number of factors present or absent at a specific point in time. This risk judgement should always be reviewed in light of changing context (e.g., living circumstances for the alleged perpetrator), which could cause the assessed risk level to either increase or decrease. We should not base our decisions about child safety on this risk judgement alone.'
- Revised guidance is also much more explicit about the need for direct work with children and how to engage them and protective carers. Within this guidance, there are clear examples about the practical work that can be undertaken.
- Defined pathways are in place at Homerton Hospital covering the management of suspected CSA. Routine awareness raising continues and best practice is promoted via the Centre of Expertise on CSA.

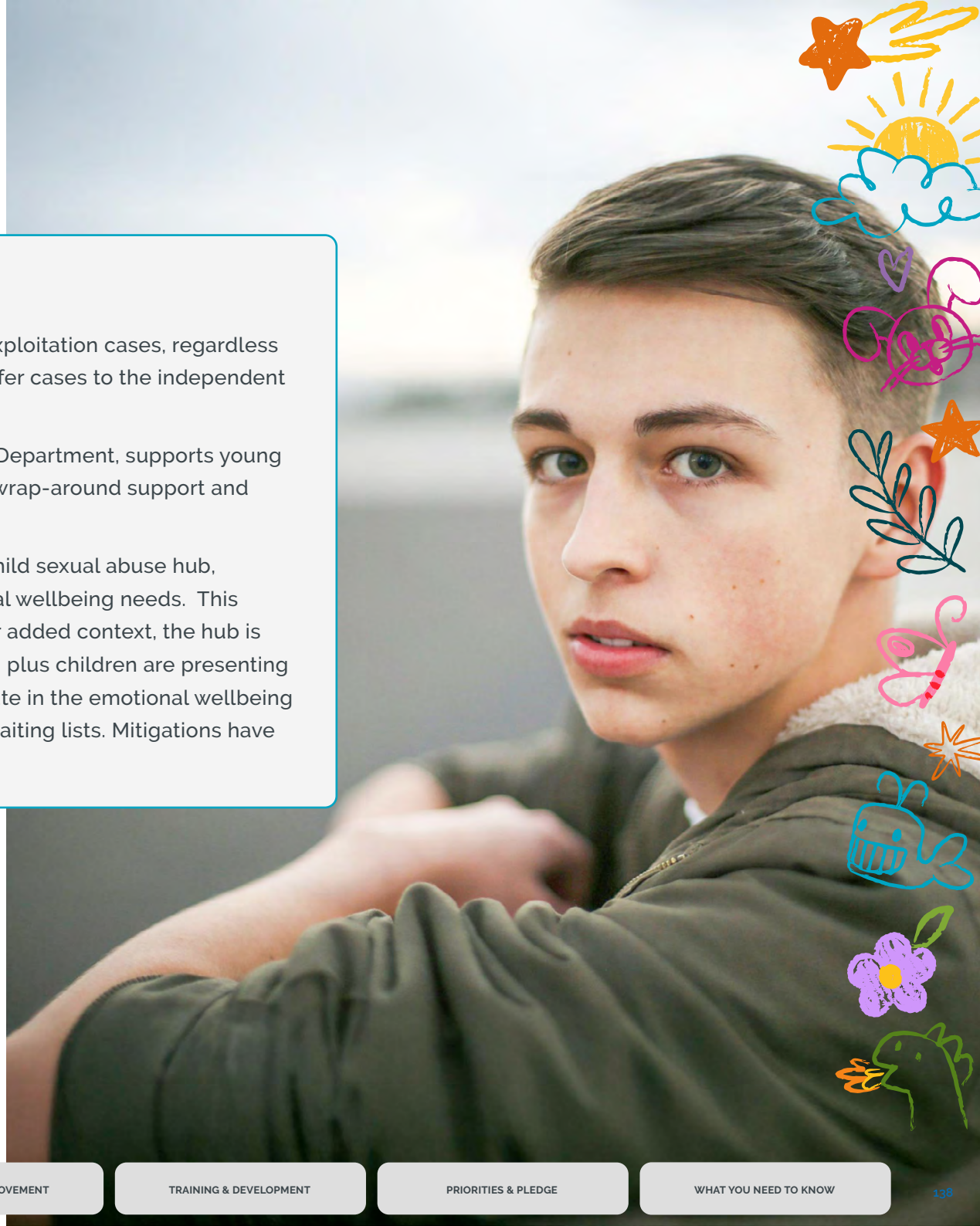
EVIDENCE AND IMPACT

Support for Victims and Vulnerable Children:

The expansion of the right to review for all child sexual abuse and exploitation cases, regardless of when they took place, is being promoted to ensure victims can refer cases to the independent Child Sexual Abuse Review Panel.

Redthread, a charity embedded in Homerton Hospital's Emergency Department, supports young people affected by or at risk of violence and exploitation, providing wrap-around support and diverting them from offending.

The Sunrise (previously NEL CSA Hub) at Royal London provides a child sexual abuse hub, collaborating with Barnardo's to address both medical and emotional wellbeing needs. This setting was visited by the Children's Commissioner in April 2025. For added context, the hub is facing increasing demands as the number of referrals are increasing plus children are presenting with increasing complexity and vulnerability. The impact is most acute in the emotional wellbeing and support service with pressures arising in terms of volume and waiting lists. Mitigations have been implemented, but the waiting list is now 12 months.



Training & Development



Summary

The training opportunities offered by the CHSCP are designed to meet the diverse needs of staff at different levels within the wide range of organisations that work with children, young people, or adult family members. Sessions range from those that raise awareness about safeguarding and child protection to specialist topics aimed at more experienced staff. The training programme focuses on areas of practice prioritised by the CHSCP, with learning from local and national case reviews integrated into the training material.

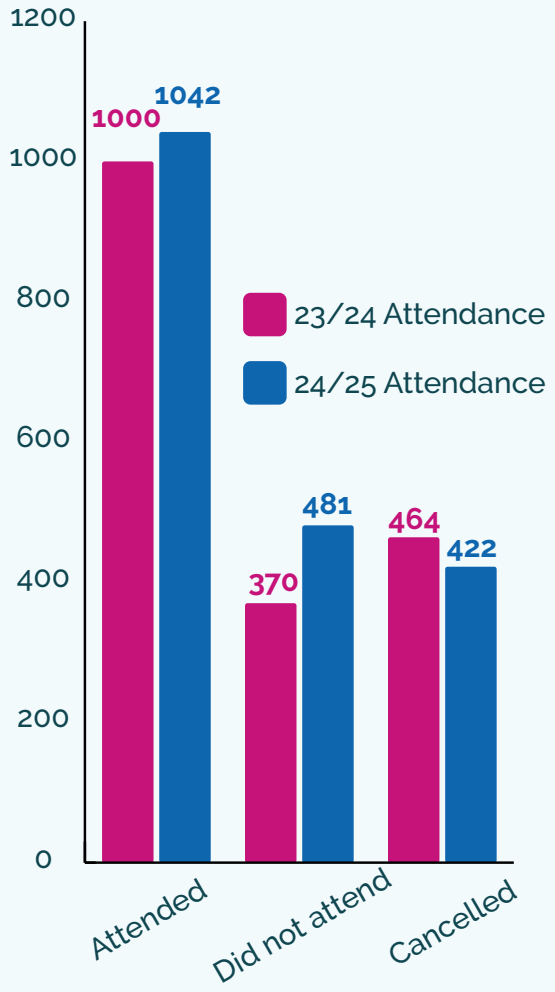
EVIDENCE

- 77 training sessions were held in 2024/25
  (An increase from 60 in 2023/24, 56 in 2022/23 and 47 in 2021/22).
- 43 safeguarding topics were covered.
- 17 new courses were introduced to the programme
- Most courses continued to be delivered virtually, with two face-to-face sessions held.

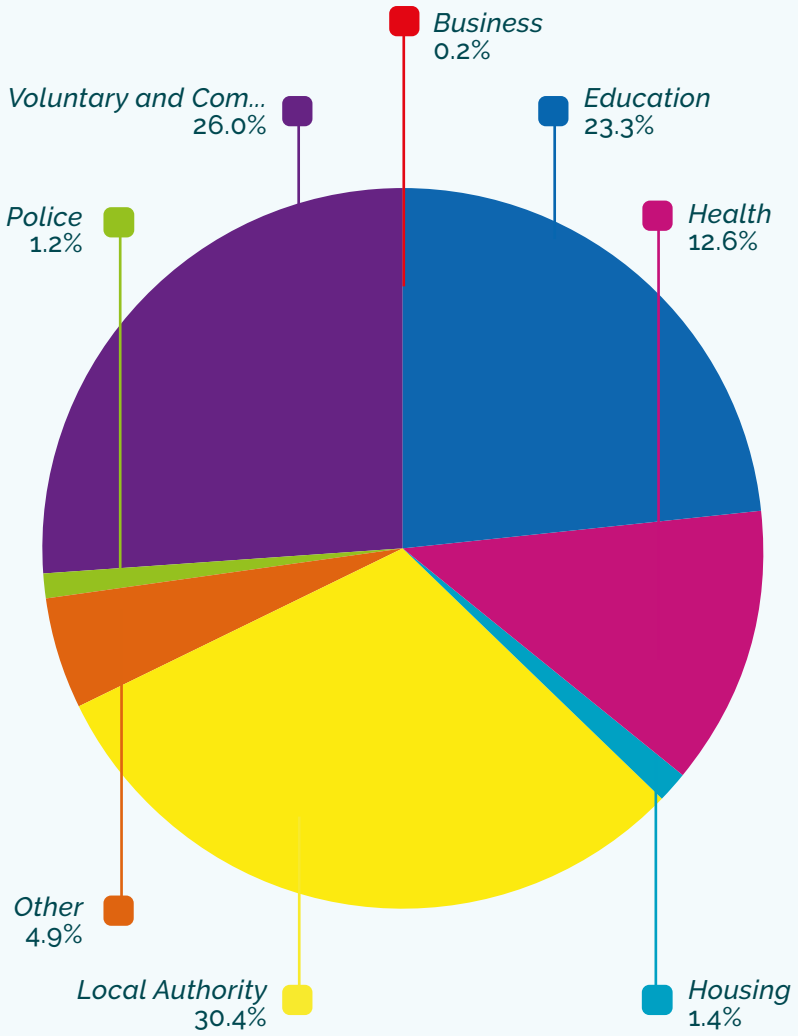
EVIDENCE

- Of the 1945 booked places (1834 in 2023/24), 1042 practitioners attended (and increase of 4% from 2023/24). 422 cancelled their training booking (a decrease of 9.1% from 2023/24). 481 did not attend the course (an increase of 30% from 2023/24).
- 67% of attended bookings were by practitioners working in Hackney, 16% in the City of London, and 17% by those working across both areas.

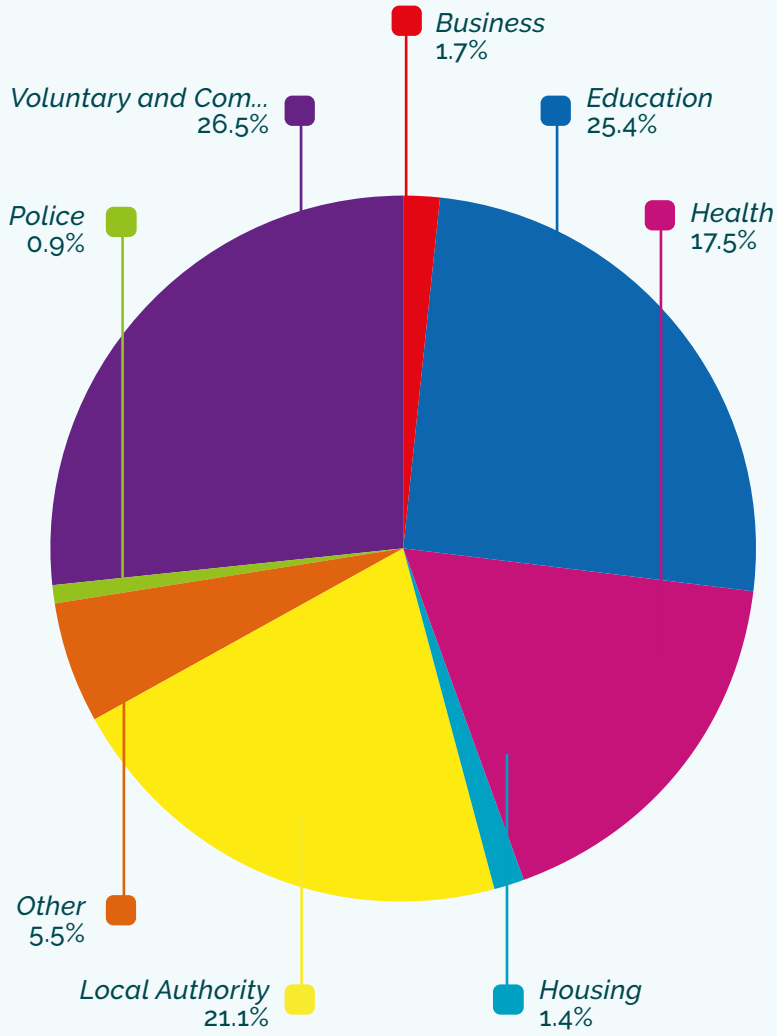
Attendance Status 2023/24 vs 2024/25



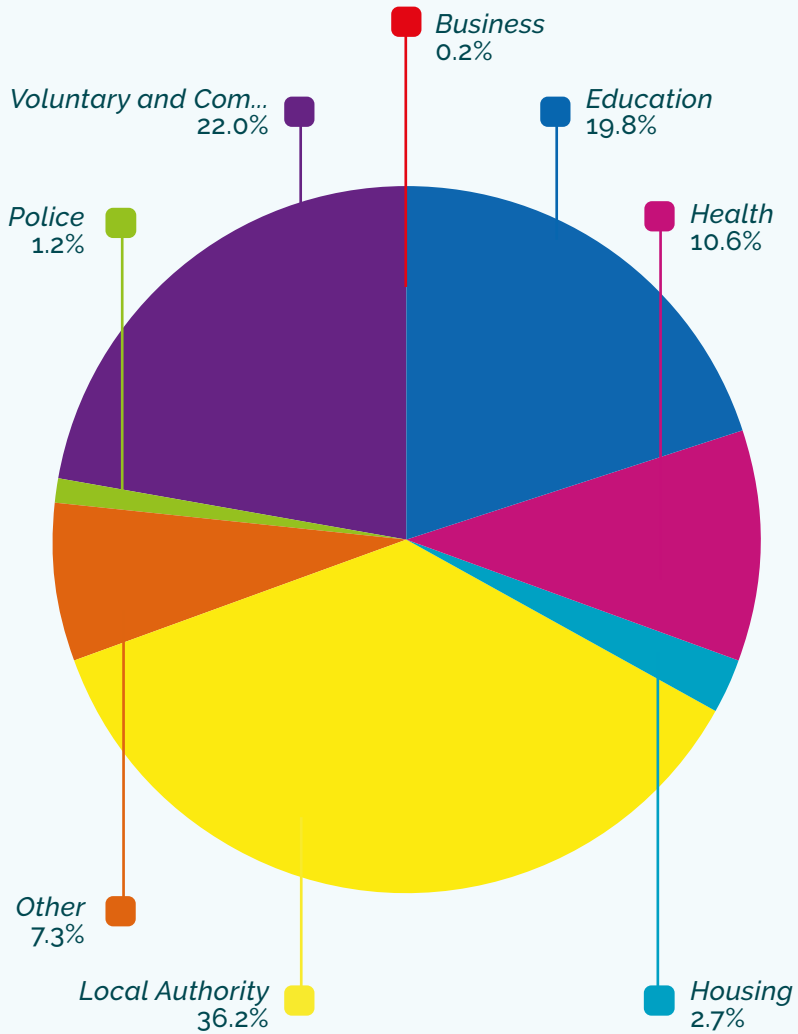
Attendance by Sector



Cancellations by Sector



Non-Attendance by Sector



EVIDENCE

In August 2025, the ISCC wrote to all partner agencies about the increase 'non-attendance' numbers.

In the current financial climate, we are all facing significant budgetary pressures. The costs associated with these no-shows are no longer sustainable. We rely on the goodwill of our knowledgeable colleagues to lead these sessions, and our budget, which supplements external training, is being wasted. Ultimately, this trend negatively impacts our ability to offer places to delegates on waiting lists, directly hindering our collective mission to provide high-quality training and support across the partnership.

We ask for your support in reinforcing the importance of this issue with your staff. Please remind them of their responsibility to prioritise and attend all pre-booked training. If a delegate cannot attend, they must follow the established cancellation process to free up the place for someone else.

If this trend of non-attendance continues, we will have no choice but to implement financial penalties to offset the wasted resources. We value your partnership and your commitment to ensuring our staff have the skills and knowledge they need to succeed. Your cooperation in addressing this matter is greatly appreciated.

EVIDENCE

Course Title	Delegates Trained 24-25
An Introduction to Child Sexual Abuse (CSA) in the Context of Exploitation	8
An Introduction to Female Genital Mutilation (FGM)	2
An Introduction to Intra-Familial Child Sexual Abuse	6
Child Criminal Exploitation and County Lines	34
Child Protection and Safeguarding Training for Faith Leaders	65
Child Sexual Abuse Education	11
Children's Wellbeing & Mental Health	28
Cultural Awareness - Gypsy Roma Traveller Cultural Competency Training	21
Cultural Awareness - Working with the Orthodox Jewish Community	49
Designated Safeguarding Lead' courses (Level 3)	180
Early Help Pathway, Request for Support Form and Assessment	12
Hear my Voice: Obtaining the Views and Opinions of Children with Communication Difficulties	33
How to Engage and Work with Fathers and other Male Caregivers	17
iCAN Dads: Working with Primary Male Caregivers	1
Identifying and Exploring Child & Adolescent to Parent Violence & Abuse	18
Impact of Neglect and Emotional Abuse on the Development of Children and Young People	30
Improving Professional Participation in Child Protection Conferences	11
LADO: Allegations Against Staff and Volunteers	7
LADO: Allegations against Staff and Volunteers Training for Faith Group Leaders	1
LADO: Completing Employment-Based Risk Assessments	10
LADO: Completing Internal Employment Based Investigations	14
Making Sense of Autism	26
Modern Day Slavery/Trafficking	7

Continued overleaf.

EVIDENCE CONTINUED

Course Title	Delegates Trained 24-25	
Non-Recent Child Sexual Abuse	14	▼
Oral Health Care	5	▼
Parental Mental Illness: Impact on Parents, Parenting Capacity and Children's Development	22	▲
Parenting Together: Improving the Relationship and Communication of Co-Parents	6	▲
Prevent Duty Awareness	53	▼
Private Fostering Workshop	4	–
Protecting Children and Vulnerable Adults from Abuse Linked to Faith or Belief	8	▼
Recognising the Difference between Domestic Abuse and Parental Conflict	13	▼
Relationship Solutions - The Relationship Toolkit for Working with Parental Conflict	15	▼
Safe Space: Structuring and Conducting Sessions with Families to Create Positive Interactions whilst Tackling CAPVA	7	▲
Safeguarding Children Basic Awareness courses (Level 1)	113	▼
Safeguarding Children with Disabilities	10	▼
Safeguarding in a Digital World	28	▼
Safer Recruitment	9	▼
Safer Sleep	24	▼
The Child Death Overview Process		
Understanding Adultification Bias	47	▲
Understanding Adults Who Sexually Abuse Children (Foundation Level)	7	▲
Understanding Adults Who Sexually Abuse Children (Intermediate Level)	25	▲
Understanding Adverse Childhood Experiences (ACEs), Trauma, and Trauma Informed Practice	37	▲
Working with Cultural & Economic Diversity	4	▼
TOTAL	**1042**	▲

EVIDENCE

To curb inconsistencies between courses, particularly relating to the admittance of, and recognition of attendance status for late attendees, the CHSCP Training, Learning, and Development Subgroup approved two versions of Course Attendance Standards for Delegates covering virtual and face-to-face training. The standards provide a comprehensive list of instructions covering before, during, and after the course. The content covers pre-evaluation completion, when and how delegates will receive joining instructions, how to cancel course registration, downloading course materials, the strict registration cut-off point, expectations related to visual and audio use during the course, and the evaluation schedule post course.

EVIDENCE

The PHEW learning management system continues to be a great addition to the training element of the CHSCP. It has helped to reduce admin time in terms of not having to download registration data and evaluation data from multiple sources and the training coordinator not having to produce individual certificates for delegates. In addition, the system sends calendar invites for each course, booking confirmations and reminder emails to delegates. Delegates are now able to download pre-course materials up to one week prior to their training session, and post course materials following their attendance being recorded online. Delegates are also able to print their own certificates after completion of the evaluation form for the relevant course. During 2024/25, the CHSCP's Training Coordinator utilised the information on PHEW to create 41 separate evaluation reports.



Evaluation

Supported by its Training Evaluation and Analysis Framework, the CHSCP continues to monitor and evaluate the effectiveness of its core training programme. The evaluation schedule involves post-course feedback and follow-up engagement with delegates and their line managers, seeking evidence of how training has influenced practice. This has enabled the CHSCP to gain important insight into the difference its training programme is making towards improving outcomes for children and young people.

EVIDENCE

99.6% of delegates stated that the trainers' facilitation skills, teaching style and knowledge were GOOD (10.2%) VERY GOOD (37.5%) or EXCELLENT (49.9%). This feedback is a testament to the skill and expertise of our internal & commissioned trainers.

IMPACT

97.7% stated what they had learned would help them safeguard children & young people more effectively.

95.6% said the course met their expectations.

IMPACT

It's a lot to pack into one day and is full on and exhausting. It's quite hard to take in all the data. However, there was no part of the day I found not useful.
An Introduction to Intra-Familial Child Sexual Abuse - Post Course Evaluation.

Being able to discuss the case study with other people and hearing others' ideas really helped me to consider things that I may not have thought about before.
LADO: Completing Internal Employment-Based Investigations, Post Course Evaluation.

It was quite rushed at the end when arguably covering the most important part.
Cultural Awareness: Working with the Orthodox Jewish Community - Post Course Evaluation.

Continued overleaf

IMPACT Continued

Training was hugely informative. There was plenty of time for discussion with others, enabling a multidisciplinary approach to analysing this bias.

Marcia was very open to questions and perspectives being shared which fostered a positive environment to learn in.
Understanding Adultification Bias, Post Course Evaluation.

[It was most useful] learning about real life situations including reviews and what can be learnt from them to improve the chance of a better outcome.
Safeguarding Children: Basic Awareness - Post Course Evaluation.

I have used some of the communication skills discussed in the training which has allowed me to capture the voice of non-verbal young children more effectively.
Designated Safeguarding Leads, Level 2 Evaluation.

I have explained to colleagues in a clinical supervision situation that what they were describing when discussing a family situation was not domestic abuse, but a conflict situation that they could help the parents to resolve.
Recognising the Difference between Domestic Abuse and Parental Conflict, Level 2 Evaluation.

The knowledge I received during the training has enabled me to become culturally sensitive and this has had a positive impact on my health assessment of children and young people.
Gypsy Roma Traveller Cultural Competency Training - Basic Awareness, Level 2 Evaluation.

[The employee] has not been directly involved in safeguarding issues and has not come across a situation where she has had to raise a safeguard in the last 6 months. However, we have discussed the training in supervision and the big takeaway from the training was that supporting the individual's communication needs is not classified as 'leading questions'.
Hear my Voice: Obtaining the Views and Opinions of Children with Communication Difficulties, Level 2 Evaluation.

[The staff member is] more confident to deal with issues as they arise and able and willing to engage in discussions at a management level.
Designated Safeguarding Leads, Line Manager Feedback.

[The member of staff now] understands drug related issues that affect young people.
Child Criminal Exploitation and County Lines, Line Manager Feedback.

No differences noted in practice. Staff members noted that they did not think the content of the training was useful and that the delivery was a little disorganised.
Working with Economic and Cultural Diversity to Safeguard Children, Line Manager Feedback.

Priorities & Pledge



CHSCP Priorities 2024/25

PRIORITY 1

The Health & Stability of the Safeguarding Workforce

Outcome

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

PRIORITY 2

Active Anti-Racist Practice

Outcome

The partnership's approach to safeguarding children is characterised by active anti-racism and aligns with the CHSCP's Anti-Racist Charter. Practice that disproportionately and negatively impacts on Black and Global Majority children (and their outcomes) is identified and reduced. Children and their families are confident in challenging their experiences of racism, have mechanisms in place to escalate their concerns and tell us that they can see change. Practitioners are confident in challenging racism, and this happens.

PRIORITY 3

The Voice of Children

Outcome

Multi-agency safeguarding practice reflects the lived experience of children. The voices of children are central to all aspects of the child's journey and are used to influence service design, develop practice and improve outcomes.

PRIORITY 4

Maintaining and Building on the Foundations of Good Practice

NEW

Outcome

Multi-agency safeguarding practice demonstrates a strong foundation, continuous improvement and alignment with the national standards for child protection. Children and families are effectively supported by early, robust, timely and coordinated multi-agency help and protection.

PRIORITY 5

Strategic Vulnerabilities & Pathways to Harm

NEW

Outcome

The CHSCP identifies and develops action in response to identified strategic vulnerabilities and the pathways to harm facing children. For 2025/26, local priorities centre on Child Sexual Abuse, Safeguarding Adolescents, Neglect and Unregistered Educational Settings.

PRIORITY 6

The Appetite to Learn

Outcome

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

Our Pledge



THE HEALTH & STABILITY OF THE SAFEGUARDING WORKFORCE

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



ACTIVE ANTI-RACIST PRACTICE

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



THE VOICE OF CHILDREN

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

NEW



MAINTAINING AND BUILDING ON THE FOUNDATIONS OF GOOD PRACTICE

The CHSCP recognises that good practice is built upon solid foundations, and we are committed to maintaining and continuously building upon these. We will maintain focus on ensuring these fundamental aspects are embedded in our work, covering the journey of the child through the safeguarding system. This includes our approaches to family help, child protection, looked after children, and care leavers.

NEW



STRATEGIC VULNERABILITIES & PATHWAYS TO HARM

We will proactively respond to local strategic vulnerabilities and identified pathways to harm through robust and focused multi-agency arrangements. We will commit to developing our understanding of these issues and work together to implement solutions that directly support practice, improve outcomes and help tackle the root causes of harm to children.



THE APPPETITE TO LEARN

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

What You Need to Know



Children and Young People

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

childline

ONLINE, ON THE PHONE, ANYTIME

childline.org.uk | 0800 1111

Parents and Carers

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





The Community

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

Practitioners

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





Local Politicians

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

Leaders

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



The Police

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





Head Teachers and Governors of Schools

- Ensure that your school / academy/ educational establishment is compliant with statutory guidance KCSIE.
- You see children more than any other profession and develop some of the most meaningful relationships with them.
- Keep engaged with the safeguarding process and continue to identify children who need early help and protection.
- Make sure your DSLs and Deputy DSLs have access to good quality supervision, support and training.

NHS
North East London



Integrated Commissioning Boards

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

The Local Media

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



chscp

SEEN | HEARD | HELPED

www.chscp.org.uk

© CHSCP 2025

Website: www.chscp.org.uk
Email: chscp@hackney.gov.uk
Phone: 0208 356 4183
Twitter: @lscp_chscp

p. 30.09.25 v.1.0.1



An INEQE Safeguarding Group Ltd CSR Publication 2025

City of London Corporation Committee Report

Committee(s): Health and Wellbeing Board - for information	**Dated:** 04/02/2026
Subject: City and Hackney Safeguarding Adults Board Annual Report 2024/25	**Public report:** For Information
This proposal: ● **delivers Corporate Plan 2024-29 outcomes**	Providing Excellent Services
Does this proposal require extra revenue and/or capital spending?	No
If so, how much?	£
What is the source of Funding?	n/a
Has this Funding Source been agreed with the Chamberlain's Department?	n/a
Report of:	Claire Solley Independent Chair of the City and Hackney Safeguarding Adults Board
Report author:	Shohel Ahmed City and Hackney Safeguarding Adults Board Manager

Summary

The City and Hackney Safeguarding Adults Board (the Board) is a statutory board required under s43 of the Care Act 2014. One of the statutory duties of the Board is to complete an annual report outlining what it has achieved in respect of adult safeguarding in the previous year. This report outlines the key achievements of the Board as well as what the Board will prioritise in the forthcoming year. An overview of the safeguarding data for the City of London Corporation is also included for reference.

Recommendation(s)

Members are asked to:

- Note the report.

Main Report

Background

1. The City and Hackney Safeguarding Adults Board (the Board) is a statutory board required under s43 of the Care Act 2014. The Board has three statutory functions:
    - Develop and publish a strategic plan outlining how the Board will meet its objectives
    - Publish an annual report detailing the safeguarding achievements for that financial year
    - Commission Safeguarding Adults Reviews (SARs) for any cases which meet the criteria
2. This report outlines the annual report for 2024/25. It focuses on the principles underpinning the strategy, its strategic priorities, key achievements and data for 2024/25.
3. Some of the key achievements for the Board in 2024/25 include:

    3.1 The Board commissions a package of training for frontline line staff working across the City and Hackney on a yearly basis. This year the Board commissioned 8 safeguarding courses delivered quarterly throughout the year. Courses on offer included the following:

    - Safeguarding awareness training (webinar).
    - Trauma informed approaches to safeguarding (in person).
    - Safeguarding, Self-neglect & Hoarding (webinar).
    - Safeguarding Adults Workshop for Manager & Safeguarding Leads (webinar).
    - SAMs – Exploring the Roles, Responsibilities and Expectations of Safeguarding Adult Managers (webinar).
    - SAE – Undertaking S42 Safeguarding Enquiries (webinar).
    - Safeguarding, mental health and social isolation (webinar)

    In total, over 150 people attended the various different training sessions on offer
4. The Board organised a series of events throughout the whole month of November, in recognition of Safeguarding Adults Week. These included events on intergenerational domestic abuse, modern slavery and organised immigration crime as well as a session with the Department for Work and Pensions around the move to Universal Credit and supporting vulnerable residents throughout this transition.
5. Board partners undertook a self assessment using the Safeguarding Adult Partnership Assessment Tool in Feb 2025, which was analysed by the Board Manager and used as evidence to help guide discussions during the Boards Development Day in April 2025.
6. The Chair of the Board hosted a Patient Panel on Safeguarding in the City of London which was open to residents and explained what safeguarding means, how to raise concerns, and what role the City and Hackney Safeguarding Adults

Board plays. This event empowered community members to protect vulnerable adults and clearly communicated important contact points and procedures.

7. In 2024/25, the Board published two discretionary Safeguarding Adults Reviews:
    - JL: The discretionary Safeguarding Adults Review (SAR) into the death of JL was commissioned by the City and Hackney Safeguarding Adults Board (SAB) in June 2023 to complement a local learning review by Adult Social Care services in Hackney. The review recommended strengthening input from housing partners within the Board as well as reviewing the Board's Escalation Policy.
    - Steve: The discretionary Safeguarding Adults Review (SAR) into the death of 'Steve' was commissioned by the City and Hackney Safeguarding Adults Board (SAB) in November 2023. A practitioners event for the 'Steve' SAR was held in July 2024, providing practitioners an opportunity to provide insight and contribute to the review, as well as draw out learning to help inform the recommendations. A further learning event was held in November 2024 for the 'Steve' SAR, where attendees were able to hear a synopsis of the review, understand the challenges that occurred in supporting 'Steve' and focus on research findings relating to the recommendations that were made; namely palliative care and mental capacity for people that are homeless.

Current Position

8. The Board has set itself the following strategic priorities for 2025/26:
    - Develop and Implement a Community Engagement Strategy
    - Establish a Multi-Agency Dashboard and Conduct regular multi-agency audits
    - Ensure Learning from Safeguarding Adult Reviews (SARs) and Other Reviews are complete in a timely manner and learning is shared.
    - Implement the updated London Association of Directors of Adult Social Services (ADASS) Pan-London Adult Safeguarding Policies and Procedure.
    - Improve outcomes for people experiencing homelessness by preventing abuse and neglect and strengthening safeguarding responses.
    - Minimise the risk of self-neglect and strengthen our multi-agency response.
    - Minimise the risk of and strengthen our multi-agency response to financial abuse.

Key Data

9. Key data was collected in relation to safeguarding for the City of London:
    - 49 safeguarding concerns were raised.
    - 30 of those concerns led to a Section 42 Enquiry.
    - A Section 42 Enquiry relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. This happens whether or not the authority is providing any care and support services to that adult. It aims to decide what, if any, action is needed to help and protect the adult.
    - The trend over the last five years shows, concerns have decreased from 57 in 2020/21 to 49 in 2023/24 and have stayed the same in 2024/25.

- The most prevalent risk noted this year in safeguarding enquiries was Neglect and Acts of Omission, accounting for 32% of all cases. This was closely followed by Self-Neglect, which constituted 29% of the risks. Financial or Material Abuse represented 18% of the total risks identified.
- In line with the national and London average, the data shows 79% of client's risk comes from someone known to the individual. This is an increase from the previous year 2023-24 of 64%.
- The majority of safeguarding enquiries related to alleged abuse that happened within the person's own home.

Corporate & Strategic Implications

Strategic implications - The City and Hackney Safeguarding Adults Board (CHSAB) plays a vital role in supporting the corporate priority of delivering excellent services by ensuring that adults with care and support needs are safe, empowered, and able to live healthy, independent lives.

Financial implications - none

Resource implications - none

Legal implications - none

Risk implications - none

Equalities implications – The work of the Board aims to improve outcomes for adults with care and support needs, many of whom fall within one or more protected characteristics, particularly in relation to age, disability, and mental health. As such, the work of the Safeguarding Adults Board is expected to have a positive impact by promoting equality of access to support services, protecting individuals from harm, and enabling people to live independently and safely.

Climate implications - none

Security implications - none

Conclusion

10. The Annual Report was published on the appropriate pages online.

Appendices

- Appendix 1 – City and Hackney Safeguarding Adults Board Annual Report 2024/25

Shohel Ahmed
City and Hackney Safeguarding Adults Board Manager
E: shohel.ahmed@hackney.gov.uk

CHSAB Annual Report 2024–25

People should be able to live a life free from harm in communities that are intolerant of abuse, work together to prevent abuse and know what to do when it happens

City and Hackney
Safeguarding Adults Board

Accessibility statement

If you require this document in a different format, please email



CHSAB@hackney.gov.uk

We will consider your request and get back to you in the next five working days.

Contents

Introduction by Claire Solley 2

What is the Safeguarding Adults Board? 3

- Role 3
- Membership 3
- Principles 4
- Board Governance 6
  - Subgroups 6
  - CHSAB strategic links 7
  - Budget 7
  - Supporting the CHSAB 7
- Strategic Plan for 2024/25 10

CHSAB Achievements for 2024/25 11

- Community and Resident Engagement 11
- Training and engagement with professionals and community voluntary sector 11
- Safeguarding Adults Week 12
- Quality Assurance 12
- Multi-agency working 12
- National work 13

Safeguarding Adults Review (SARs) 15

- Key Learning and Themes 16

Safeguarding Data for 2024/25 20

- City of London Corporation Performance Data for 2024/25 20
- London Borough of Hackney Performance Data for 2024/25 24
- East London NHS Foundation Trust Performance Data for 2024/25 26

CHSAB Board Partners Safeguarding Achievements 30

- London Borough of Hackney Adult Social Care 30
- City of London Corporation Adult Social Care 30
- North East London Integrated Care Board 31
- Homerton University Hospital NHS Foundation Trust 31
- East London Foundation Trust 32
- Barts Health NHS Trust 32
- Metropolitan Police Service 32
- City of London Police 33
- Turning Point 33
- London Borough of Hackney Benefits and Homeless Prevention 34
- Age UK 34
- London Borough of Hackney Domestic Abuse Intervention Service 34



Introduction by Claire Solley

I am pleased to present the City and Hackney Safeguarding Adults Board (the board) Annual Report for 2024/25.

The Care Act 2014 places a duty on Safeguarding Adult Boards to publish an Annual Report outlining what it has done to achieve its objective, implement its strategy, and the actions it has taken in response to learning and recommendations from Safeguarding Adult Reviews.

I would like to take this opportunity to thank Dr Adi Cooper, the previous independent chair, for a comprehensive and supportive handover. The board's strong foundations, robust and effective partnerships and achievements were achieved under Dr Cooper's leadership and I am committed to building on these.

I would also like to thank residents, community organisations, volunteers, people who work across City and Hackney and board members for their very warm welcome and unwavering dedication and hard work to keeping people safe and championing their rights. Every single action and contact with someone can make a real difference and the impact of this is presented in this annual report.

I joined as the newly appointed independent chair in June 2025. I am committed to ensuring the voice and rights of individuals are central at all times, and to working collaboratively with others to optimise safety and wellbeing. Everyone has the right to live free from abuse and neglect, to feel safe and thrive, achieving and doing the things that are important to them.

As a partnership we have set the board's strategy for 2025-2028, our key priorities for 2025-26, and are reflecting on and reviewing our governance arrangements to make sure they are most effective in supporting us to achieve our objectives. In 2025-26, the board's key areas of focus will be prevention of, and our response to, self- neglect, financial abuse and multiple exclusion homelessness. These key priorities will be underpinned by Making Safeguarding Personal (the voice and rights of adults), Mental Capacity (an adult's rights in relation to decision making) and equity (addressing inequity).

I am honoured to be leading the partnership in the role as independent chair of the board and am looking forward to working with everyone across City and Hackney - safeguarding is everybody's business.

Claire Solley, Independent Chair,
City and Hackney Safeguarding Adults Board

What is the Safeguarding Adults Board?

Role

The City and Hackney Safeguarding Adults Board (CHSAB) is a partnership made up of both statutory and non-statutory organisations. A range of organisations attend the Board including health, social care, housing, criminal justice and fire services, voluntary sector and residents who use services in the City of London and Hackney.The main objective of a SAB is to assure itself that local adult safeguarding arrangements and the actions of partners are effective in preventing and responding to abuse and neglect.

The CHSAB has three core legal duties under the Care Act 2014:

1) Develop and publish a Strategic Plan outlining how the Board will meet its objectives and how partners will contribute to this
2) Publish an Annual Report detailing actions that the Board has taken to safeguard the community and how successful it has been in achieving this
3) Commission Safeguarding Adults Reviews (SARs) for any cases that meet the criteria.

In addition to this, the CHSAB is able to lead or undertake work in respect of any other adult safeguarding issue it feels appropriate.

Membership

The CHSAB has three statutory partners: the Local Authority, Integrated Care Board and Police service and a wide range of non-statutory partners.

Below is a full list of our partners and their attendance at our quarterly Board meetings:

2024-25	
Independent Chair	100%
London Borough of Hackney Adult Social Care	100%
Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture, London Borough of Hackney	100%
City of London Corporation Adult Social Care	100%
North East London Integrated Care Board	100%
Homerton University Hospital	75%
Barts Health NHS Trust	75%
East London NHS Foundation Trust	100%

2024-25	
London Fire Brigade	50%
Metropolitan Police	100%
City of London Police	100%
Hackney Council Voluntary Service	50%
London Borough of Hackney Housing	75%
London Borough of Hackney Benefits and Homeless Prevention	75%
Age UK East London	75%
Turning Point	100%
Older People's Reference Group	100%
Department for Work and Pensions	75%
City and Hackney Public Health	75%
Healthwatch Hackney	75%
Healthwatch City of London	75%
City of London Corporation Housing	100%

Principles

The Board's strategy and annual strategic plan is underpinned by the six safeguarding principles:

- **Prevention –** It is better to take action before harm occurs.
  "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."
- **Proportionality –** The least intrusive response appropriate to the risk presented.
  "I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."
- **Protection –** Support and representation for those in greatest need.
  "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

- **Partnership –** Local solutions through services working together and with their communities. Services share information safely and each service has a workforce well trained in safeguarding. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

  "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

- **Accountability –** Accountability and transparency in delivering safeguarding.

  "I understand the role of everyone involved in my life and so do they."

- **Empowerment –** Support and representation for those in greatest need.

  "I was asked what I want as the outcomes from the safeguarding process and this directly informs what happens."



Board Governance

Subgroups

The Board has a number of subgroups in place to ensure the delivery of its annual priorities:

Quality Assurance:

The group examines quantitative and qualitative data to help identify safeguarding trends and issues across the City and Hackney. This information is provided to the Executive group and helps inform the work and priorities of the Board. In 2024/25, the subgroup worked on developing a CHSAB dashboard that could be used to help identify and respond to emerging safeguarding trends. Although not yet finalised, the subgroup has made progress on the dashboard and hope to have a final version ready for the 2025/26 year. The subgroup also made progress on undertaking a multi agency case file audit, with the subgroup agreeing on an audit template as well as a methodology for the audit itself.

SAR action plan task and finish group:

This group was designed to ensure that the actions from our most recent SARs are completed in a timely manner. The group also identified how to ensure that learning from SARs has a long term impact on improving practice. In 2024/25, the group focused on ensuring the recommendations from the 'Steve' SAR were progressed, and supported the organisation of the practitioners and learning events held for the SAR. It also focused on progressing any outstanding learning from previous SARs, including the JL discretionary SAR.

Safeguarding Adults and Case Review

The group fulfils the Board's s44 Care Act duty by considering requests for a Safeguarding Adults Review (SAR). The group reviews referrals and makes recommendations to the Chair when it considers a SAR is required. In 2024/25, the group agreed to undertake two discretionary Safeguarding Adult Reviews, details of which can be found further down the report.

City of London Adult Safeguarding Committee

The City of London has a Safeguarding Adult Committee, which focuses on safeguarding issues affecting residents living in the City of London. The Committee meets quarterly, where it allows partners to share their responses and responsibilities in relation to different safeguarding issues and provides updates in respect of their progress against the Board's strategic priorities. In 2024/25, the Committee received reports on various safeguarding issues pertinent within the City of London, including rough sleeping, social isolation, fire safety and mental capacity.

CHSAB strategic links

The CHSAB has links with partnerships and boards working with residents in the City of London and Hackney, including: the City and Hackney Safeguarding Children's Partnership, Community Safety Partnerships and Health and Wellbeing Boards. The Board will also engage with other partnerships where there may be opportunities to work collaboratively or provide an adult safeguarding expertise.

Budget

In 2024/25 the budget was £234,325 from the partners listed below:

Partner contributions to the CHSAB	CHSAB Partnership 2023/24 (£)
City of London Corporation	(28,875)
East London NHS Foundation Trust	(27,500)
Homerton University Hospital	(12,000)
North East London Integrated Care Board	(20,000)
Metropolitan Police Authority	(5,000)
Barts Health NHS Trust	(5,000)
City of London Police	(4,400)
LB Hackney	(131,550)
Total income	**234,325**

The expenditure for the Board in 2024/25 was £179,138

The remaining £55,186.82 was transferred to the reserve pot.

Supporting the CHSAB

The CHSAB has a full-time Board Manager and Business Support Officer to manage the work of the Board.

CASE STUDY 1:



... Adult Social Care has remained involved, offering continued support focused on safety planning, financial advice, and maintaining independence...

London Borough of Hackney Adult Social Care

Joan was targeted by an individual who posed as a helpful friend offering assistance in her home. Over time, the situation escalated; this person caused damage to the property, behaved threateningly, and attempted to take control of her accommodation. They even demanded payment for building work that was never completed. Joan was supported to explore her options and decide what she wanted to happen next. Through close joint working with the Police, the individual was safely removed from the property, and Joan regained control of her home. Adult Social Care has remained involved, offering continued support focused on safety planning, financial advice, and maintaining independence. Joan has expressed a strong desire to remain self-sufficient, and ongoing support is being tailored to help her do so with confidence and security.

CASE STUDY 2:

East London Foundation Trust

Mr Wilkinson, a 53-year-old man with schizoaffective disorder, had been supported by ELFT mental health services for three years. He was previously engaged with treatment but became increasingly isolated and stopped attending appointments following the death of his partner 18 months earlier. After repeated missed visits, his care team attempted home outreach. During one visit, clinicians found Mr Wilkinson in a significantly deteriorated state. He presented as manic, with disorganised thoughts and speech, and admitted to stopping his medication. He appeared malnourished, and his home environment was cluttered and unsafe, raising concerns about self-neglect. The mental health team escalated concerns to the Trust's safeguarding lead and initiated a Section 42 enquiry. Self-neglect was identified as the primary issue. ELFT led the enquiry in partnership with housing and community day services. Mr Wilkinson was also found to be experiencing complex grief and depression, which further impacted his motivation and self-care. With his consent, Mr Wilkinson was admitted to a mental health ward for short-term stabilisation. He responded well to treatment, and a coordinated discharge plan was developed. This included a deep clean of his home, weekly support from a carer agency, and bereavement-focused psychological therapy. His care coordinator increased contact, and community engagement was encouraged through local groups. This multi-agency, person-centred approach led to a positive outcome. Mr Wilkinson re-engaged with services and his community, and his mental and physical health stabilised. The safeguarding process enabled effective collaboration to reduce risk and support sustained recovery.



Strategic Plan for 2024/25

The City and Hackney Safeguarding Adults Board had the following strategic priorities for 2024/25:

1. **To continue to improve the quality of mental capacity assessments.**
2. **To engage with the community and voluntary sector to support them to build their confidence in delivering their safeguarding duties and raise awareness of adult safeguarding.**
3. **To continue to embed engagement with people with lived experience and ensure that they can influence all aspects of the Board's work.**
4. **To identify and respond to the safeguarding needs of people who are homeless, people experiencing modern day slavery, people experiencing discriminatory abuse (hate crime) and young people (18-25 year olds).**
5. **To work collaboratively with agencies and partnerships across the City and Hackney to respond to the safeguarding needs of residents.**
6. **To support frontline practitioners to respond to complex issues relating to self-neglect.**
7. **To deliver and implement recommendations that arise in relation to both local, regional and national Safeguarding Adults Reviews.**
8. **To ensure that all agencies across the City and Hackney deliver their core duties in relation to safeguarding.**

The City and Hackney Safeguarding Adults Board (CHSAB) Strategy 2025-28 and the Strategic Work Plan 2025/26 are publicly available and can be accessed **here**.

CHSAB Achievements for 2024/25

Community and Resident Engagement

- The Board engaged with residents via the CHSAB newsletter, which was reinstated in February 2024. The purpose of the newsletter is to ensure residents are kept up to date with the work of the Board and are able to join any planned events in the future.
- The Chair of the Board hosted a Patient Panel on Safeguarding in the City of London which was open to residents and explained what safeguarding means, how to raise concerns, and what role the City and Hackney Safeguarding Adults Board plays. This event empowered community members to protect vulnerable adults and clearly communicated important contact points and procedures.
- The Board is part of a wider range of different stakeholder groups that includes the: Carers Partnership Board, Suicide Prevention Board and domestic abuse work streams.

Training and engagement with professionals and community voluntary sector

- The Board commissions a package of training for frontline line staff working across the City and Hackney on a yearly basis. This year the Board commissioned 8 safeguarding courses delivered quarterly throughout the year.
- Courses on offer included the following:
    - Safeguarding awareness training (webinar).
    - Trauma informed approaches to safeguarding (in person).
    - Safeguarding, Self-neglect & Hoarding (webinar).
    - Safeguarding Adults Workshop for Manager & Safeguarding Leads (webinar).
    - SAMs – Exploring the Roles, Responsibilities and Expectations of Safeguarding Adult Managers (webinar).
    - SAE – Undertaking S42 Safeguarding Enquiries (webinar).
    - Safeguarding, mental health and social isolation (webinar).
- In total, over 150 people attended the various different training sessions on offer.

Safeguarding Adults Week

- The Board organised a series of events throughout the whole month of November, in recognition of Safeguarding Adults Week.
- These included events on intergenerational domestic abuse, modern slavery and organised immigration crime as well as a session with the Department for Work and Pensions around the move to Universal Credit and supporting vulnerable residents throughout this transition.
- The City and Hackney Safeguarding Adults Board also organised an in-person learning event for the 'Steve' Safeguarding Adults Review (SAR) during November (further details on the Steve SAR can be found below), whereby attendees were able to hear from Jess Harris, a senior research fellow at Kings College London, on Mental Capacity and Multiple Exclusion Homelessness, as well as from Dr Caroline Shulman, an honorary research fellow at University College London, on Palliative Care.
- The learning event was very well attended, with approximately 50 professionals across the City and Hackney SAB partnership joining on the day.

Quality Assurance

- Board partners undertook a self assessment using the Safeguarding Adult Partnership Assessment Tool in Feb 2025, which was analysed by the Board Manager and used as evidence to help guide discussions during the Board's Development Day in April 2025.
- The Quality Assurance Subgroup developed and agreed on an audit template, which will be used by partners when undertaking multi agency case file audits.
- The Independent Chair of the Board continued to meet with Board partners, in order to ensure that all safeguarding issues affecting residents were identified and addressed and that engagement with Board partners continued to increase. These check-ins also helped resolve any issues partners experienced within the system, and served to improve relationships with key stakeholders.
- The Board received presentations from both the London Borough of Hackney and the City of London Corporation on their Adult Social Care Self Assessment as part of the CQC assurance process.

Multi-agency working

- There was Board attendance at a number of partnership groups including the suicide prevention group, strategic vulnerability board, community safety officer group and domestic abuse work streams.

National work

- The City and Hackney Safeguarding Adults Board responded to the letter from the Department of Health and Social Care regarding individuals rough sleeping. The letter made several recommendations to SABs around how Boards can support individuals who are rough sleeping, and sought to seek assurance on mechanisms that are in place within each local authority.
- The Board has also sent published Safeguarding Adults Reviews (SARs) to the national SAR library as well as the National Analysis of Safeguarding Adult Reviews.

CASE STUDY 3:

Barts Health NHS Trust

Lewis, a 58-year-old man with cancer and schizophrenia, was flagged by the hospital nursing team after missing multiple chemotherapy and clinic appointments. He appeared unkempt, had a bedbug infestation, and faced possible eviction from his hostel, raising concerns about his ability to manage his health and living conditions. The hospital safeguarding team reviewed community records and found Lewis was already supported by mental health, homelessness, and community health services. These teams were contacted to share concerns and coordinate a response. A safeguarding referral was also made to Hackney Adult Social Care to ensure hospital concerns were included in ongoing community care planning. This multi-agency collaboration allowed professionals across settings to work together effectively. Community teams helped Lewis attend appointments, while hospital staff made reasonable adjustments such as tailored communication and flexible care delivery to improve his engagement. When Lewis was later admitted, discharge planning benefited from this prior coordination. The care team was already aware of his risks and support needs, enabling a smoother, safer discharge. This coordinated approach ensured Lewis remained central to care decisions. By sharing information and working jointly, professionals reduced treatment disruption, enhanced engagement, and provided appropriate support for both his health and social needs.



Safeguarding Adults Reviews (SARs)

The Board has a statutory duty to undertake Safeguarding Adults Reviews (SAR) under section 44 of the Care Act 2014. The following criteria must be met for a SAR:

1. An adult has died or suffered serious harm.
2. It is suspected or known that it was due to abuse or neglect.
3. There is concern that agencies could have worked better to protect the adult from harm.

The Board is also able to undertake a discretionary SAR under the Care Act, where a case does not meet the threshold for a review but it is considered that there is valuable learning to be gained in terms of addressing abuse and neglect.

In 2024/25, the Board published two discretionary Safeguarding Adults Review.

JL: The discretionary Safeguarding Adults Review (SAR) into the death of JL was commissioned by the City and Hackney Safeguarding Adults Board (SAB) in June 2023 to complement a local learning review by Adult Social Care services in Hackney.

JL was aged 77 when he sadly died in his flat in February 2022. An inquest held in April recorded that his death was caused by pneumonia, frailty, chronic alcoholism, hyperthyroidism and frostbite. The review recommended strengthening input from housing partners within the Board as well as reviewing the Board's Escalation Policy. The Board published the 7 minute briefing in September 2024 which can be found **here**.

Steve: The discretionary Safeguarding Adults Review (SAR) into the death of 'Steve' was commissioned by the City and Hackney Safeguarding Adults Board (SAB) in November 2023. 'Steve' had been known to services in Hackney since April 2020 and was an extremely vulnerable individual who had cancer, and a long history of homelessness, trauma, alcohol misuse and substance misuse. A safeguarding referral was made to Hackney Adult Social Care in April 2023 due to concerns about his inappropriate housing, self neglect and inability to manage medication safely. 'Steve' experienced numerous hospital admissions and discharges between December 2022 and May 2023. 'Steve' was admitted to hospital in early May 2023 due to a fall and a head injury and sadly died a few days later. The Coroner's report noted his cause of death as 1a) Acute Respiratory Failure, 1b) Combined Opioid and Opiate Use and 2) Metastatic Testicular Seminoma, Hypertension, Chronic Obstructive Pulmonary Disease.

A practitioners' event as part of the 'Steve' SAR was held in July 2024, providing practitioners an opportunity to provide insight and contribute to the review, as well as draw out learning to help inform the recommendations.

A further learning event was held in November 2024 for the 'Steve' SAR, where attendees were able to hear a synopsis of the review, understand the challenges that occurred in supporting 'Steve' and focus on research findings relating to the recommendations that were made; namely palliative care and mental capacity for people that are homeless.

The Board published the 'Steve' SAR in November 2024 which can be found **here**.

Key Learning and Themes

The JL review made four recommendations including strengthening multi agency coordinations especially around complex safeguarding cases, reviewing policies such as the escalation policy and the hospital discharge policy and improving partnership engagement in order to enhance communication, challenge, and the ability to respond to risk holistically.

The Steve SAR made ten recommendations, including improving multi-agency coordination, strengthening safeguarding and escalation pathways, and ensuring timely access to advocacy for people experiencing homelessness. It also called for enhanced workforce training in areas such as palliative care, self-neglect, and mental capacity, as well as better integration between health, housing, and social care services.

...Eight weeks after discharge, a joint review by adult social care and mental health services found Anna's mental health had stabilised...



CASE STUDY 4:

City of London Corporation Adult Social Care

Anna, a woman in her 40s from Eastern Europe, had been rough sleeping across the City of London and surrounding boroughs. A safeguarding concern was raised after she was seen walking into traffic and threatening members of the public. She spoke little English, was not registered with a GP, and was subsequently detained under the Mental Health Act due to significant concerns about her mental state. Following assessment, the City of London assumed Section 117 aftercare responsibility. Anna was assessed as needing supported accommodation upon discharge. A City social worker led the capacity assessment, and a best interests meeting was held with an interpreter, an advocate, health professionals, and the social worker to ensure her voice remained central to the process. Anna was discharged into a supported living placement with one-to-one staffing. She was registered with a GP and connected with the local neighbourhood mental health team. She also received immigration support through Praxis. The adult social care team used discretionary funding to provide her with clothing and secure identification, including a passport. Eight weeks after discharge, a joint review by adult social care and mental health services found Anna's mental health had stabilised, and her physical health had improved. Her support team introduced her to local communities who spoke her language and shared her interests, and supported her to access familiar films and media. Anna reported feeling settled and expressed interest in future employment or returning to her home country. Her support hours were reduced as she became more independent. The case demonstrated strong partnership working, legal literacy, and a strengths-based approach, leading to meaningful and sustained outcomes for Anna.



CASE STUDY 5:

Turning Point

Kyle is a 65 year old male with a long history of severe alcohol dependence which resulted in significant cognitive and memory impairments. Kyle was previously residing in a hostel which became unsuitable for his needs as he suffered from frequent seizures and falls putting him at serious risk of injury and potential fatality. The confined space and lack of accessible support further exacerbated these risks. During this period, Kyle experienced multiple hospital admissions due to his deteriorating physical health. Following a referral to Adult Social Care, a care package was implemented. However, despite this support, Kyle continued to suffer from recurrent seizures, resulting in ongoing hospitalisations. Due to these risks, he was relocated to alternative temporary accommodation where a twice-daily care package remained in place. It became evident that Kyle required more stable, supported housing. However, barriers to securing appropriate accommodation included historic rent arrears. During this time, Kyle was also subject to financial exploitation by another resident. In response, Turning Point and Social services collaborated to safeguard him with practical support and education around financial safety. A multi-agency approach was taken, involving services such as adult social services, housing, the GP, a Groundswell worker, and a recovery worker from Turning Point. This collaborative effort was instrumental in resolving his rent arrears and facilitating his transition into supported housing. Kyle has now successfully moved into a safer placement and is able to engage positively with services to address his ongoing needs. Kyle has been able to maintain independence and has been able to reduce his alcohol use.

CASE STUDY 6:

City of London Police

Sara entered the UK on a spousal visa without any English language skills, no recourse to public funds, and was completely financially reliant on her husband and in-laws, who subjected her to escalating honour-based violence and coercive control under the guise of protecting family "honour." Her case was escalated to the City of London Multi-Agency Risk Assessment Conference a multi-agency panel convened to safeguard those at highest risk and she was supported by an Independent Domestic Violence Adviser. Together they devised an urgent safety plan while simultaneously securing safe, confidential housing, applying for the Migrant Victims of Domestic Abuse Concession (MVDAC), and obtaining a non-molestation order against the perpetrators. Through this coordinated effort which included police, housing services and guidance from the Independent Domestic Violence Advisor, Sara moved into safety, gained legal protections, accessed vital financial support, and began learning English and managing her own finances, reclaiming autonomy in a life that had been controlled by others.



...Sara moved into safety, gained legal protections, accessed vital financial support, and began learning English and managing her own finances, reclaiming autonomy in a life that had been controlled by others...

Safeguarding Data for 2024/25

The safeguarding data for 2024/25 is presented separately for the City of London Corporation, London Borough of Hackney and the East London NHS Foundation Trust.

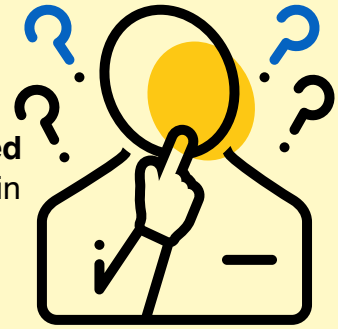
City of London Corporation Performance Data for 2024/25

49 safeguarding concerns were raised.

49

30 of those concerns led to a Section 42 Enquiry.

21 S42 enquiries concluded in 2024-25 compared to **19** the previous year. **62%** of adults were asked about their desired outcomes, and they were expressed. From that total, **69%** had their outcomes fully or partially met.



Concerns and Enquiries

The trend over the last five years shows, concerns have **decreased from 57** in 2020/21 **to 49** in 2023/24 and have stayed the same in 2024/25. The conversion rate (the proportion of concerns that turned into enquiries) was **63%** in 2023/45 before experiencing a slight decrease to **61%** in 2024/25.

For the concerns and enquiries rates per **100,000** population, we use data from the NHS Safeguarding Adults Collection (SAC), which incorporates mid-year population estimates from the Office for National Statistics (ONS). This approach allows us to compare our rates with those of other local authorities and with the national average.

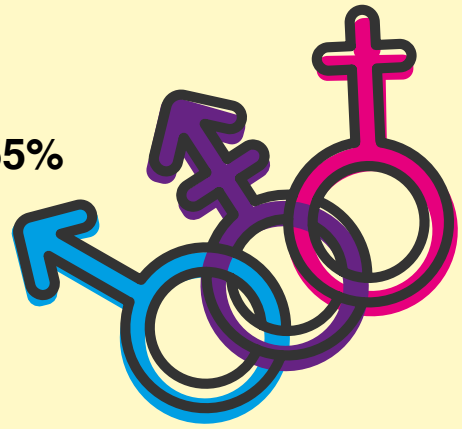
The rate of safeguarding concerns per **100,000 has generally increased** in line with the national average since 2016/17. However, it has **recently fallen, decreasing from 626** in 2022/23 **to 478** in 2024/25. Similarly, the rate of safeguarding enquiries per **100** (including enquiries commenced during the reporting period) **has declined from 283** in 2023/24 **to 195** in 2024/25.



Ethnicity

The adult population structure of the City of London is mostly from the white ethnic background. White was the highest recorded ethnicity for individuals who the City of London received a concern about. Out of **44** individuals that had a concern in the year, **30** were from a white ethnic background.

Gender



The male population in the City of London makes up **55%** in the **18+** group in the 2021 Census. The data shows the male clients had slightly more safeguarding concerns this year than female clients which is similar to previous years.



The data shows of the **44** individuals who had a concern during the year 2024-25, **15** were in the **18-64 age grouping**. The remaining **29** individuals were in the **65+** grouping.

Type of Risk



Upon concluding **21** Enquiries, a total of **28** distinct risks were identified. The most prevalent risk noted this year in safeguarding enquiries was Neglect and Acts of Omission, accounting for **32%** of all cases. This was closely followed by Self-Neglect, which constituted **29%** of the risks. Financial or Material Abuse represented **18%** of the total risks identified.

In terms of the concerns raised during the 2024-25 period, Self-Neglect was the highest, representing **33%** of all cases. This was followed by Neglect and acts of omission at **27%**, Financial or Material abuse at **14%**, and Physical at **14%**.

Source of Referral and Risk

In line with the national and London average, the data shows **79%** of risk to adults comes from someone known to the individual. This is an increase from the previous year 2023-24 of **64%**. **There was a significant decrease in service providers at 14% compared to 32% the previous year.**

Location of Risk

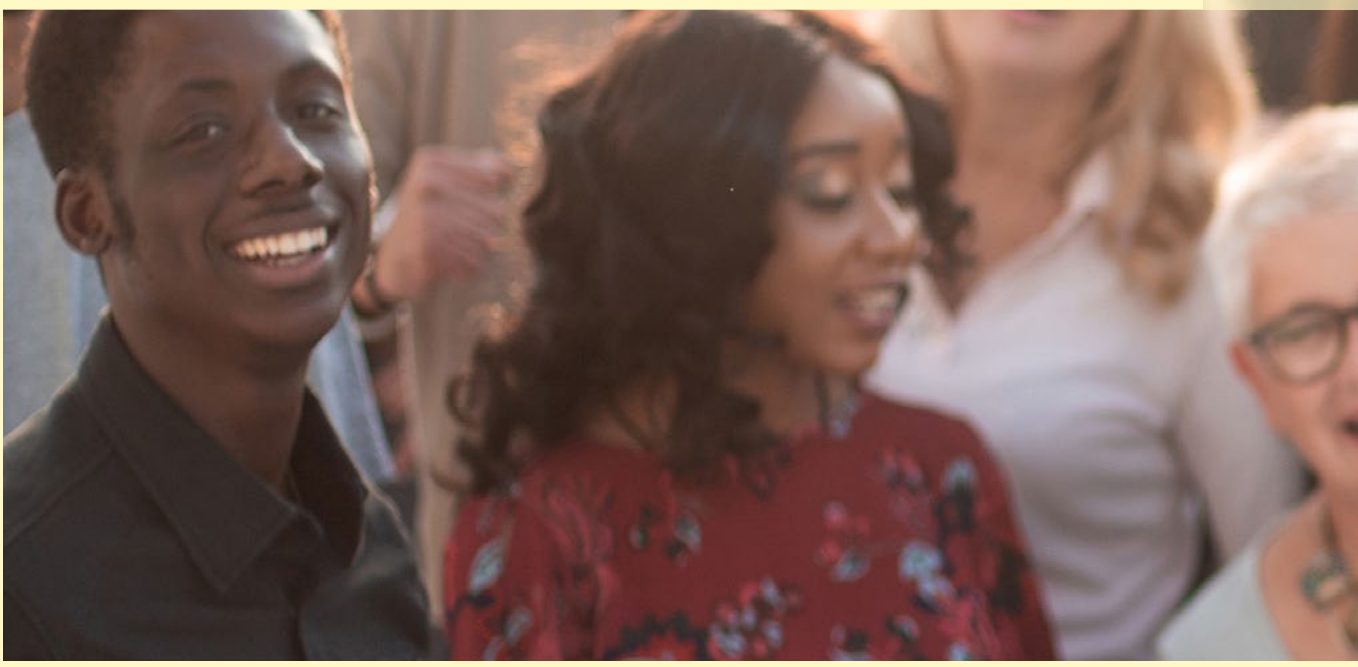
The **majority** of safeguarding enquiries related to alleged abuse that happened within the **person's own home. Four** enquiries took place in acute hospital settings, **one** in the community, **one** in a community hospital, **and four** in other locations. The continued increase in people's own homes being the location of risk is consistent with national data which identifies that abuse typically happens within someone's own home.

Making Safeguarding Personal

There were **21** concluded enquiries in 2024-25 compared to **19** the previous year. **62%** of adults were asked about their desired outcomes and they were expressed. Of which 69% had their outcomes fully or partially met. The **local management recording system has been improved to capture the outcomes better than in previous years** and there has been some discussions at Safeguarding Adults Board Quality Assurance group around whether further improvements could be made to the form data fields to capture a more in-depth understanding of the Making Safeguarding Personal data.

Deprivation of Liberty Safeguards (DoLS)

	2022/23	2023/24	2024/25
Number of DoLS referrals received	**30**	**30**	**30**
Number of DoLS authorised	**30**	**35**	**34**
DoLS Not Granted	**0**	**0**	**0**
Applications withdrawn	**0**	**0**	**0**



...The male population in the City of London makes up 55% in the 18+ group in the 2021 Census. The data shows the male clients had slightly more safeguarding concerns this year than female clients which is similar to previous years.



London Borough of Hackney Performance Data for 2024/25

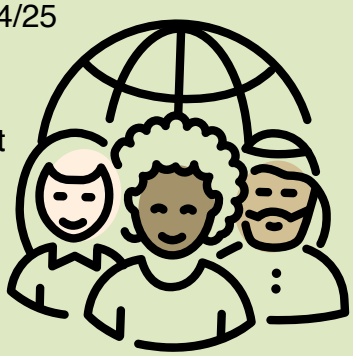
Concerns and Enquiries



1780 safeguarding concerns were raised.

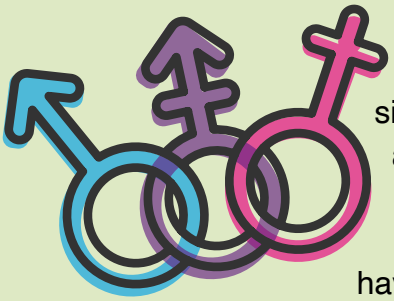
The number of accepted enquiries (538) is generally in line with the previous two years (a little lower, and Enquiries concluded in 2024-25 period is also lower).

Ethnicity

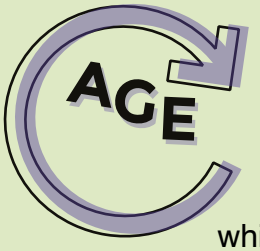


The proportion of concerns broken down by ethnicity for 2024/25 remains very similar to previous years. The most concerns continue to relate to adults from a White or Black African, Caribbean, or British background, and is generally consistent with the demographic profile of the borough. The proportion of cases where ethnicity was not declared remains similar to last year, at **8.3%.**

Gender



The proportion of concerns split by gender remains very similar to previous years, with females still the majority, **amounting to 51.7% of concerns.** This is consistent with the 2021 census for Hackney, which shows the borough has more females compared to males, and therefore expected to have a higher proportion of concerns.



The highest number of concerns being raised in respect of age has remained the same as previous year; **those between the ages of 26-64.** This contrasts with the national picture of safeguarding, which highlights that abuse is typically experienced by older adults. The younger demographic within Hackney could be an explanation for this.

Type of risk



The most common form of abuse reported **continues to be self-neglect, which makes up 28.2%** of all concerns reported. **Financial or Material Abuse and Neglect and Acts of Omission make up second and third most common types of abuse** (a reversal of second and third highest since last year since last year).

Source of Referral and Risk

The data shows that, in most cases, the source of risk is someone known to the individual, **accounting for 80.4% of concerns referred** to adult safeguarding. There has been an increase in cases where a service provider was identified as the source of risk, **rising from 8.8%** in 2023/24 to **12.5% in** 2024/25.

The number of safeguarding concerns from Hospitals remains the most common source of referrals, amounting to 23.6%. There continues to be a consistent number of concerns raised by friends and family, which is encouraging for the Board and evidence of the engagement work done with many community groups over the past couple of years.

Location of Risk

The data continues to show that most abuse occurs within the home, which is consistent with previous years and likely to correlate to self-neglect being the most common type of abuse.

Making Safeguarding Personal

In **92.2% of concluded,** adults were asked what their desired outcome was. This is **slightly higher than the previous year's figure of 89%.** Of those that were asked and expressed their desired outcomes, **94.1%** had their desires partially or fully achieved **(up from 92% last year)**. This information is helpful to ensure that safeguarding is person-centred and focuses on the wishes and needs of the individual.

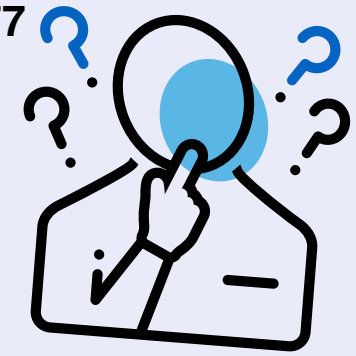
Deprivation of Liberty Safeguards

	2022/23	2023/24	2024/25
Number of DoLS referrals received	**917**	**843**	**971**
Number of DoLS authorised	**568**	**542**	**587**
DoLS Not Granted	**56**	**80**	**64**
Applications withdrawn	**293**	**221**	**320**

East London NHS Foundation Trust Performance Data for 2024/25

Concerns and Enquiries

515 safeguarding concerns were raised. This is an increase of 36% compared to 2023/24 (when 377 concerns were raised).

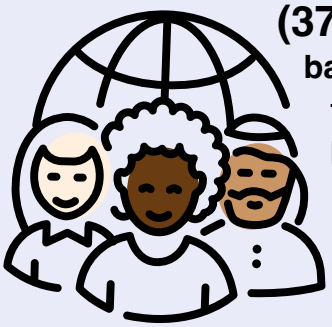


143 of those concerns led to a Enquiry

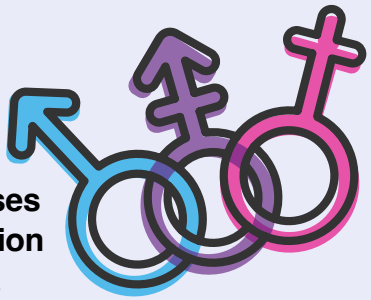
The proportion of concerns that were accepted as enquiries was 28%, which is broadly in line with 2023/24 (30%).

Ethnicity

The majority of safeguarding cases relate to adults from a Black background (37%), with **32% relating to adults from a White background, 15% from a Mixed background,** and **9% from an Asian background.** While this does not mirror the borough population profile, it is broadly representative of our Adult Social Care service user population, which is likely to be a more appropriate comparator of vulnerable adults.



Gender



A significantly higher proportion of safeguarding cases involve males (58%) compared to their representation in the borough population (48%). Though again, this mirrors the over-representation of males within the mental health service user population, so is indicative of the wider inequalities around mental health rather than relating to safeguarding specifically.



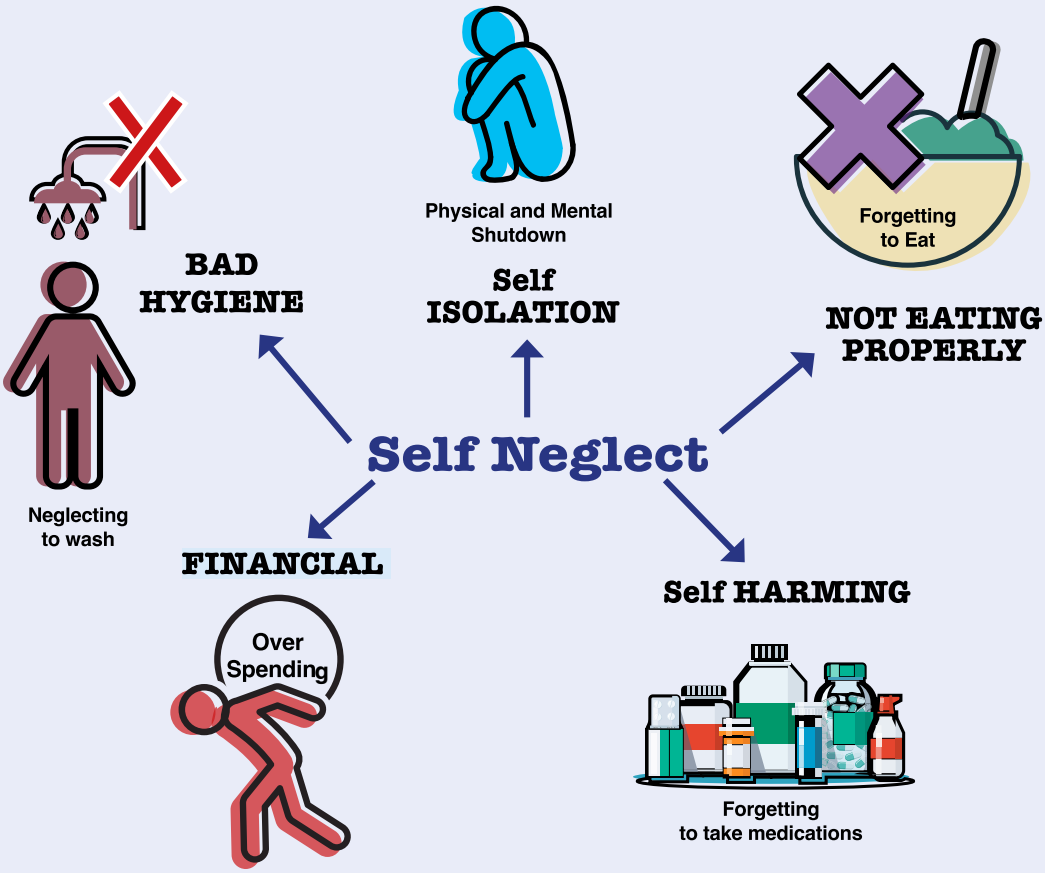
The **largest proportion** of safeguarding cases relates to **adults aged 18-64 (89%), with 8%** coming from **65-74 year olds,** and **the remaining 3% from over 75s.**

Type of Risk

The top three types of abuse reported for the year 2024/2025 were:

- Self-neglect **(30%)**
- Financial or Material Abuse **(19%)**
- Physical abuse at **(11%)**

Self-neglect has seen a significant increase in both the proportion and number of concerns since last year; **with 155 concerns (30%) reported in 2024/25, compared to 68 concerns (18%) in 2023/24.**



As a result of this, we have carried out self-neglect specific audits and subsequently developed bespoke self-neglect training to all services to bolster knowledge, competence and practice.

Source of Referral and Risk

Similar to previous years and consistent with national trends, the source of risk is most likely to be someone known to the individual, **which makes up 85%** of safeguarding concerns.

Location of Risk

The data continues to show that **most abuse occurs within the home (51%),** which is **consistent with high levels of self-neglect and abuse from known individuals. Mental Health hospitals are the second most common location at 32%** of concerns, illustrating the really positive work that has been carried out with the psychiatric wards in responding to concerns and reviewing within a safeguarding framework. The Matrons regularly attend Safeguarding Adults Managers forums and involve the Named Professional for Safeguarding in delivering robust safeguarding processes. **Of the remaining concerns, 10% occur in the wider community, 2% in a community service, 2% in residential care homes, 1% in acute hospitals and 3% in other locations.**

Making Safeguarding Personal

In **59%** of completed enquiries, adults were asked about their desired outcomes. In a further **24%** of cases, it was not recorded whether this was asked, and **17%** it was not asked. Of those asked, **73% stated that their outcomes had been fully or partially achieved,** while **15%** stated they were not achieved, and **12%** the response was not recorded. Making Safeguarding Personal remains a priority in Mental Health and East London Foundation Trust has been working with clinicians to address the process issue of not always documenting views of outcomes. The Adult Social Care Service Review in East London Foundation Trust has Making Safeguarding Personal and safeguarding as a priority and we are confident that the new reporting process will allow the service user perspective to be clearly heard.



...The ASC Service Review in ELFT has MSP and safeguarding as a priority and we are confident that the new reporting process will allow the service user perspective to be clearly heard.

CHSAB Board Partners Safeguarding Achievements

This section outlines the Board Partners main achievements in relation to adult safeguarding for 2024/25:

London Borough of Hackney Adult Social Care

- Adult safeguarding first and foremost is about the outcomes that can be achieved for the adult at risk, focused on their recovery and resilience. In Hackney, we are proud of the continuing focus on 'making safeguarding personal', meaning adults are supported to express what they would like to happen in response to concerns of abuse. At the end of a safeguarding enquiry, we ask the adult to what extent those outcomes were achieved and 94.1% of residents report we helped them fully or partially achieve what matters to them.
- We have seen a culture fostered that promotes organisational learning, where we have capacity to reflect, adapt and improve. During the last year, we continued to focus on ensuring all actions that arose from safeguarding adult reviews, audit or individual cases were evidenced as being embedded into how we work. For example, following one review we have strengthened the knowledge and understanding of the intersection of homelessness and adults who may have need for care and support under the Care Act.
- Our commitment to a human rights approach and ensuring people are enabled to live with as much choice as possible and least restriction, means we place great importance on the Deprivation of Liberty Safeguards. In Hackney we are really proud that there is no 'backlog' of applications, which is an issue elsewhere nationally, and that we are able to utilise the safeguards within these legal rules to have additional assurance that people, who lack mental capacity, are not being deprived of their liberty in care homes or hospitals.

City of London Corporation Adult Social Care

- We have continued to strengthen our Early Intervention and Prevention work, aligning this with the second principle of safeguarding; preventing harm before it occurs. This has involved a focused review of both in-house and commissioned services to understand how effectively they identify and respond to emerging risks. By using data analysis and service user feedback, we have been able to assess the real-world impact of these interventions, identify gaps, and target improvements.
- Following an independent safeguarding audit in October 2023, the Adult Social Care workforce engaged in a comprehensive cycle of learning and reflection to strengthen practice. This included targeted development in

key areas such as decision-making at the point of safeguarding concerns, application of the Mental Capacity Act (MCA) within safeguarding contexts, and Making Safeguarding Personal (MSP). The process not only helped to address areas of improvement identified by the audit but also reinforced a culture of continuous learning and professional accountability across teams.

North East London Integrated Care Board

- We have embedded safeguarding across many areas of our organisation, ensuring it is a key focus in groups such as the Homeless Health Steering Group and the Refugee Health Steering Group. This helps us address the complex needs of vulnerable populations more effectively.
- We are proud to lead the national work on the NHS England Case Review Tracker, which brings together important data from Safeguarding Adult Reviews, Domestic Homicide Reviews, and Children's Safeguarding Reviews. This helps improve learning and safety across the health system.
- Our Learning Disability Mortality Review Programme is making strong progress. We have developed clear learning pathways that support staff in understanding both effective practices and where improvements are needed, ensuring lessons from these reviews are put into action.
- In response to growing demand, we have expanded domestic violence training and case management support for staff working in primary care and community health settings. This strengthens their ability to identify and respond to domestic abuse, improving outcomes for those affected.

Homerton University Hospital NHS Foundation Trust

- We established a Complex Patient Panel in response to a high number of absconsions, complex safeguarding incidents, and the need for a Multi-Disciplinary Team (MDT) forum to support staff working with patients who have complex behavioural and social needs. The Head of Safeguarding Adults co-chairs the panel alongside the Head of Physical Therapies. Meetings are held weekly, face to face, and last one hour. Themes discussed so far have included distressed or disruptive behaviour on the wards, concerns about mental capacity, and complex discharge planning.
- We commissioned Prevent training with the Prevent Lead in the London Borough of Hackney. These sessions are now face to face sessions and take place bi monthly. We have also launched a digital version of the training.
- We have made significant improvements to the Mental Capacity Act form on the Electronic Patient Record system. The updated form is now more user-friendly and offers a better direction to clinicians who struggle with this part of their work duties. This will likely lead to assessments being of better quality and withstand scrutiny when challenged – if recorded allows to withstand more legal scrutiny.

East London Foundation Trust

- We have continued to build on a strong and sustainable safeguarding leadership framework. This includes active collaboration through the Directorate Management Adults and Children's Safeguarding Sub-Group, the Safeguarding Adults Managers Forum, our weekly Complex Case Panel, and dedicated safeguarding drop-in sessions within community teams. These platforms ensure robust oversight and timely response to safeguarding concerns across the Trust.
- We provide regular, bespoke safeguarding training across ELFT, with consistently high levels of staff compliance. Our Corporate Safeguarding Team actively reviews safeguarding data to tailor training to current needs; for example, delivering Self-Neglect training in response to identified risks. Domestic abuse training modules are now readily accessible through the ELFT Learning Academy, and DIAS (Domestic Abuse Intervention Service) drop-in sessions are available to staff within our community teams, offering practical support and advice.
- Our Community Mental Health Services are undergoing a significant transformation through the Adult Social Care Review and ELFT's wider Service Redesign. As part of this work, safeguarding processes are being strengthened to ensure every safeguarding concern receives oversight from a Social Care Safeguarding Adults Manager within the London Borough of Hackney. This will enhance support to both community-based mental health services and inpatient psychiatric care, ensuring safeguarding remains at the heart of service delivery.

Barts Health NHS Trust

- We have significantly improved the number of Deprivation of Liberty Safeguards referrals via a significant training and improvement program across the Trust. The quality of these referrals has also improved (checked as part of our audit program) with recording clearer, quality of capacity assessments has improved etc.
- We have reviewed and rolled out a new Level Adult 3 face to face training, revised in line with new intercollegiate guidance and NHS E Core Skills training framework. This has meant staff receiving this training (which includes Mental Capacity Assessment/Deprivation of Liberty Safeguards training) has gone up from a few hundred to around 7000 across the Trust. We are on track to reach the compliance rate (85%) within three years.
- We have introduced a Trust wide safeguarding audit program, which includes domestic abuse processes, self-neglect, MCA ec.

Metropolitan Police Service

- We worked closely with experts inside and outside the Met to develop a clear framework for Vulnerability and Public Protection Notices (VPTN),

aligning our definitions with the Care Act. We also updated our Standard Operating Procedures and improved the SharePoint site so officers can easily access the information they need.

- We provided training to around 4,400 frontline officers and MASH teams on completing VPTNs, common issues, and key adult safeguarding topics like consent and identifying adults at risk. We developed the training with input from our partner organisations to reflect real issues on the ground.
- Together with partners and MASH teams, we created a new decision-making guide to help officers better understand safeguarding legislation when making referrals. This has improved referral quality, reducing inappropriate referrals to Adult Social Care by 15%, allowing them to focus on those most at risk. Feedback from partners has been very positive.

City of London Police

- We have launched and implemented a new Victim Strategy in February 2025, which aims to put the wellbeing of victims at the heart of policing. It has helped improve communications with victims, embedded procedural justice, and ensured real-time feedback was acted upon.
- We have also delivered Operation Reframe, in partnership with the City Corporation, Hackney Council, Good Night Out, and local licensed venues with an aim to bring targeted focus to women's safety in the night-time economy. Through training, posters, social media campaigns, and the “Ask for Angela” scheme in bars, the initiative has helped address harassment and sexual violence in late-night venues.
- We have also developed Operation Servator, which aims to disrupt terrorism and serious crime within the City of London. We work closely with businesses and community partners to ensure everyone understands how they can help by reporting anything unusual.

Turning Point

- We have seen an increase in referrals to safeguarding adults, demonstrating that our staff are vigilant in identifying concerns and taking prompt action to protect individuals who are at risk of experiencing abuse or neglect. This reflects our ongoing commitment to raising awareness and ensuring that safeguarding remains a top priority in our service.
- Compliance with our mandatory safeguarding adult awareness training remains high, ensuring all staff have the knowledge and skills needed to recognise and respond effectively to safeguarding issues. This strong training culture helps us maintain high standards of care and protection for the people we support.
- Over the past year, we have actively participated in a wide range of professional and external safeguarding meetings. This engagement

strengthens our collaboration with partners and enhances our ability to share information, learn best practices, and improve outcomes for adults at risk within our service.

London Borough of Hackney Benefits and Homeless Prevention

- We continue to develop our Shared Planning approach for applicants with more than two support needs, ensuring we collectively safeguard our residents. We work closely with partners like the Greenhouse service and Homerton Mental Health discharge team, meeting weekly to discuss homeless patients on mental health wards and share vital care and risk information for safe housing decisions.
- Our team includes two embedded social workers; one generalist and one mental health specialist who support frontline staff in assisting residents facing multiple disadvantages. They run weekly drop-in sessions and quarterly learning sessions covering key topics such as mental health crisis pathways, Care Act Assessments, and Mental Capacity Assessments. In 2024, we welcomed our second student social worker and began mentoring to expand in-reach support for single homeless and rough sleepers.
- We assist many residents who fall into the “Edge of Care” group, presenting complex needs that don’t meet statutory thresholds for Adult Social Care or Mental Health services. To better support these residents, we’ve delivered trauma-informed and reflective practice training to all frontline officers, alongside mandatory training on improving access for individuals experiencing multiple disadvantages and co-occurring conditions.

Age UK

- We launched the 'centring safeguarding' programme across the organisation which included a review and launch of our safeguarding policy, radically streamlining our safeguarding process to remove barriers to staff in raising their concerns, reducing risk through delegation of responsibility across a wider group of colleagues and new bespoke training programme of deep dives into trending themes e.g. Self-Neglect and capacity and consent.

London Borough of Hackney Domestic Abuse Intervention Service

- We launched the Hackney trauma-informed multi-agency guidance: responding to child victims of domestic abuse, the UK’s first local guidance focused on trauma caused by domestic abuse.The guidance helps professionals working with parents or carers to understand and respond to trauma caused by domestic abuse.

- We achieved Respect accreditation of both our Domestic Abuse Prevention Programme and the Intensive Case Management approach used with those harming family members through intergenerational domestic abuse. Hackney is the only Local Authority service to have achieved dual accreditation for these two areas of work.
- We took over the commissioning and overseeing of refuge provision in Hackney, thus enabling greater integration of the refuges within the wider Violence Against Women and Girls partnership.
- We launched the Hackney Sexual Exploitation Meeting, a monthly multi agency meeting which takes a proactive approach to safeguarding those at risk and disrupting those causing harm.



CASE STUDY 7:

Metropolitan Police

A joint community problem-solving initiative was launched to tackle serious anti-social behaviour linked to several high-risk properties. These homes had become centres for drug-related activity, causing distress to local residents and businesses. Vulnerable tenants were being exploited by drug users who used the addresses for criminal purposes. Neighbourhood police officers carried out targeted patrols, welfare checks, and gathered evidence, leading to the issuance of Anti-Social Behaviour Warnings and Community Protection Notices. Their work focused on disrupting offending and protecting vulnerable individuals. Working closely with the housing association and support partners, a joint action plan was developed. Regular meetings allowed agencies to share information, assess risks, and coordinate interventions. Vulnerable tenants were offered additional support, while housing providers took enforcement actions, including Notices Seeking Possession and injunctions against perpetrators. As a result, anti-social behaviour significantly decreased. Exploitative individuals were removed or legally barred from returning, and properties were secured to prevent further misuse. Vulnerable residents received safeguarding support, helping them regain safety and stability. This case highlights the power of partnership working; combining enforcement and support to address complex issues and achieve lasting positive outcomes for both individuals and the wider community.



...This case highlights the complex balance of risk, capacity, and autonomy. It demonstrates the importance of multi-agency collaboration, executive capacity assessments, and creative problem solving to support individuals in high-risk situations.



CASE STUDY 8:

Homerton University Hospital

David, a 73-year-old man with multiple long-term conditions, lived at home with his 17-year-old son. Though separated from his wife, he maintained occasional contact with her and received remote support from his adult daughter, who helped with online grocery orders. David was under the care of district nurses and the foot health team for leg ulcers and a sacral pressure ulcer, and received a four times daily care package. Concerns grew around David's non-engagement with his care plan. He often sat for long hours with his legs down, worsening his swelling and wounds, and regularly slept in a recliner while lying on his pressure ulcer. Despite appropriate equipment being in place, he continued to make decisions that placed him at risk. A bedbug infestation triggered a safeguarding referral. The community safeguarding practitioner coordinated emergency fumigation and arranged temporary respite accommodation. However, David soon returned home, stating he disliked the respite setting. Care was arranged for his son during this period. After his return, professionals raised further concerns about David's hygiene, nutrition, and non-concordance with treatment. Although he had previously been assessed to have capacity, his ongoing choices suggested impaired decision-making. A joint visit was arranged with the GP and tissue viability nurse, and a mental capacity assessment found David lacked executive capacity; he could understand information, but struggled to act in ways that kept him safe. The safeguarding team led a series of personalised interventions. These included delivery of a second air mattress to encourage bed use, repositioning the TV to allow him to lie flat and still watch it, and setting alarms on his phone to prompt pressure relief and leg elevation. Carers were advised to escalate concerns about unmet needs directly to district nurses or family. Despite ongoing support, David's condition worsened. The safeguarding practitioner had repeated discussions with him about respite care. Although initially resistant, he agreed to a trial placement outside the borough, secured through collaborative work with the local authority. The new setting better matched his preferences. David responded well and, after six weeks, chose to remain there permanently. This case highlights the complex balance of risk, capacity, and autonomy. It demonstrates the importance of multi-agency collaboration, executive capacity assessments, and creative problem solving to support individuals in high-risk situations.

Accessibility statement

If you require this document in a different format, please email



CHSAB@hackney.gov.uk

We will consider your request and get back to you in the next five working days.

City & Hackney Safeguarding Adults Board
1 Hillman Street
Hackney
London
E8 1DY

Email: **CHSAB@hackney.gov.uk**

Tel: **020 8356 6498**

City and Hackney
Safeguarding Adults Board

Design and printed by Hackney Council • September 2024 • HDS18284

This page is intentionally left blank

City of London Corporation Committee Report

Committee(s): Health & Wellbeing Board	**Dated:** 04/02/2026
Subject: Adult Mental Health Joint Strategic Needs Assessment	**Public report:** For Information
This proposal: ● **delivers Corporate Plan 2024-29 outcomes**	Diverse Engaged Communities 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 Director of Public Health
Report author:	Jennifer Millmore Senior Public Health Specialist

Summary

The City and Hackney Adult Mental Health JSNA collates evidence on mental health needs, services, inequalities and service user experiences and uses this to increase awareness of the challenges faced and make a set of evidence-based recommendations.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. This adult mental health needs assessment was undertaken to inform the strategic decision making and action planning for adult mental health in the City

and Hackney. To do this, evidence on mental health needs, services, inequalities and service user experiences was collated and used to inform a set of evidence-based recommendations.

2. This needs assessment also aims to increase stakeholder awareness of local challenges, as well as good practice, and inform service planning and resource allocation.

3. The adult mental health JSNA reports includes:

- A description of the prevalence of mental health conditions in the local population
- Identification of inequalities in the prevalence
- A summary of local mental health services available, including key outcome and performance measures
- An analysis of inequalities within services, including identification of underserved population groups
- An overview of residents' experiences of services and support available, highlighting some of the main challenges they face
- A summary of how mental health services work with each other, key partners and within the wider support system
- Consideration of the governance and accountability underpinning mental health systems and services locally
- A list of all the challenges identified in the needs assessment and a set of recommendations to address these challenges

Methods

4. The needs assessment employed a multi-method approach incorporating:

- A review of national and local available literature, including strategic reports and evaluations,
- A quantitative analysis of GP and service data, comparing this against national benchmarks and the local population, where appropriate and where data were available.
- Stakeholder engagement, including service user representatives
- Interviews with wider support service leads, whose services see a high proportion of people with mental health conditions.

5. The Mental Health Integration Committee agreed the scope of the needs assessment and a steering group was established to oversee the progress.

Key Findings

6. <u>Local Picture:</u>

6.1. Between 2012/13 and 2022/23 the rate of diagnosed depression significantly increased in the City of London from 3.6% to 7.3%. For comparison, in Hackney the rate rose from 5% to 12%. This trend mirrors both London and England and may reflect an increase in awareness, as well as prevalence.

6.2. The City of London had a lower rate than both London and England during this time, whereas Hackney's rates have generally been higher than London's but similar to England's. The rate of diagnosed anxiety is 4% in the City of London and 7% in Hackney.

6.3. In 2024, 1% of adults (18+) experienced a severe mental illness in the City of London and 2% in Hackney. Rates have not changed significantly in recent years. The City of London's severe mental illness rate has remained significantly lower than London and England while Hackney's rate has been significantly higher by approximately 50%. Complex mental health needs are also frequently raised as becoming increasingly prevalent.

6.4. The burden of mental health conditions is not spread equally across the local population:

- Gender: in the City and Hackney, rates of diagnosed depression and anxiety were significantly higher in women than men, whereas for severe mental illness, rates were higher in men.
- Age: depression was most commonly diagnosed in 40-74 year olds, anxiety in 25-39 year olds and severe mental illness in 50-64 year olds.
- Ethnicity: depression and anxiety were most common in mixed white and black Caribbean, white British and white Irish ethnicities. Severe mental health conditions were highest among Caribbean and other non-African black ethnicities.
- Deprivation: for depression, anxiety and severe mental illness, rates were highest locally in the more deprived areas of City and Hackney.
- Other population groups identified as having high mental health needs and often additional complexities include: residents living in temporary accommodation, residents experiencing rough sleeping, Gypsy and Traveller communities, refugees and asylum seekers, LGBTQIA+ communities.

7. Local Services:

7.1. Talking Therapies for Anxiety and Depression broadly supports residents with common mental health conditions and assesses and treats approximately 7,000-8,000 patients a year.

7.2. The Wellbeing Network supports residents with complex mental health needs and sees approximately 1,170 clients a year, with an additional 5,866 person hours through their Open Access activities.

7.3. East London Foundation Trust (ELFT) supports residents with more severe mental illness and did not provide data on patients seen.

7.4. Using the Short Warwick-Edinburgh Mental Wellbeing Scale to assess outcomes, Wellbeing Network clients experienced a 4.6 point increase, a clinically significant improvement. Improvements were greater for women, non-African and Caribbean Heritage communities, adults aged 18-39 and heterosexual adults. Clients also improved on measures of social

connectedness, physical health and employment between entering and exiting the service.

7.5. Of Talking Therapies for Anxiety and Depression patients, 54.4% recovered and 49.9% were considered to have ‘reliably recovered’, meaning that their recovery is significant and lasting. This is in line with national standards and significantly above the outturn for the whole North East London Integrated Care Board area for 2024/25. The ‘Asian or Asian British’ ethnicity group had significantly lower overall recovery rates than average. ELFT did not provide outcomes data.

7.6. Overall service satisfaction rates in Talking Therapies for Anxiety and Depression vary from 95%-100% each month. In the Wellbeing Network 92% of service users ‘strongly agreed’ that they were happy with the service in 2023/24. ELFT did not provide service satisfaction data.

7.7. Service use was not evenly distributed across the local population:

- Gender: men are underrepresented in many of the largest commissioned services locally. However, in ELFT inpatient services, a significantly higher proportion of patients were men. In crisis services there was not a significant difference.
- Age: broadly, Talking Therapies for Anxiety and Depression has an underrepresentation of those aged 45 and over. In ELFT community services, age groups up to 49 years old are overrepresented. In the Wellbeing Network, rates of clients in the service increased with age up to the 60-64 age group.
- Ethnicity: in both the Wellbeing Network and Talking Therapies for Anxiety and Depression, the rate of clients from African and Caribbean heritage communities was slightly higher than the rate of people from other ethnicities, following targeted work to reduce underrepresentation in these communities. In ELFT community services, the rate of patients from African and Caribbean heritage communities was lower than expected but higher in inpatient services.
- Deprivation: residents from the most deprived areas locally appear underrepresented in both the Wellbeing Network and Talking Therapies for Anxiety and Depression. Patients seen in all three ELFT services had higher attendance rates from residents living in more deprived areas locally.
- Sexual orientation: in the Wellbeing Network, rates of service users from most sexual orientations reflected the local population. The rate of service users identifying as ‘any other sexual orientation’ was significantly higher. Completion rates for sexual orientation in ELFT and Talking Therapies for Anxiety and Depression were too low to be analysed meaningfully.

7.8. The average waiting time is 22 days for the Wellbeing Network and 14 days from referral to treatment for Talking Therapies for Anxiety and Depression. For some specialist pathways the waiting times can be longer. ELFT did not provide waiting time data for this report.

7.9. For the larger mental health services, 25%-35% of people dropped off waiting lists, either before assessment or before starting the main interventions.

7.10. Many residents experience difficulties navigating the numerous mental health services, their different criteria, referral pathways and processes, especially where residents have complex and intersecting needs. Some staff from a range of wider support services report not making referrals, believing it will do more harm than good. Most providers also report having to turn away many residents who are ineligible for their services.

7.11. There is limited provision for residents needing longer term support.

7.12. Talking therapies are the most common mental health support available locally but they are not suitable for everyone. Some stakeholders and service user representatives have suggested they have a western bias. More skills, social, activity, practical and learning based support was requested.

7.13. Governance and accountability systems could be improved. Roles and responsibilities are not always clear or well defined and there are some significant gaps in areas of responsibility, such as around less medicalised support offers.

7.14. More in-reach and outreach support options were requested by stakeholders and service user representatives, especially for the most excluded population groups.

7.15. Despite some improvements in service inclusivity, some residents continue to report discrimination, distrust and a lack of cultural competence in relation to mainstream services.

7.16. While there have been efforts to improve partnership working, integration between different mental health services is still limited.

Recommendations

8. Based on the data presented in the needs assessment, four main themes of recommendations emerged:

- Difficulties experienced by residents in accessing and navigating local mental health services,
- Inequalities in mental health need and how inclusive services are,
- Gaps in the quality of insight, driven by fragmented data and inconsistent approaches, limiting effective decision-making.
- Improving underlying accountability and governance structures for mental health.

9. While discussed the least in the reports, the accountability and governance issues appear to underpin the other three and their success is likely to be limited if these governance and accountability issues cannot be solved.

Corporate & Strategic Implications

Financial implications - none

Resource implications - none

Legal implications - none

Risk implications- none

Equalities implications: equity considerations are central to the data collection, analysis, needs assessment and recommendations of this Joint Strategic Needs Assessment.

Climate implications - none

Security implications - none

Conclusion

10. Overall there is a lot of positive mental health work happening and high quality mental health services in the City and Hackney.
11. Nevertheless, rates of mental health conditions are high and there are a number of key challenges that need to be addressed, including around inequalities, service offers, availability of data and the underlying governance structures.
12. Strong partnership working, transparency and accountability will be essential going forwards.

Appendices

The full City and Hackney Adult Mental Health JSNA reports are linked below. The Local Picture report covers information on mental health needs in the local population and the Local Services details includes information on local mental health support services. The Challenges and Recommendations report summaries the challenges identified in the previous two reports and make recommendations for how these could be addressed.

- Appendix 1: Local Picture
- Appendix 2: Local Services
- Appendix 3: Challenges and Recommendations

Jennifer Millmore

Senior Public Health Specialist

E: jennifer.millmore@cityandhackneyph.hackney.gov.uk

City and Hackney Adult Mental Health Joint Strategic Needs Assessment

Part 1: The Local Picture

2025

Authors
This report was written by: Jennifer Millmore (Senior Public Health Specialist), Mariana Autran (Public Health Analyst) and Tom Moore (Public Health Analyst)

Report Approvers
This report was approved by Andrew Trathen

Acknowledgements
We would like to sincerely thank everyone who has contributed towards the production of this report, including our commissioned providers and wider system partners, colleagues in the Public Health team and wider Council and City of London Corporation colleagues.

Cite this report as:
City and Hackney Public Health. City and Hackney Adult Mental Health Joint Strategic Needs Assessment, Part 1: Local Picture. (December 2025)

Contents

Contents 3
Abbreviations and Acronyms 4
Executive Summary 5
1. Introduction 7
2. Prevalence of Mental Health Conditions 8
Common mental health conditions 9
Depression 9
Anxiety 11
Severe mental illness 11
Complex mental health needs 12
3. Inequalities 13
Gender 13
Age 14
Ethnicity 15
Deprivation 16
Location (Primary Care Networks) 17
4. Co-occurring Health-Related Conditions 18
Physical health, learning disabilities and neurodivergence 18
This section is outstanding and will be added at a later date 18
5. Other Communities With Unmet Need 18
Residents living in temporary accommodation 18
Residents experiencing rough sleeping 19
Gypsy and Traveller communities 21
Refugees and asylum seekers 21
LGBTQIA+ communities 22
6. Local Context 22
Housing 22
Deprivation 23
Experience of discrimination 23
Substance use 24
Social isolation 24
Physical environment 25
Employment 25
Coronavirus and cost of living crisis 25
7. Policy context 26
References 31

Abbreviations and Acronyms

GP:	General Practitioner
LGBTQIA+:	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and all other related identities
NHS:	National Health Service
SMI:	Severe Mental Illness

Executive Summary

This Local Picture Joint Strategic Needs Assessment considers mental health of adults in the City and Hackney, local prevalence, including inequalities, and local issues. It is the first of three linked reports, along with the " Local Services" and "Local Challenges and Recommendations"[1].

Everyone has mental health. It is influenced by and intersects with a wide range of socioeconomic, environmental, physical health and genetic factors. In the City and Hackney some key influencing factors include: the lack of affordable housing, high levels of deprivation, high levels of alcohol and substance use, high number of street homeless, social isolation and environmental issues, including lack of access to green spaces, noise and air pollution.

Many people also experience mental health conditions, most commonly anxiety and depression. Between 2012/13 and 2022/23 the rate of diagnosed depression significantly increased in the City of London and Hackney, from 3.6% to 7.3% and 5% to 12% respectively. This trend mirrors both London and England and may reflect an increase in awareness, as well as prevalence. Hackney's rates have generally been higher than London's but similar to England's during this time, while the City of London has a lower rate than both. The rate of diagnosed anxiety is 4% in the City of London and 7% in Hackney.

In 2024, 1% of adults (18+) experienced a severe mental illness (SMI) in the City of London and 2% in Hackney. Rates of SMI in the City and Hackney have not changed significantly in recent years. The City of London's SMI rate has remained significantly lower than London and England while Hackney's rate has been significantly higher, approximately 50% higher. Complex mental health needs are also frequently being raised by mental health services as becoming increasingly prevalent among service users.

The burden of mental health conditions is not spread equally across the local population. The available data highlight the following inequalities between population groups in the City and Hackney. Data are based on diagnosed conditions, so may be influenced by factors such as awareness, service attendance and diagnostic biases, as well as true prevalence.

- **Gender**: 18% of women were diagnosed with depression and 9% with anxiety, significantly higher than the 11% and 5% of men respectively. For

[1] A Children and Young People's JSNA was published on October 2025: https://cityhackneyhealth.org.uk/wp-content/uploads/2024/10/Hackney-and-City-Health-Needs-Assessment-for-Children-and-Young-People-with-Special-Educational-Needs-and-Disabilities-1.pdf

severe mental illness, 2.0% of men were diagnosed compared to 1.7% of women.

- **Age**: depression was most commonly diagnosed in the 40-74 year age groups, peaking in the 50-64 age group at 19.9%. Anxiety was most commonly diagnosed in the 25-39 age group at 7.9%, after which prevalence decreased with age. Severe mental illness was most common in the 50-64 age group and remained above average in older age groups.
- **Ethnicity**: depression and anxiety were most common in mixed white and black Caribbean, white British and white Irish ethnicities. Severe mental health conditions were highest among Caribbean and other non-African black ethnicities.
- **Deprivation**: For depression, anxiety and severe mental illness, rates were highest locally in the more deprived areas of City and Hackney.
- **Location**: Rates of depression, anxiety and severe mental illness were highest in the Well Street Common Primary Care Network. Clissold Park and Woodberry Wetlands Primary Care Network also had relatively high rates of anxiety and depression. Woodberry Wetlands, Hackney Downs and Hackney Marshes also had high rates of severe mental illness compared to the other PCNs.

Other population groups where mental health needs are high are listed below. Most these groups also have high levels of complexity and additional challenges accessing services and support.

- **Residents living in temporary accommodation**: all mental health conditions appear to be more prevalent in people living in temporary accommodation and services report that most have complex needs.
- **Residents experiencing rough sleeping:** most rough sleepers have intersecting needs, with mental health needs being the most common, at 79% of rough sleepers in the City of London. In Hackney, 61% of rough sleepers were assessed as having mental health needs.
- **Gypsy and Traveller communities:** a 2024 door to door survey of 84 households across the five Traveller sites in Hackney found that 71% of adults declared being diagnosed with a mental health condition.
- **Refugees and asylum seekers:** mental health data are not systematically recorded for this group but professionals working with these residents report that mental health conditions, such as depression, anxiety and post-traumatic stress disorder, are common.
- **LGBTQIA+ communities:** Sexual orientation is not reliably recorded by primary care but a study found that over the previous year, half of Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and all other related identities (LGBTQIA+) people had experienced depression, and three in five had experienced anxiety, higher than the general population.

1. Introduction

The World Health Organization defines mental health as 'a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. (...) Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes'. (1) Most people will move on this continuum throughout their lives, to a greater or lesser extent.

Figure 1: Mental health continuum



Source: created by the authors

Poor mental health can include everyday feelings, emotions, and thoughts, such as stress and low mood, as well as common mental health conditions like depression and anxiety, and severe illnesses such as schizophrenia and bipolar disorder. Similar to physical health, some people are more at risk of poor mental health and some people will experience life long serious conditions, while others will maintain broadly good mental health. As with physical health, the appropriate interventions can prevent mental ill health, promote recovery or improve quality of life for those with lasting mental health conditions.

Mental health conditions are very common. Estimates vary but a recent national survey found that 22.6% of 16 to 64 year olds were identified as having a common mental health condition, such as depression or anxiety. Psychotic disorder was identified in 0.5% of adults, 2% of adults screened positive for bipolar disorder.

Improving the population's mental health, strengthening protective factors and reducing detrimental risk factors is important in its own right but also for the impact it has on people's physical health, wider outcomes and opportunities, as well as the knock-on socioeconomic benefits.

In total, a very conservative estimate in 2019 found that mental health problems cost the UK economy at least £117.9 billion annually, equivalent to around 5% of the UK's Gross Domestic Product. Most of these costs are due to people living with mental health conditions being unable to work or working less, costs associated with support from informal carers, specialist mental health care costs

and provision of special educational needs. Depression alone is ranked as the third leading cause of disability across the UK. (2)

Poor mental health can seriously exacerbate physical illness and this is estimated to cost the NHS at least £8 billion a year. (3) Additionally, physical health problems significantly increase the risk of poor mental health, meaning they can negatively reinforce each other. Around 30% of all people with a long-term physical health condition also have a mental health problem. Of people with a mental health problem, 46% have a physical health condition. [4] People with a severe mental illness (SMI) on average have a 15-20 year shorter life expectancy than the general population, which is largely attributed to the higher rate of physical health conditions. (4)

Poor mental health is also influenced by a range of other factors, including unemployment, low income, insecure housing, alcohol use, substance use, experience of discrimination, domestic violence, trauma, social isolation, gambling, genetic predisposition, learning disabilities and neurodivergence. When someone experiences poor mental health and one or more of these factors, it may not be effective to treat their mental health in isolation, without addressing the other issues concurrently. This is considered to be complex mental health needs. Having multiple complexities can be especially harmful and can become negatively reinforcing. For example, people who are working and have poor mental health are likely to have reduced productivity, increased sickness absence, and a higher probability of losing employment and difficulties maintaining secure housing, which all in turn can contribute to poor mental health. (2)

This mental health joint strategic needs assessment report on the local population aims to improve understanding of the mental health needs of adults living in the City of London and Hackney and potential areas for action and improvement.

2. Prevalence of Mental Health Conditions

To understand the mental health needs in the City and Hackney, data from local City and Hackney general practitioners (GPs) on diagnosed conditions have been used. It is important to note that these data have limitations. Some residents are not registered with a GP, some records may be out-of-date, and the data reflect those who seek help, rather than the entire population. Some

individuals with mental health conditions may not have received a formal diagnosis. Overall these considerations mean that prevalence data for mental health conditions are likely an underestimate.

In 2023/4 it was estimated that only 47.7% of 16 to 74 year olds in England, with symptoms of common mental health conditions, reported having treatment for this. (5) Low perceived need, attitudinal barriers, lack of health literacy and structural barriers have all been found to prevent people from accessing mental health services. (2) Stigma relating to mental illness can result in delayed access to care. (4).

To accurately understand local mental health needs, a population survey could be conducted. The adult psychiatric morbidity survey is designed to do this, but it also has drawbacks. It relies on people reporting their own experiences, it is based on a sample of the population and the most recent results available at the time of analysis were from 2014. (6) A first installment of the 2023/4 results had been published at the time of writing, with the second due afterwards. A future update could include the analysis of these updated results.

Common mental health conditions

Common mental health conditions cause marked emotional distress and interfere with daily function but do not usually affect insight or cognition. They are usually less disabling than severe mental illness. Common mental health conditions include depression, generalised anxiety disorder, panic disorder, phobias and obsessive compulsive disorder(7). Depression and anxiety are the most frequently diagnosed mental health conditions. They can significantly impact individuals, their families, and the local community. These conditions can be identified and often effectively treated.

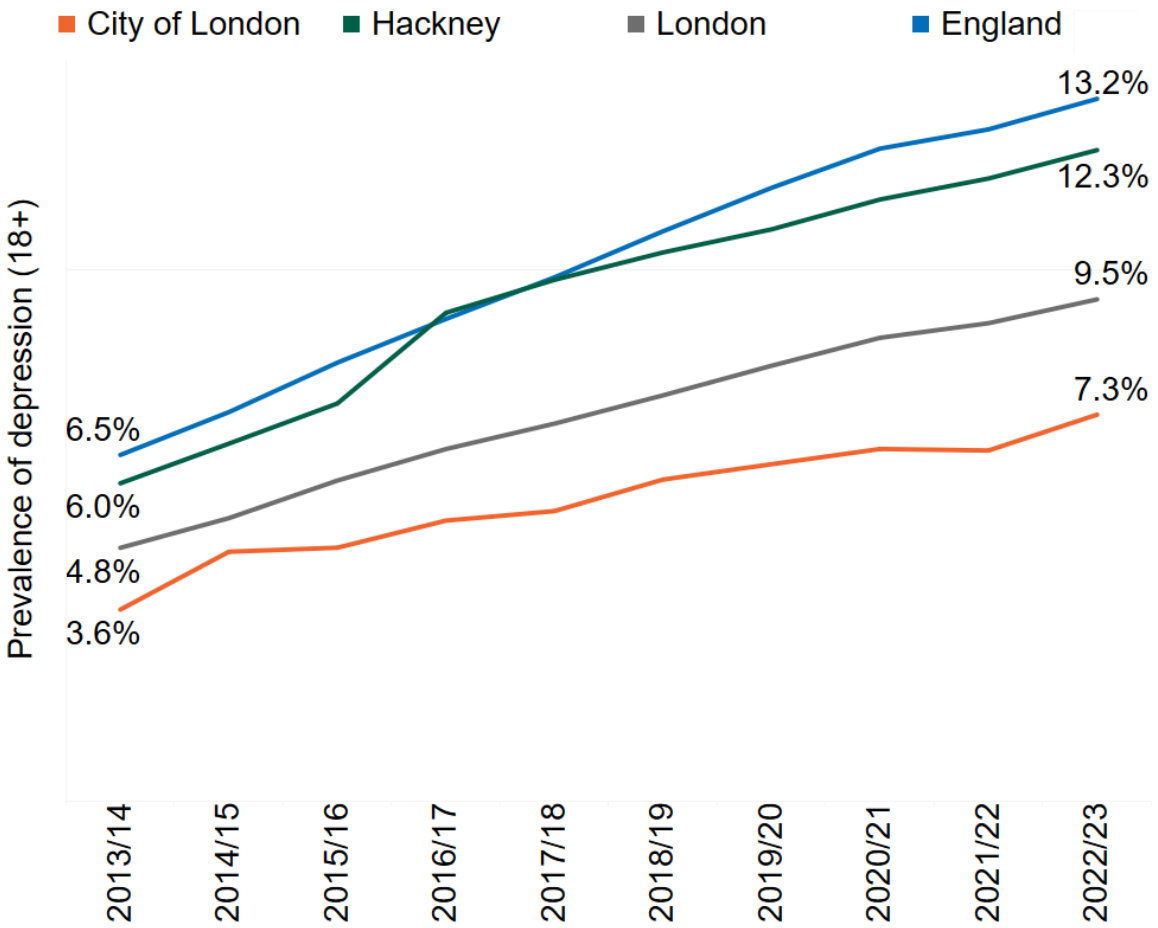
Depression

Over the past decade, the diagnosed depression rate[2] has significantly risen in Hackney, more than doubling from 5% in 2012/13 to 12% in 2022/23 (Figure 2). This increase mirrors trends seen in both London and England as a whole. Hackney's rates have generally been higher than London's but lower than England's during this time.

[2] The diagnosed depression rate is calculated by dividing the number of adults (18+) with a depression diagnosis on their GP records by the total number of adults living in City and Hackney and registered with a GP in North East London.

The City of London has a lower rate of depression compared to London and England, but it has still seen a significant increase from 3.6% to 7.3% over the same ten-year period.

Figure 2: Trends in the rate of diagnosed depression, City, Hackney, London and England, 2012/13 to 2022/23



Source: Office for Health Improvement and Disparities, Fingertips, 2025.
Note: there is a data quality issue with the London and England values for 2012/13 stated on Fingertips.

The increase in diagnosed depression may reflect a genuine increase in prevalence but could also be influenced by increased awareness and acceptability of mental health in the population, meaning more people come forward and health professionals may be more likely to consider a diagnosis of mental health.

It is worth noting that the 2014 adult psychiatric morbidity survey found Hackney's rate of common mental health conditions to be among the worst of all boroughs nationally and depression accounts for the majority of these conditions. Keeping in mind the limitations of both datasets, this does raise the possibility that there may be lower than average diagnosis of common mental illnesses in Hackney primary care. This could be due a range of reasons, including fewer people with common mental health conditions presenting to their GP. It could also be that the survey data did not accurately reflect true prevalence or that prevalence has changed since the survey.

Anxiety

The rate of diagnosed anxiety[3] is 4% in the City of London and 7% in Hackney. These rates were similar in 2023 and 2024 but data prior to that are not available. National and London comparator data are not available for anxiety.

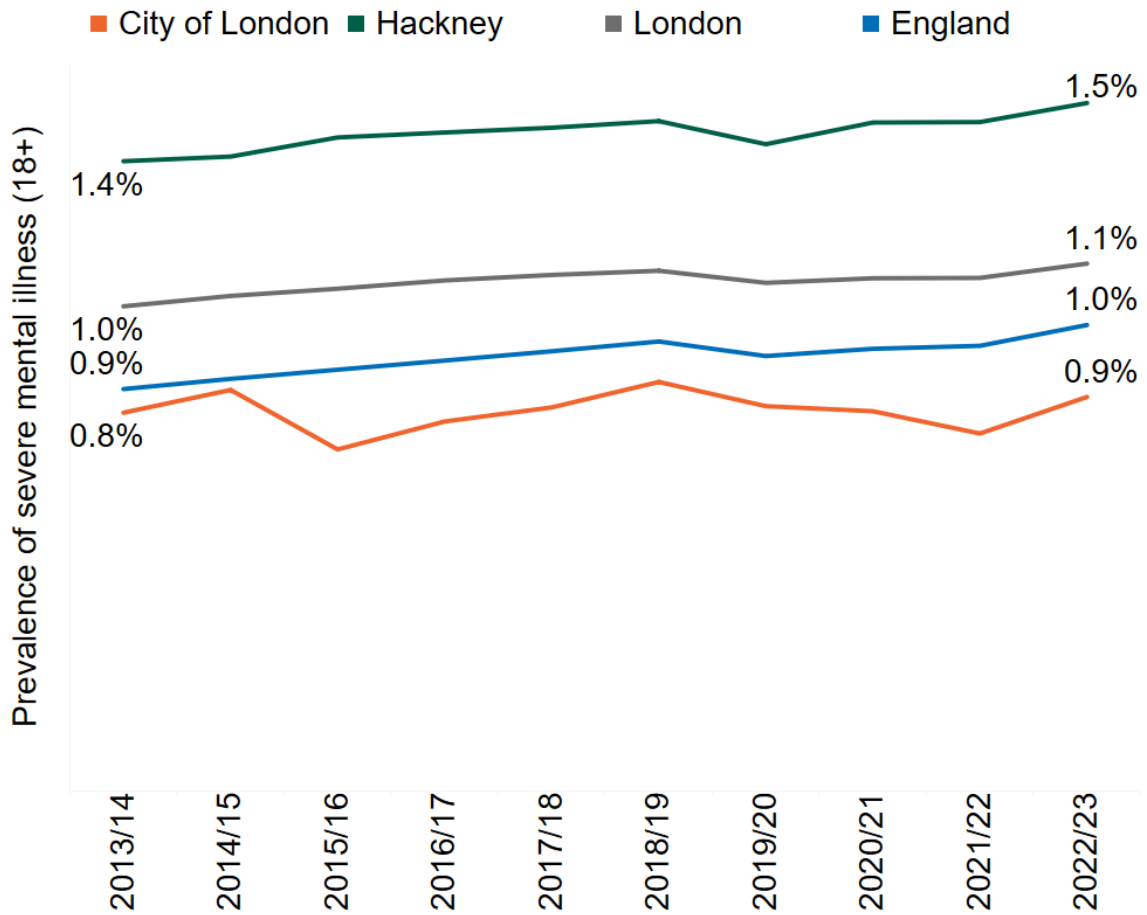
Severe mental illness

Severe mental health problems include psychosis, bipolar disorder, complex emotional needs or 'personality disorder' and eating disorders. They often occur alongside mood difficulties including depression, anxiety and post-traumatic stress disorder(8).

The rates of SMI in the City and Hackney have not changed significantly in recent years. The City of London's SMI rate has been significantly lower than London and England at under 1%. Hackney's SMI rate has been significantly above London and England at about 1.5%, approximately 50% higher.

[3] The rate of diagnosed anxiety is calculated by dividing the number of adults (18+) with a diagnosis of anxiety in the previous 24 months by the total number of adults living in City and Hackney registered to a GP in NEL.

Figure 3: Trends in the rate of severe mental illness (all ages), City, Hackney, London and England, 2013/14 to 2022/23



Source: Office for Health Improvement and Disparities, Fingertips, 2024.

In 2024, 1% of adults (18+) experienced an SMI in the City of London and 2% in Hackney. These figures are higher than the percentages in the graph because they cover only the adult population, whereas the graph includes all ages. The adult only figures have been consistent over the last four years.

Complex mental health needs

As described above, complex mental health needs are when a person has mental health needs that intersect inextricably with other issues, such as housing, financial concerns, unemployment, long-term physical health conditions, substance use etc. When combined with poor mental health, these issues often negatively reinforce each other, such that treating one individually is unlikely to lead to recovery. A whole person approach is usually needed,

There is currently no quantitative data to capture the number of residents with #complex mental health needs in the City and Hackney. However, mental health and wider support service leads have reported notable increases in the number

of people presenting with complex needs, especially since the coronavirus and cost of living crises. Residents with complex needs can be more difficult to treat and achieving good outcomes often requires a lot of resources and multiple services. Therefore, an increase in need in this group is likely to put additional pressure on system capacity. However, not providing the right support to this group means they are likely to deteriorate, leading to an increase in severity of mental health and other support needs. They will be at increased likelihood of going into crisis or losing their accommodation.

Currently, despite many of the issues that cause complex life circumstances being interrelated, services tend to be offered for each issue individually, with each service collecting data specific to their offer and not the overall client need. Where residents are unable to get joined up support, they frequently end up being held by voluntary and community sector organisations, who often do not have sufficient resources to manage this. Integrated services, such as the Community Connectors service, which is blended between East London Foundation Trust and voluntary and community sector providers, can therefore be immensely beneficial to people with complex needs.

3. Inequalities

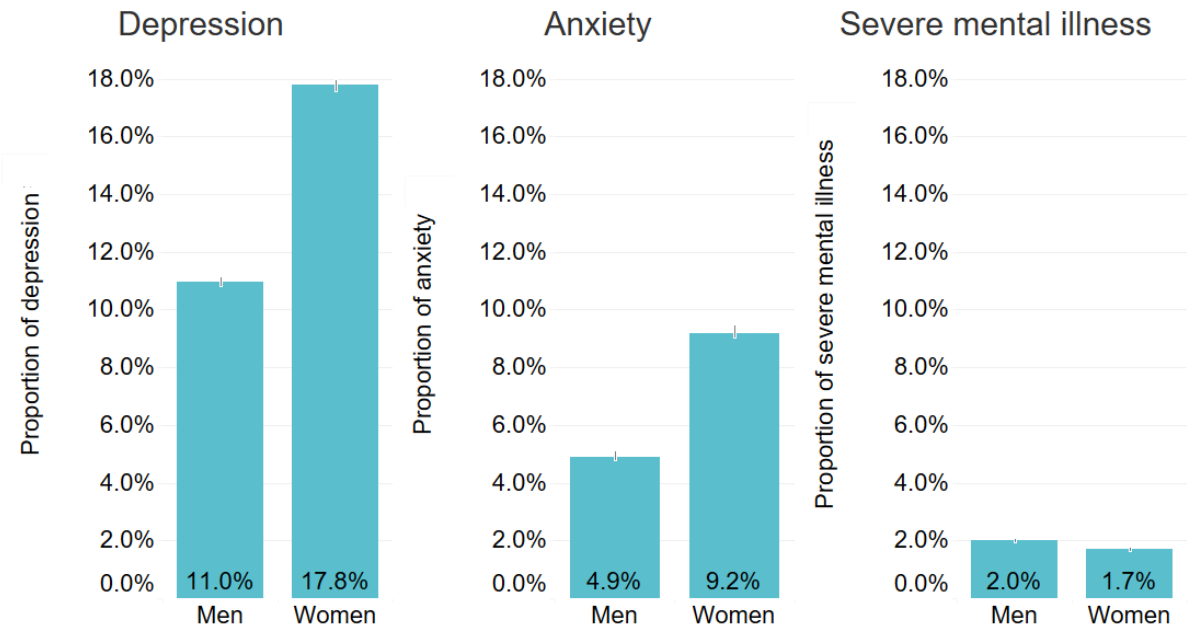
For the inequalities analysis below, using local GP data, the City of London and Hackney data have been combined, due to the City having a much smaller resident population. While this more accurately reflects the Hackney picture, overall the trends are similar in both areas. The data presented below are what is available; some other relevant characteristics are either not available or not sufficiently complete to analyse.

Gender

In the City and Hackney, women are significantly more likely to be diagnosed with common mental health conditions than men, reflecting national trends. For women, 18% are diagnosed with depression and 9% with anxiety, This compares to 11% and 5% of men respectively. It is not clear how much of this difference is due to higher awareness, acceptability, help seeking and possible over-diagnosis in women and how much is a true difference in prevalence.

For SMI 2.0% of men were diagnosed, more than the 1.7% of women diagnosed. This may be due to a higher prevalence of SMI in men but may also be influenced by other factors, such as men potentially reporting later and only when their condition becomes serious, underreporting perhaps being less of an issue for SMI as it is potentially harder to manage without intervention or biases in diagnosis.

Figure 4: Proportion of residents with either depression, anxiety or severe mental illness (18+) by gender, City and Hackney, 2024



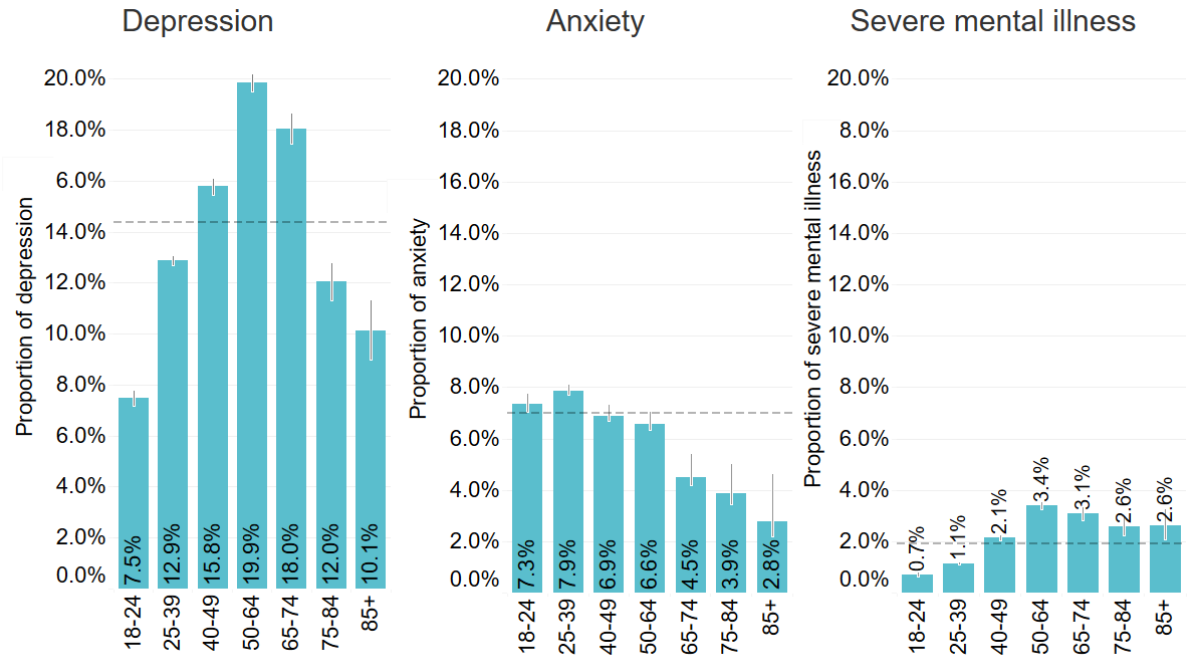
Source: Clinical Effectiveness Group, 2024 (data not publicly available).

Age

The proportion of people with depression by age group increased with age from 7% among individuals aged 18 to 24 years old to 20% among those aged 50 to 64 years old. The proportion in the 65-74 age group remained high, after which it began to reduce again. For anxiety, the proportion of people diagnosed roughly decreased with age, from 8% among individuals aged 25 to 29 years old to 3% among those aged 85 years old and older.

The proportion of people with SMI initially increased with age, starting from 0.7% among individuals aged 18 to 24 years old and peaking at 3.4% among those aged 50 to 64 years old. After 65 years and older, there was a slight reduction in the proportions, though they still remained higher than average.

Figure 5: Proportion of residents with either depression, anxiety or severe mental illness among adults (18+) by age group, City and Hackney, 2024



Source: Clinical Effectiveness Group, 2024 (data not publicly available).

Ethnicity

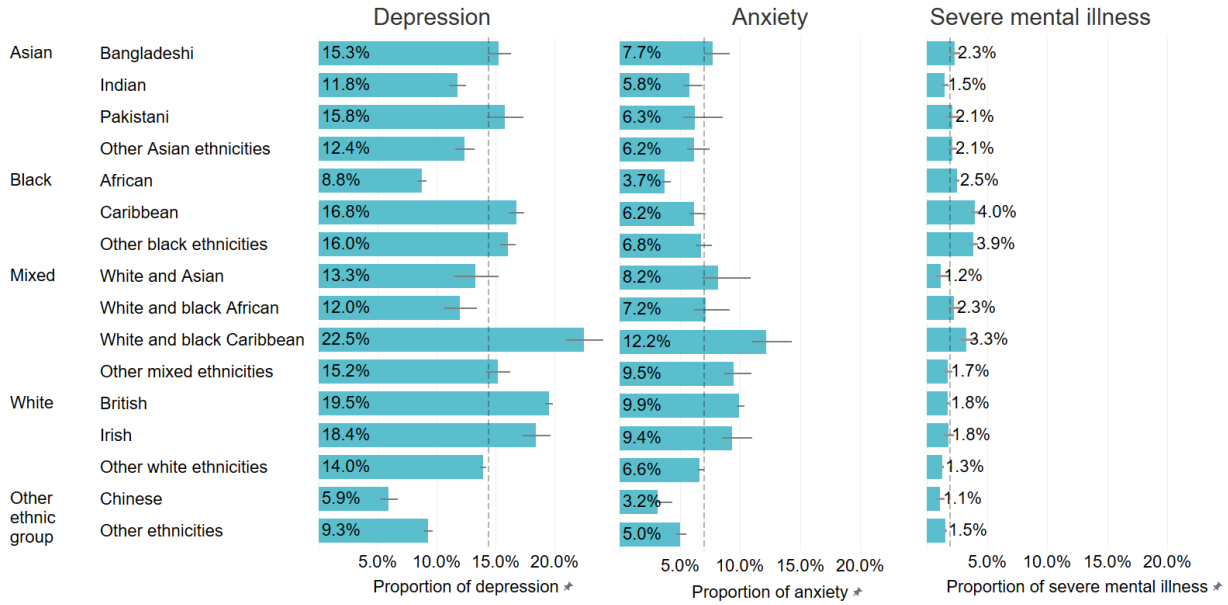
Proportions of diagnosed depression, anxiety and SMI differ across different ethnic groups locally. It is possible some ethnicity groups will be less likely to present to services for a diagnosis, meaning prevalence would be underestimated. Health professionals may also be more likely to diagnose some ethnicity groups than others.

In 2024, mixed white and black Caribbean residents had the highest proportion of both anxiety and depression and the proportion with SMI was significantly higher than average.

Black Caribbean residents and other non-African black ethnicities had the highest proportions of diagnosed SMI and above average for depression but the proportion diagnosed with anxiety was not significantly different to average. The proportion of black African residents with SMI was significantly higher than average but this group had some of the lowest levels of anxiety and depression. The comparatively high proportion of SMI in black ethnic groups overall is concerning.

White British and white Irish residents had some of the highest rates of anxiety and depression but the proportion with SMI was not significantly different to average. There is qualitative evidence that acceptability of both mental health and talking therapies is higher in white, western communities. Therefore, these ethnicity groups may be more likely to seek help for common mental health conditions or to request talking therapies, increasing recorded diagnosis rates.

Figure 6: Proportion of residents with depression, anxiety or severe mental illness among adults (18+) by ethnicity, City and Hackney, 2024



Source: Clinical Effectiveness Group, 2024 (data not publicly available).
Note: the scales for the different conditions shown on the graphs are different.

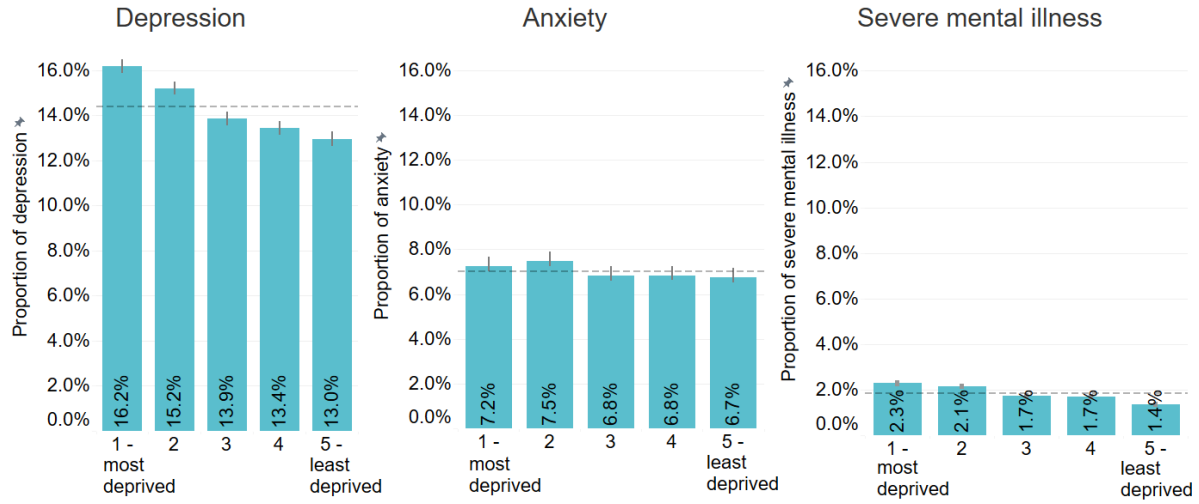
Due to how these data are categorised by the source, some key local communities, such as Turkish/Kurdish and Orthodox Jewish are not really visible. It may be possible to manually classify these categories in a future piece of work.

Deprivation

People living in more deprived areas of City and Hackney, were more likely to be diagnosed with depression, anxiety and SMI, although the trend was less marked for anxiety. This reflects wider trends.

People living in the most deprived areas are also more likely to have additional complexities, such as those relating to housing, employment and financial security.

Figure 7: Proportion of residents with either depression, anxiety and severe mental illness among adults (18+) by local deprivation, City and Hackney, 2024

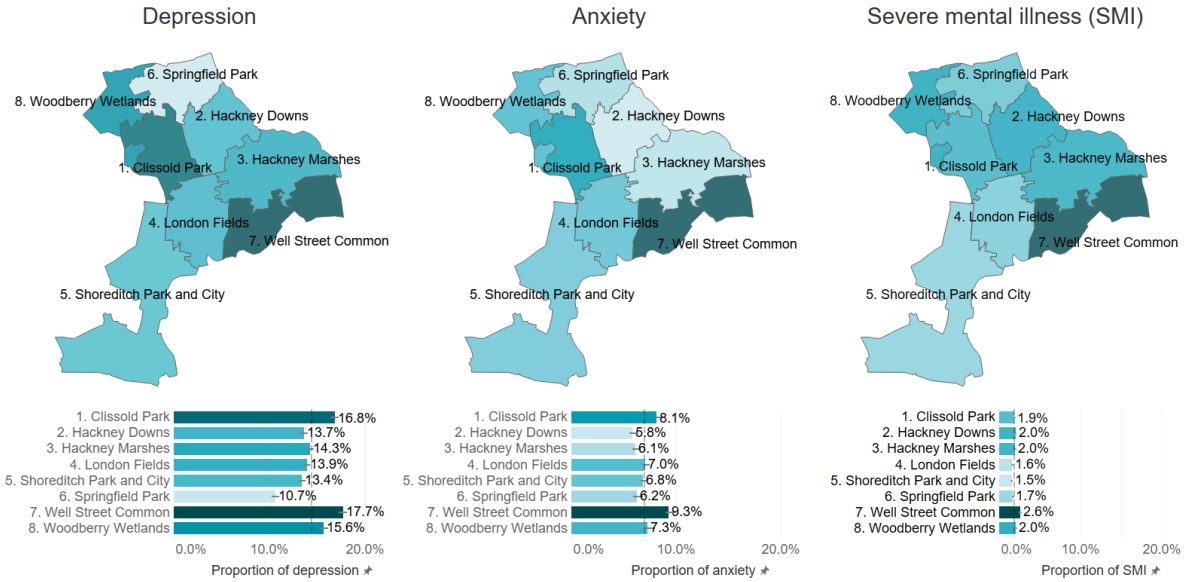


Source: Clinical Effectiveness Group, 2024 (data not publicly available).

Location (Primary Care Networks)

The proportion of residents with depression, anxiety and SMI was highest in the Well Street Common Primary Care Network compared to the average in City and Hackney, indicating a clear high mental health need in this area. Clissold Park and Woodberry Wetlands Primary Care Network also had relatively high rates of anxiety and depression. Diagnosed SMI was also more common than average in Woodberry Wetlands, Hackney Downs and Hackney Marshes.

Figure 8: Proportion of depression, anxiety and severe mental illness among adults (18+) by primary care network, City and Hackney, 2024



Source: Clinical Effectiveness Group, 2024 (data not publicly available).

4. Co-occurring Health-Related Conditions

Physical health, co-occurring substance use learning disabilities and neurodivergence

This section is outstanding and will be added at a later date

5. Other Communities With Unmet Need

While the GP data above offer valuable insights into mental health needs locally, there are areas of unmet need it does not cover. Below are a number of population groups, highlighted by a range of stakeholders locally as having high unmet needs, which are not captured in the primary care data. It was also noted that where there is intersectionality between these groups, or with other factors associated with higher levels of need, this is where the greatest need often arises.

Residents living in temporary accommodation

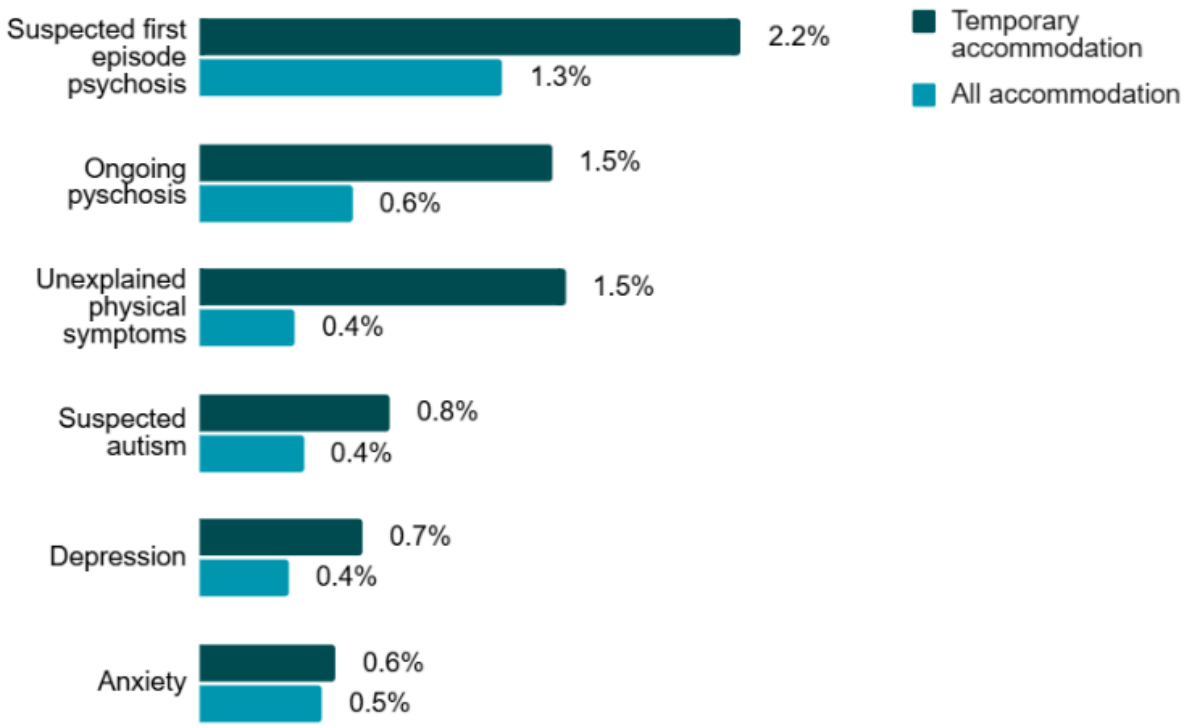
Stakeholders working with people living in temporary accommodation report high levels of mental health needs and usually these are complex needs. For example, people living in temporary accommodation are more likely to have financial difficulties and long-term physical health conditions. Their housing situation can result in feelings of shame, stigma and isolation, as well as making socialising and working more difficult.

The number of households in temporary accommodation is rising nationally, disproportionately affecting London boroughs, with Hackney ranking among the highest. As of March 2025, Hackney has 2,237 households in temporary accommodation, including hostels and bed and breakfasts, often exceeding

recommended stay limits in the latter. Approximately half of these families are placed outside the borough, leading to significant disruption to their lives.

While primary care does not routinely record a person's accommodation status, some mental health services do, although the completion rate is only about 55%. Based on the available data, all mental health conditions appear more prevalent in people living in temporary accommodation, as well as suspected autism.

Figure 9: Proportion of referrals by primary reason[4] for individuals in temporary accommodation[5] compared to the average across all accommodation types, 2025



Source: Mental health services dataset, NHS England, 2025.

Note: missing accommodation types were excluded from the analysis, this accounted for 45.2% of referrals.

Residents experiencing rough sleeping

The City of London has the third-highest rate of rough sleeping in London. Of longer term rough sleepers in the City of London, 79% were assessed as having a mental health support need. Most of these rough sleepers have intersecting needs, with 81% recorded as having two or more support needs. Mental health is

[4] Primary referral reason is the primary presenting condition or symptom for which the patient was referred to a Mental Health Service.

[5] Temporary accommodation includes temporary housing, hostels and bed and breakfast to relieve or prevent homelessness.

the most common need (79%), with substance use (58%) being the second most common. Of the wider rough sleeping population, in the last quarter, 22% were assessed as having high mental health needs, 32.5% medium and 18.5% low (73% in total). (9)

In Hackney, in 2024/25, 125 (61%) rough sleepers out of 206 were assessed as having mental health needs.

Specific challenges relating to rough sleepers and mental health include:

- The transitory nature of rough sleeping means people with chronic and enduring mental health issues are often not in the same location for long enough to have meaningful engagement services.
- Digital exclusion is a significant barrier for people who are rough sleeping, as many do not have phones and if they do it is a basic phone without internet capabilities.
- Carrying out mental health act assessments can be very difficult. Even gathering basic information on someone's capacity or lack thereof can be complicated, as people experiencing rough sleeping will often decline to talk to workers. Additionally, finding an available AMHP can be difficult, waiting lists are long and the assessment needs to be carried out at a pre-arranged time and place, which can be very difficult for someone that has no fixed place where they are living. As a result many people who are rough sleeping are being left untreated.
- There is very little accommodation available for people with complex intersecting needs around mental health and substance use and many can end up in adult homeless pathways, which may have been avoidable with specialist support. People with high levels of mental health needs may find shared supported housing settings difficult and this can also lead to rough sleeping as a result. Schemes like Housing First and use of navigator services to provide enhanced support can help ensure that people are accessing the correct support in order to make meaningful changes and recovery in their lives.
- Once somebody is rough sleeping, delivering successful interventions is very difficult, especially where they have significant complexity. Earlier intervention to prevent people from getting to this point is key.

In the City of London there are two main mental health offers of support: Rough Sleepers and Mental Health Programme and A Place Within. The latter service is specific to the North East London sub region and offers specialised psychotherapy. Both these services work with people who are rough sleeping and importantly, co-occurring substance use is not an exclusion criteria for accessing psychotherapy. The public health funded Supporting Transition and

Empowering People Service also works across City and Hackney and provides a high level of support to clients with complex needs.

Rough sleeping services often adopt a trauma informed approach, recognising that anyone who is rough sleeping will have experienced trauma at some point, which might have led to them rough sleeping or as an impact of rough sleeping.

There are also many people who are homeless but not rough sleeping. Homelessness encompasses people who have no settled base and are possibly sofa surfing. The lack of settled base and insecurity of housing may contribute to mental health problems and can make it difficult for residents to access mental health services, as they are not consistently in any single borough. It may be more difficult for these residents to know what mental health services are available and they might not have a local GP or access to other services that require a fixed address.

Gypsy and Traveller communities

Data on Gypsy and Traveller communities in the City and Hackney are also limited. This is partly due to Gypsy and Traveller status not being systematically recorded by many health services but also because many residents choose not to disclose this, for reasons, such as stigma, faced by this population group.

However, a 2024 door to door survey, which engaged 84 Traveller households across the five Traveller sites in Hackney, found that 71% of adults declared being diagnosed with a mental health condition. Additionally, the social isolation, economic stress, and uncertainty caused by the pandemic disproportionately impacted the local Irish Traveller communities. (10)

Outreach and engagement work with the local Irish Traveller communities was successful in improving uptake of a range of health interventions, indicating the importance of outreach for increasing uptake and inclusivity of services for these communities.

Refugees and asylum seekers

There are approximately 650 Hackney residents seeking asylum living in contingency hotels, as well as Hackney residents seeking asylum living in dispersal accommodation. Mental health data are not systematically collected on refugee and asylum seekers and immigration status is generally not captured by health services. Additionally, the cohort is not stable in the borough and many asylum seekers move to lower cost areas once they have been granted leave to

remain. However, professionals working with these residents report that mental health conditions, such as depression, anxiety and post-traumatic stress disorder, are common in this group. They have almost no income, are living in cramped accommodation, often experience discrimination and have high uncertainty around their futures.

LGBTQIA+ communities

Sexual orientation is not reliably recorded by primary care, so local data on mental health rates in these population groups is not available. However, a study by Stonewall found that over the previous year, half of Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and all other related identities (LGBTQIA+) people had experienced depression, and three in five had experienced anxiety, higher than the general population. (11) Given both the City of London and Hackney have higher than average rates of people from LGBTQIA+ communities, it can be inferred that there is a significant mental health need in these communities locally.

6. Local Context

Several factors make mental health a key issue in both the City of London and Hackney and provide some explanation as to why mental health need is high, as well as perhaps why providers report such high levels of complexity locally. However, it should also be noted that most of these are negatively reinforcing, so causality is not linear.

Additionally, the factors listed below are key for prevention of poor mental health. For example, if somebody has a safe, warm place to live, sufficient income, secure and meaningful employment, as well as opportunities to be social and physically active, they are much more likely to be able to maintain good mental health than somebody who does not.

Housing

Not having a safe and comfortable place to live is a major risk factor for mental health. Being unable to afford decent housing has been found to increase depression and anxiety, while the reductions in housing benefit, introduced in 2011 were associated with a statistically significant increase in mental health problems among those affected. (12) Even for those in private accommodation, the high rent and mortgage costs can be a significant financial burden, taking a toll on mental health.

In Hackney there is a significant shortage of affordable housing. The average house price in Hackney in May 2025 was £605,000 and average monthly rent was £2,557. Waiting times for social housing can range from 3 to 53 years. Sadly, many people waiting never secure a social home, even those who are homeless, have serious medical needs, or live in overcrowded conditions. Many residents also live in unsuitable housing. For example, 12.7% of households in Hackney are overcrowded, compared to 11.1% in London and just 4.4% in England. (13)

In the City of London the average house price was approximately £849,356 at the time of writing and the average rent was estimated to be £2,237. In the City, 4.8% of households are overcrowded, which is similar to England.

Deprivation

Mental health conditions are much more prevalent among people living in more deprived areas. People living in the lowest fifth of household income are twice as likely to have common mental health problems than in the highest and prevalence of psychotic disorders is nine times higher.

Hackney experiences high levels of deprivation and was the 10th most deprived local authority overall in England in the 2025 Indices of Multiple Deprivation, based on rank, across a range of summary measures. Hackney had the third highest rate of income deprivation in England with 40% of its population living in income deprived households. It also had the 2nd highest income deprivation affecting both children and older people, with 64.1% of children living in income deprived households and 54.7% of older people. (14)

The City of London has a small resident population of 8,600 residents (Census 2021) compared to 614,500 people who work daily there (Office for National Statistics 2022). Although the City is generally considered a wealthy area overall, it still has a number of communities living in deprivation. This relative deprivation can have a significant impact on those facing challenging circumstances.

Experience of discrimination

Experience of discrimination, such as racism or against LGBTQIA+ people is a type of trauma and as such can have a negative impact on mental health. Experience of trauma not only impacts mental health directly but also increases the risk of other related issues, such as drug and alcohol use, reduced self-care, difficulty maintaining employment, social isolation and physical health problems (15). A meta-analysis confirmed that perceived discrimination has a significant negative effect on mental health, produces significantly heightened stress

responses and is related to participation in unhealthy and nonparticipation in healthy behaviours. (16)

Hackney has a diverse community, with 47% of residents coming from Global Majority[6] communities, plus 19% from non-British white ethnicities, and 9% from LGBTQIA+ communities. The City of London also has a fairly diverse population. Residents from Global Majority communities represent 30% of the City population, which is low for London but high nationally. A further 27% of the City of London population are from non-British white ethnicities. At 10%, the City of London has the second highest proportion of people from LGBTQIA+ communities, in England. While this diversity makes the City and Hackney a welcoming and inclusive place, it also means that a considerable number of residents may have experienced discrimination.

Substance use

Mental health problems and substance use are highly correlated, with 70% of drug users and 86% of alcohol users in community substance use treatment having a mental health problem. A history of alcohol or drug use is also recorded in 54% of all suicides by people with mental health problems. Despite guidance to the contrary, many people find themselves excluded from mental health or substance use care due to their problems with the other. (17).

Both the City of London and Hackney have relatively high rates of drug and alcohol dependence. It was estimated that in 2019/20, 15.4 per 1,000 Hackney residents and 56.8 per 1,000 City of London residents had an opiate and/or crack dependence, compared to 9.5 per 1,000 in England. The very high City of London figure is largely explained by the high rough sleeping population compared to the small resident population. Estimated alcohol dependence was 18.1 and 16.7 per 1,000 in Hackney and the City of London respectively, both higher than 13.8 per 1,000 in England.

Social isolation

Social isolation and loneliness are also detrimental to mental health. A study found that 60% of people experiencing chronic loneliness experienced mental distress, compared to only 15% of those who were not chronically lonely. Longitudinal analysis found that loneliness was a predictor of the onset and continuation of mental distress. (18)

[6] Global Majority ethnicities refer to people who are black, Asian, brown, dual-heritage, indigenous to the global south, and or have been racialised as 'ethnic minorities' (Rosemary Campbell-Stephens, 2020). They correspond to all Census categories under 'Asian', 'black', 'mixed', or 'other ethnic group'. All categories under 'white' are excluded, despite some of them still experiencing marginalisation in the UK such as Eastern European and Jewish.

The percentage of adults in the City of London and Hackney who feel lonely often, always or some of the time was 21% in 2019/20.

Physical environment

Lack of access to green spaces, noise, air pollution, litter, traffic volume, crime and fear of crime all impact mental health (12). Being a built up, city environment, living in the City and Hackney exposes its residents to all of these issues. While similar to comparable inner city boroughs, Hackney's crime rate is high compared to the national rate.

Employment

Conversely, living in a busy area can provide more employment opportunities, which usually has a positive impact on people's mental health. For the year ending December 2023, 81.5% of people aged 16 to 64 years living in Hackney, compared to 74.6% for London and 75.1% for England were in employment.

Employment can be a protective factor for mental health, whilst unemployment is associated with poor mental health. People on housing benefits are more than twice as likely to have a common mental health problem than those who are not (35.1% vs 14.9%). (19) Additionally, poor quality, stressful and insecure employment can also be detrimental to mental health. Increasingly, work is not a way out of poverty and with insufficient income being associated with poor mental health, it is therefore likely that the stress of working and not being able to afford a decent standard of living has also been rising. (12)

Locally services have reported that they are seeing an increase in residents with financial concerns following the recent changes made to welfare benefits, with some residents becoming very anxious or ending up in crisis as a result.

Coronavirus and cost of living crisis

Recent events, such as the coronavirus crisis and the cost of living crisis have taken a disproportionate toll on City and Hackney residents and their mental health.

Prevalence of moderate and severe depressive symptoms among adults in Great Britain rose from 10% in surveys taken July 2019-March 2020 to 19% by June 2020 and 21% by January to March 2021. Rates were relatively higher for women, young people, disabled people, clinically extremely vulnerable adults, those with low incomes, unemployed people and those already experiencing

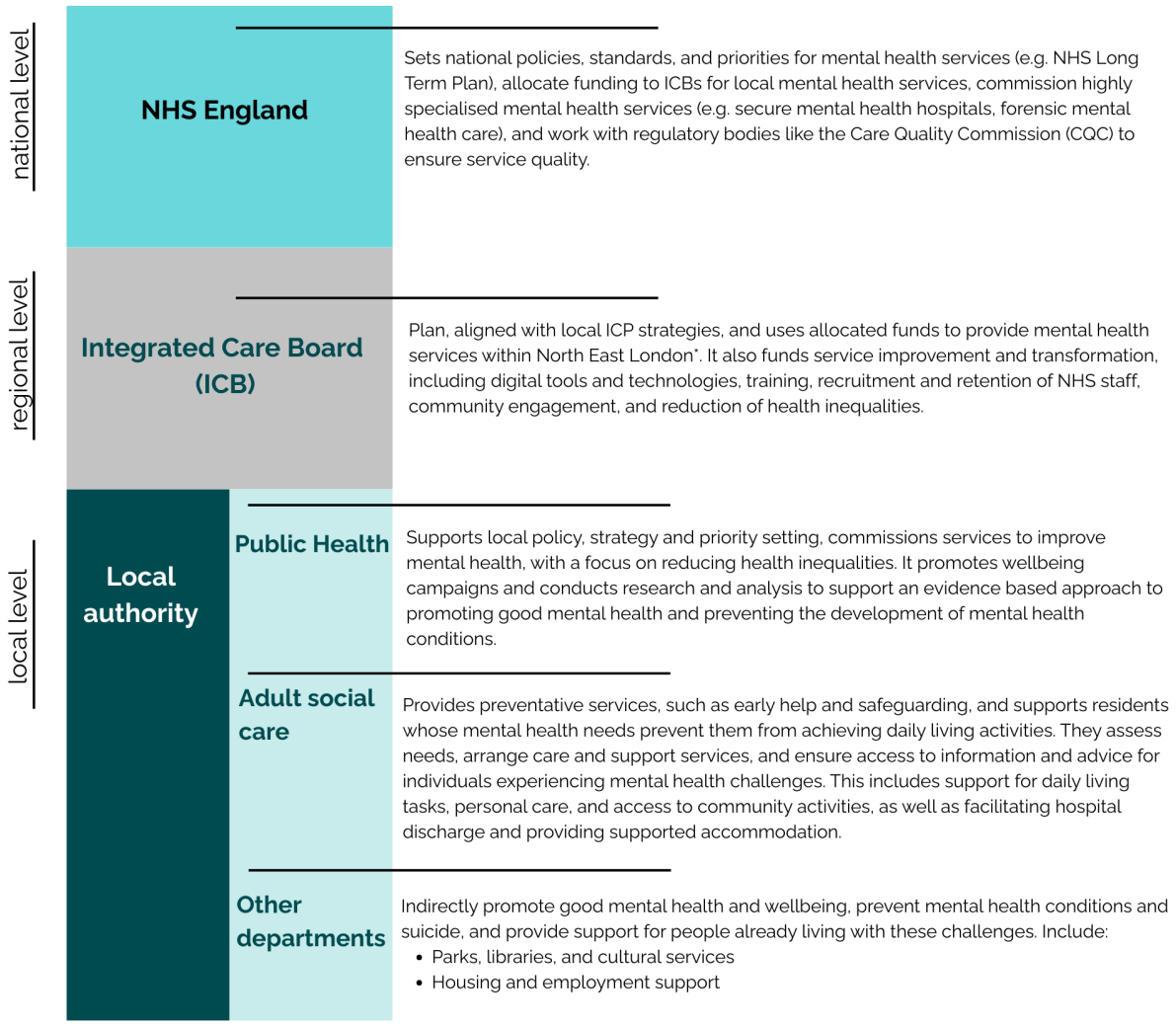
depressive symptoms (20). Hackney was hit particularly badly by the pandemic, having the third highest rate of infection recorded in the UK.

Although at the time of writing, the full impact of the cost of living crisis is not yet known, the negative correlation between financial security and mental health is very well established, with those already on low incomes being hit the hardest. Given the high levels of deprivation locally, it is very likely that the increased cost of living will disproportionately impact Hackney's residents.

7. Policy context

There are different responsibilities in adult mental health service provision. They are summarised in Figure 10.

Figure 10: Responsibilities of adult mental health service provision.



*Services include Primary Care, such as GPs and pharmacies; Secondary Care, such as community mental health teams, crisis, inpatient mental health care, and talking therapies; and Public Health initiatives, in collaboration with local authorities.

Source: created by the authors.

Numerous national, regional, and local policies and strategies, described respectively in Boxes 1, 2, and 3, influence mental health decisions in our area.

Box 1: National policies and strategies related to adult mental health

Policy/strategy (year)	What the documents commits that influences adult mental health services in the City and Hackney
Mental Health Act Reform (2021)	• Raise the threshold for detention and ensure it is used only when absolutely necessary. • Reduce racial and other disparities in the application of detentions based on mental health.

	• Encourage local authorities to adopt preventative mental health strategies to avoid detention. • Ensure individuals have more say in their treatment and care. A new Mental Health Bill was introduced to Parliament in November 2024.
Fit for the Future: 10 Year Health Plan for England	The 10 Year Health Plan makes three big shifts to how the NHS works: from hospital to community from analogue to digital from sickness to prevention
Prevention Concordat for Better Mental Health (2017)	• Facilitate local and national action around preventing mental health problems and promoting good mental health. • Encourage use of community-based programmes, artificial intelligence, and digital tools to identify mental health risks early. • Embed mental health support within general care settings such as primary care. • Encourage addressing factors like housing, employment, and education to improve overall wellbeing. • Recognise diverse needs and interventions tailored in accordance. City and Hackney were the first local authorities in London to sign up for it, demonstrating a joint commitment to improving mental health outcomes in their jurisdictions.
Five Year Forward View for Mental Health (2016)	• Establish that mental health needs should be treated with equal importance to their physical health needs. • Reduce mental health stigma. • Reshape mental health care, increase access to the right care at the right time, reduce variation of quality of care and improve outcomes. • Set that co-production with experts-by-experience should also be a standard approach to commissioning and service design. • Acknowledge the impact of housing on mental health and encourage evidence base for specialist housing support for vulnerable people with mental health problems. • States that employment should be recognised as a health outcome. • Sets additional investment to deliver these ambitions.
No Health Without Mental Health (2011)	• Highlight that mental health is not just an add-on to healthcare but an essential part of overall health.

	• Merge mental health services with primary care to treat the whole person. • Ensure that mental health receives the same priority, funding, and attention as physical health. • Encourage employers to support mental wellbeing through flexible policies, training, and workplace wellness programmes. • Address past trauma, social determinants of health, and lifestyle factors in mental health treatment. • Expand peer-led programmes, local initiatives, and social prescribing to promote wellbeing beyond clinical settings

Box 2: Regional policies and strategies related to adult mental health in North East London

Policy/strategy (year)	What it influenced mental health in City and Hackney
North East London Integrated Care Strategy (2021)	• One of its flagship priorities is to improve the mental health and wellbeing of the people of North East London
North East London Integrated Care Board Strategy	• One of its four priorities is Mental Health, improving community wellbeing and also access to, experience of and outcomes from services
North East London Integrated Care System Working with People and Communities Strategy	It commits to: • Develop an infrastructure of participation within our governance and leadership • deepen our collaboration across the Integrated Care system and with its people and communities • Gather insight and evidence to inform priorities and target our participation efforts • Ensure that all people and communities are aware of and are supported to participate • Ensure that the impact of participation is clear to people, communities, and partners Although it does not directly refer to mental health, it defines key concepts on how to work holistically with people and communities, which includes mental health.
Mental Health, Learning Disabilities and Autism Collaborative	The North East London Mental Health, Learning Disability, and Autism Collaborative is a partnership between North East London Integrated Care Board, East London Foundation Trust, North East London Foundation Trust, and the seven place-based partnerships in close collaboration with service users and carers, communities, local authorities, primary care, the voluntary and community sector, and other services.

	The aim of the collaborative is to work together to improve outcomes, quality, value, and equity for people with, or at risk of, mental health problems and/or learning disability and autism in North East London.
London's Mental Health Strategy	A ten-year strategy for mental health services in London

Box 3: Local policies and strategies related to adult mental health in City and Hackney

Policy/strategy (year)	Impact
City & Hackney Mental Health Strategy 2019-23	• The strategy focuses on 5 priorities: - Prevention: promoting positive mental wellbeing, reducing stigma, and providing early support. - Access: improving access to mental health support and services, reflecting the diversity of communities. - Neighbourhood: supporting people in the community through local partnerships with schools, GPs, and voluntary services. - Personalisation and co-production: empowering service users to control their care and recovery, involving them in shaping services. - Recovery: championing social inclusion, focusing on strengths, housing, jobs, and social networks. The 2019-23 strategy is now outdated. New priorities and a system-wide action plan are being agreed.

References

1. WHO Mental health [Internet]. [cited 2023 Aug 31]. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

2. Mcdaid D, Park AL, Davidson G, John A. The economic case for investing in the prevention of mental health conditions in the UK [Internet]. [cited 2023 Aug 30]. Available from: https://www.mentalhealth.org.uk/sites/default/files/2022-06/MHF-Investing-in-Prevention-Full-Report.pdf

3. Strang J. How mental health loses out in the NHS [Internet]. [cited 2025 Sep 17]. Available from: https://www.kcl.ac.uk/archive/news/ioppn/records/2012/june/mental-health-in-the-nhs

4. The King's Fund [Internet]. [cited 2023 Aug 30]. Mental health. Available from: https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-mental-physical-health

5. NHS England Digital [Internet]. [cited 2025 Sep 17]. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24

6. NHS Digital [Internet]. [cited 2023 Aug 31]. Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

7. NHS England Digital [Internet]. [cited 2025 Dec 4]. Chapter 1: Common mental health conditions. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions

8. England NHS. NHS England » Implementation guidance 2024 – psychological therapies for severe mental health problems [Internet]. [cited 2025 Dec 4]. Available from: https://www.england.nhs.uk/long-read/implementation-guidance-2024-psychological-therapies-for-severe-mental-health-problems/

9. Rough sleeping in London (CHAIN reports) [Internet]. [cited 2025 Nov 5]. Available from: https://data.london.gov.uk/dataset/rough-sleeping-in-london-chain-reports-2n88x/

10. City and Hackney Public Health. Irish Traveller Health Matters Project Summary Report [Internet]. Available from: https://hackney.moderngov.co.uk/documents/s92279/2a+Irish+Traveller+Health+Matters+Project+Summary+Report.pdf

11. Mental Health Foundation [Internet]. [cited 2025 Sep 17]. LGBTIQ+ people: statistics. Available from: https://www.mentalhealth.org.uk/explore-mental-health/statistics/lgbtiq-people-statistics

12. The Health Foundation [Internet]. [cited 2024 Jan 11]. Health Equity in England: The Marmot Review 10 Years On. Available from: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

13. Housing prices in Hackney [Internet]. [cited 2025 Sep 17]. Available from: https://www.ons.gov.uk/visualisations/housingpriceslocal

14. GOV.UK [Internet]. [cited 2026 Jan 6]. English indices of deprivation 2025: statistical release. Available from: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2025/english-indices-of-deprivation-2025-statistical-release

15. Mental Health Foundation [Internet]. [cited 2024 Jan 17]. Trauma. Available from: https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/trauma

16. Pascoe EA, Smart Richman L. Perceived discrimination and health: a meta-analytic review. Psychol Bull. 2009 Jul;135(4):531–54.

17. Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf. Available from: https://assets.publishing.service.gov.uk/media/5a75b781ed915d6faf2b5276/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

18. GOV.UK [Internet]. [cited 2024 Jan 16]. Investigating factors associated with loneliness in adults in England. Available from: https://www.gov.uk/government/publications/factors-associated-with-loneliness-in-adults-in-england/investigating-factors-associated-with-loneliness-in-adults-in-england

19. Mental Health Foundation [Internet]. [cited 2023 Aug 31]. Poverty: statistics. Available from: https://www.mentalhealth.org.uk/explore-mental-health/statistics/poverty-statistics

20. Leach C, Finning K, Kerai G, Vizard T. Coronavirus and depression in adults, Great Britain - Office for National Statistics [Internet]. Office for National Statistics; 2021 [cited 2023 Aug 31]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/julytoaugust2021

This page is intentionally left blank

City and Hackney Adult Mental Health Joint Strategic Needs Assessment:

Part 2: Local Services

2025

Authors
This report was written by: Jennifer Millmore (Senior Public Health Specialist), Mariana Autran (Public Health Analyst) and Tom Moore (Public Health Analyst)

Report Approvers
This report was approved by Andrew Trathen

Acknowledgements
We would like to sincerely thank everyone who has contributed towards the production of this report, including our commissioned providers and wider system partners, colleagues in the Public Health team and wider Council and City of London Corporation colleagues.

Cite this report as:
City and Hackney Public Health. City and Hackney Adult Mental Health Joint Strategic Needs Assessment, Part 2: Local Services. (December 2025)

Contents

Contents 3
Abbreviations and acronyms 4
Executive summary 6
Local services 6
Outcomes 6
Inequalities 7
Challenges identified 7
1. Introduction 9
2. Local Mental Health Services 9
Commissioned services 9
The City and Hackney Wellbeing Network 10
Talking Therapies for Anxiety and Depression 11
East London NHS Foundation Trust 12
Voluntary sector services 16
Core Arts 16
Coffee Afrik 17
Immediate Theatre 17
St Mary's Secret Garden 17
Mind in the City, Hackney and Waltham Forest 18
Other services 18
General Practitioners 18
3. Service data 19
Mental health outcomes 20
Wellbeing Network 20
Talking Therapies for Anxiety and Depression 22
ELFT 26
Service waiting lists 27
Waiting times 27
Lost referrals 28
Demographic data 28
Gender 28
Age 31
Ethnicity 34
Deprivation 37
Location (Primary Care Networks) 39
Sexual orientation 41
Other characteristics 42
Unavailable data 42
Challenges in data collection 43
4. Service User Experience 44

Service data 44
Wider feedback 44
Navigating the system 45
Length of support offer 46
Insufficient or inappropriate support 47
Governance and accountability 48
Delivery channels 48
Cultural competency 49
5. Prevention 49
Individual behaviours and resources 49
Early intervention 50
Wider local support 50
6. Partnership Working 52
7. Trauma Informed Services 54
8. Section 117 Aftercare 54
9. Support of Carers 55
10. Service Response 57
The Wellbeing Network 57
Service flexibility and data requirements 57
Innovation and service delivery 57
Community engagement and inclusion 58
Data capture and inequalities analysis 58
Enhancing service provision for men 58
Collaboration and future funding 59
Talking Therapies for Anxiety and Depression 59
East London Foundation Trust 59
References 61
Appendix 1: Data completeness 62
Appendix 2: Wellbeing Network Providers 63
Appendix 3: The Wellbeing Network Peer Pathway 66
Case Studies 2024-25 66
Appendix 4: Services in the City and Hackney Public Health team that influence mental health of our residents 69

Abbreviations and acronyms

ACH:	African Caribbean Heritage
CAMHS	Child and Adolescent Mental Health Services
ELFT:	East London Foundation Trust
GP:	General Practitioner
ICB	Integrated Care Board
JSNA:	Joint Strategic Needs Assessment
LGBTQIA+:	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and all other related identities
MHIC:	Mental Health Integration Coordinating Committee
MindCHWF:	Mind in the City, Hackney and Waltham Forest
NHS:	National Health Service
PCN:	Primary Care Network
SMI:	Severe Mental Illness
SWEMWBS:	Short Warwick-Edinburgh Mental Wellbeing Scale
TTAD:	Talking Therapies of Anxiety and Depression
VCS:	Voluntary and Community Sector
WBN:	Wellbeing Network

Executive summary

Local services

This Local Services Joint Strategic Needs Assessment considers local mental health services, their outcomes, inequalities, some of the challenges they face and residents' experiences. It is the second of three linked reports, along with the "Local Picture" and "Local Challenges and Recommendations"[1].

In the City and Hackney, mental health support is delivered by a number of specialist commissioned mental health services, voluntary and community sector (VCS) providers and GPs (general practitioners). This report focuses on three of the largest services: East London Foundation Trust (ELFT), Taking Therapies for Anxiety and Depression (TTAD) and the Wellbeing Network (WBN), which very broadly support severe mental illness, common mental health conditions and complex mental health needs respectively. Data for other services are included where available. For the purpose of this report, ELFT services were split into community, inpatient and crisis services.

TTAD assesses and treats approximately 7,000-8,000 people a year and has seen increasing numbers of referrals over the last few years. The WBN is comparatively smaller, seeing approximately 1,170 clients a year and an additional 5,866 person hours through their Open Access activities. ELFT did not provide these data.

Outcomes

Using the Short Warwick-Edinburgh Mental Wellbeing Scale to assess outcomes, clients of the WBN experienced a 4.6 point increase, a clinically significant improvement. Improvements were greater for women, non-African and Caribbean Heritage communities, adults aged 18 to 39 and heterosexual adults. WBN data also indicate that clients' social connectedness, physical health and unemployment improves between entering and exiting the WBN.

Of TTAD patients, 54.4% recovered and 49.9% were considered to have 'reliably recovered', meaning that their recovery is significant and lasting. This is in line with national standards and significantly above the outturn for the whole North East London Integrated Care Board area for 2024/25. The 'Asian or Asian British' ethnicity group had significantly lower overall recovery rates than average.

[1] A Children and Young People's JSNA was published on October 2025: https://cityhackneyhealth.org.uk/wp-content/uploads/2024/10/Hackney-and-City-Health-Needs-Assessment-for-Children-and-Young-People-with-Special-Educational-Needs-and-Disabilities-1.pdf

Overall service satisfaction rates in TTAD vary from 95%-100% each month. In the WBN 92% of service users 'strongly agreed' that they were happy with the service in 2023/24. ELFT did not provide outcomes or satisfaction data.

Inequalities

Service use was not evenly distributed across the local population.

- **Gender:** Even taking into account differences in the prevalence of mental health conditions, men are underrepresented in most of the largest commissioned services locally. The exception was inpatient services, where a significantly higher proportion of ELFT inpatients were men, which might be expected given men's higher SMI rate locally. In crisis services there was not a significant difference.
- **Age:** Broadly, TTAD has a younger cohort of patients and an underrepresentation of those aged 45 and over. ELFT community services data indicate that older residents may be underrepresented in ELFT community services. For ELFT crisis care, the 45-49 to 60-64 age groups had above average attendance rates and ELFT inpatient age distribution was quite varied. In the WBN, rates of clients in the service increased with age up to the 60-64 age group.
- **Ethnicity:** In both the WBN and TTAD, the rate of people from African and Caribbean heritage communities was slightly higher than the rate of people from other ethnicities, using population based estimates. In ELFT community services, the rate of patients from ACH communities was lower than expected but higher in inpatient services. The rates for crisis services were not significantly different.
- **Deprivation**: Residents from the most deprived areas locally appear underrepresented in both the WBN and TTAD. Patients seen in all three ELFT services had higher attendance rates from residents living in more deprived areas locally, in line with local prevalence.
- **Location:** there are not very clear trends with service use based on areas with higher mental health needs.
- **Sexual orientation:** In the WBN, rates of service users identifying as gay or lesbian, straight or heterosexual, and bisexual, reflected the relative proportions of local residents. The rate of WBN service users who self-described as any other sexual orientation was significantly higher than in the local population. Completion rates for sexual orientation in ELFT and TTAD were too low to be analysed meaningfully.

Challenges identified

- **Waiting times:** The average waiting time is 22 days for the WBN and 14 days from referral to treatment for TTAD. For some specialist pathways the waiting times can be longer than average for both services. Silver

Cloud and Open Access Activities can be accessed while on the waiting lists. ELFT did not provide updated data for this report but have previously reported wait times of over a year for some ELFT services, which unfortunately is not unusual for secondary care services nationally.

- **Lost referrals:** For the larger services, 25%-35% of people dropped off waiting lists, either before assessment or before starting the main interventions. Not much is known about these people and why they dropped off but it does indicate a high number of people who reach out for help but do not receive it.
- **Navigating the system:** many resident representatives reported difficulties navigating the numerous mental health services, their different criteria, referral pathways and processes, especially where residents have complex and intersecting needs. Some staff from wider support services report not making referrals, believing it will do more harm than good. Most providers also report having to turn away many residents who are ineligible for their services. These issues navigating the system are not experienced with other support services and a number of stakeholders specifically requested a much simpler system for mental health referrals.
- **Length of support offer:** there is limited provision for residents that need longer term or ongoing support.
- **Insufficient support offer:** The most common type of mental health support offered locally is talking therapies. While this can be effective, evidence suggests, and local resident representatives agree that it is not suitable for everyone, with some suggesting it has a western bias. More skills, social, activity, practical and learning based support was requested.
- **Governance and accountability:** the underlying governance systems are currently not working well. Roles and responsibilities are not always clear or well defined and there are some significant gaps in areas of responsibility, such as around less medicalised support offers.
- **Service accessibility:** many stakeholders requested more in-reach and outreach options, especially for the most excluded population groups.
- **Service inclusivity:** despite some improvements in this area, some residents continue to report discrimination, distrust and a lack of cultural competence in relation to mainstream services.
- **Lack of partnership working:** while there have been various efforts to improve this, integration between different mental health services is still limited. This is likely partly a result of the underlying governance and accountability system, which differs for each service. Some target setting can also discourage partnership working.

1. Introduction

This joint strategic needs assessment (JSNA) on local services aims to improve understanding on what mental health support is in place locally, how well this is meeting the needs of adults living in the City of London and Hackney, as well as identify what is working and areas for improvement.

In the City and Hackney, mental health support is delivered by a number of specialist commissioned mental health services, voluntary and community sector (VCS) providers and GPs (general practitioners). This report considers the data provided by these services and resident experiences of them.

There are also many local services that support mental health indirectly, by supporting other issues that can negatively impact mental health, such as substance use, housing, employment etc. While a detailed analysis of these services is beyond the scope of this report, these wider services are often well placed to identify mental health needs, offer basic mental health advice and make referrals to formal support services. For the purposes of this report, a number of these services shared their experiences of this, as well as insight regarding their perspectives of local mental health services.

Additionally further insight into resident experiences of mental health services was provided by service user representatives, such as Mental Health Voice, and other stakeholders. Residents were not surveyed directly but this could be a potential future piece of local research. Insights from the Better Mental Health funding projects and VCS assembly evaluations, as well as insights from community champions and key local stakeholders have also been drawn upon in the report.

The JSNA provides an overview of the information available and key issues locally. It does not consider specific issues in-depth but it may highlight areas where more detailed research may be useful.

2. Local Mental Health Services

Commissioned services

The largest commissioned mental health support services in the City and Hackney are East London Foundation Trust (ELFT), City and Hackney Talking Therapies for Anxiety and Depression (TTAD) and the City and Hackney Wellbeing Network (WBN). Broadly these provide mental health support to people with severe mental illness (SMI), common mental health conditions and complex mental health needs respectively, although in reality the distinctions are not always so clear cut.

Within ELFT there are numerous different services and it was not possible to split the analysis by each one, so they have been grouped, using guidance from ELFT, into crisis, community and inpatient services. The WBN and TTAD have a number of different providers and pathways within the services but for the purposes of this report they are mostly analysed as whole. More detailed analysis into the different services, providers or pathways could be possible in the future, if there is a specific area of interest.

The City and Hackney Wellbeing Network

The City and Hackney Wellbeing Network (WBN) has grown and adapted since its beginning in 2015, to better meet the needs of the local communities. Currently, the WBN has two distinct types of support. The first is the core service, which provides integrated, holistic and person-centred support. It is delivered by a variety of voluntary sector organisations to residents with complex mental health needs. The second is Open Access, a range of activities. The WBN service was designed to fit a gap in need for residents who were too complex for TTAD but also not meeting the ELFT criteria, or for whom traditional NHS services may not be appropriate. With the WBN contract ending in 2027, this will leave a significant group of residents with no service that meets their needs.

The core service operates through an individualised approach, in which each service user is paired with a dedicated coach. Together, they develop a personalised care plan that includes various interventions tailored to the individual's unique requirements. These interventions address mental and physical health, daily living skills, and social connections. Support offered includes talking therapies, crisis care, advocacy, employment assistance, and housing support. These services can be provided by organisations within the network, as well as external services outside the WBN. Importantly, some interventions are designed for particular community groups, aiming to make the service more inclusive and help reduce mental health inequalities.

The service's Open Access activities are open to all City and Hackney residents and complement the core service. They can be especially valuable to people on waiting lists, those who may be hesitant to engage with or commit to formal services and people who are not comfortable sharing personal information. These services are mainly peer-led and offer community based, preventative initiatives. They do not require any formal registration. This function also provides a valuable asset for clients upon discharge from core service as a way to remain connected to community infrastructure and to support the maintenance of improvements whilst in service.

The WBN has a range of specialist providers to ensure that tailored support can be offered to a wider range of communities. For example, Bikur Cholim, Derman, the African Community School and IRIE Mind each focus on providing culturally sensitive services to the Jewish, Kurdish and Turkish, African heritage, and Caribbean communities respectively. A summary of each organisation is provided in Appendix 2.

The service is relatively flexible, which allows it to be innovative and to respond to identified needs. An example of this is Mind Forward, a one at a time therapy offer, developed by MindCHWF (City Hackney and Waltham Forest) to ensure quicker access to therapy for those that need it. This complements its longer term therapeutic offer.

Talking Therapies for Anxiety and Depression

The City and Hackney Talking Therapies for Anxiety and Depression (TTAD) service, previously called Improving Access to Psychological Therapies, is commissioned to deliver National Institute for Health and Care Excellence recommended psychological therapies for people suffering from common mental conditions, such as depression, generalised anxiety disorder, social anxiety, panic disorder, health anxiety, obsessive compulsive disorder and post-traumatic stress disorder. Patients do not need a formal diagnosis but must have a clinical need for one of the conditions treated.

NHS Talking Therapies for Anxiety and Depression is a national programme with locally delivered services. City and Hackney NHS Talking Therapies is delivered by four providers, with NHS Homerton Foundation Trust being the largest. Bikur Cholim delivers culturally specific psychological therapies to the Charedi communities and Derman, to the Turkish and Kurdish-speaking communities. MIND is shifting its support toward Global Majority clients and delivers two specialist pathways: African Caribbean heritage (ACH) and LGBTQIA+ (lesbian,

gay, bisexual, transgender, queer or questioning, intersex, asexual, and all other related identities).

TTAD also provides an adapted service, which considers the bidirectional relationship for patients who have cooccurring common mental health and physical health conditions, such as diabetes, chronic obstructive pulmonary disease and chronic pain.

The service has also just been awarded funding from Sport England to integrate physical activity with TTAD as part of a three year project.

East London NHS Foundation Trust

East London NHS Foundation Trust (ELFT) provides a wide range of mental health services, including community, crisis, forensic and inpatient services, to young people, working age adults and older adults across the City of London and Hackney, as well as Newham, Tower Hamlets, Bedfordshire and Luton.

All ELFT services are coproduced and are provided in collaboration with service users. ELFT also collaborates with a number of VCS providers, including their community connectors service and step down and supported accommodation by Look Ahead. They are part of several alliances, including the Psychological Therapies and Wellbeing Alliance and the Dementia Alliance. ELFT takes a population health approach to mental health care, with an increasing focus on prevention.

In the City and Hackney ELFT provides seven inpatient wards, including a specialised Mother and Baby Unit and a male psychiatric intensive care unit. Its working age adult community services aim to be place based, providing integrated mental health care as near to residents as possible. In Hackney, ELFT is part of a Section 75 agreement with the London Borough of Hackney, where mental health and social care is provided in an integrated manner.

In 2024, 8,593 adults (18+) living in the City and Hackney were referred to ELFT. Community services received 7,315 referrals, crisis services 2,111 and inpatient services 892. These figures are not mutually exclusive as patients can be referred to multiple types of services within a calendar year.

Most of the ELFT data presented in this report was obtained from the North East London Snowflake data system. Additional data were requested directly from ELFT but not received, meaning it could not be included in all the analysis. Where data are missing, this is noted in the relevant sections.

Table 1: Summary of services provided by the WBN, TTAD and ELFT

Service	WBN	TTAD	ELFT
Providers	MindCHWF (lead provider), African Community School, Bikur Cholim, Centre for Better Health, Core Arts, Derman, IRIE Mind CIC, Shoreditch Trust[2]	NHS Homerton Foundation Trust, MindCHWF, Bikur Cholim, and Derman.	East London NHS Foundation Trust
Commissioned by	City and Hackney Public Health	North East London Integrated Care Board	North East London Integrated Care Board
Target population (eligibility criteria)	Residents with complex mental health needs.	Residents with a clinical indication of need relating to one or more of the conditions treated, such as anxiety, depression, generalised anxiety disorder, health anxiety etc.	Residents in crisis and residents with severe mental illness
Other criteria	- City or Hackney resident, registered with a City or Hackney GP, or a City or Hackney care leaver up to age 25 - Adult (18+)	- Adults (18+) registered with a City or Hackney GP or a resident of City & Hackney - People working in the City or Hackney - Some providers also have specific population group targets	- Residents registered with a City or Hackney GP or a resident of City & Hackney - Varies depending on the service
How to refer	Self-referral, referral by any health professional or support worker	Self-referral, GP referral or other health professionals	Most community and inpatient services require a GP referral, although patients may self-refer

[2] This is the current list of providers, there have been a number of changes in providers throughout the history of the service, though they have always come from the VCS. Appendix 2 provides further details on each provider.

			within a year of discharge. Crisis services can be accessed directly via self referral.
Length of offer	Core service: Until the service user has recovered sufficiently that they can successfully look after their mental health outside of the service, which is expected to be within one year. In some exceptional circumstances can work with individuals longer. There is a check-in option with no time limit. Open Access: no time limit.	The length of the offer depends on the patient needs and treatment offer but usually do not exceed 20 weeks over a period of six months.	Varies depending on the service, level of illness, level of functioning and speed of recovery. For example, crisis interventions may last a few days or weeks, whereas Care Programme Approach patients may stay up to several years. Some psychotherapies follow a set programme, e.g. a 10 week course and some support, such as care coordinators, can last 6 months to a few years,
Capacity	New Core Service Users[3] 2023/24: 1,150 2025/26: 748 Total Core Service Active Clients[4] 2023/24: 1,800 2025/26: 1,170 5,866 person hours of support via Open Access in 23/24	,Approximately 7-8,000 assessed and treated per year	ELFT did not provide these data

[3] Reductions due to reduced funding.
[4] Reductions due to reduced funding.

Number of referrals in the last year available	1,959 referrals in 2024/25	Around 13-14,000 adults per year	Around 7,200 adults (2024)
Outreach	Open Access activities in the community and a regular presence at key community events	Homerton: dedicated community outreach worker. Mind: at community events. Work with council's health inclusion team to connect with other services Bikur Cholim - support workers in hospital wards Derman - awareness sessions / promotional sessions	Information not provided
Service budget	1.334 million in 2023-25, £834k across all providers from 2025/26[5]	£6.8 million per year (£6 Million for Homerton services)	ELFT did not provide this information

Another service: Primary Care Psychotherapy Consultation Service, was decommissioned around the time this report was being written, Data from this service were not made available.

[5] £2,055,781.00 in 2015.

Voluntary sector services

Mental health support from VCS services is a vital part of the local mental health system. Not only does it add capacity but VCS services also can often be more flexible in their approach and reach residents through their position in the community, including those who may be unwilling to attend mainstream services. However, many VCS organisations have recently experienced funding cuts from their contracted activity, alongside reductions in donations, reducing capacity in the vital support services they provide.

The VCS services that submitted data for this JSNA report were Core Arts, Coffee Afrik, Immediate Theatre and St Mary's Secret Garden. Their client numbers varied from a few tens to approximately 650 clients for Core Arts. Data provided were variable across the different services, sometimes limited and the majority were summary data rather than the patient level data received for the main commissioned services. Therefore, while it has been included throughout this report where relevant and available, the VCS data may not always be directly comparable to the commissioned services data. Numbers were also sometimes small and so had to be suppressed/combined,

While ideally data would have been received from more VCS services, it is acknowledged that their capacity is limited and they often do not have the same access to data systems or analysts. Non-commissioned services can be invited but not compelled to share their data. However, this does mean that a large and very important section of the mental support system is missing from the analysis in this report and overall picture of mental health support locally. Nevertheless the data from those who did provide it still offers some valuable insight.

Core Arts

Core Arts offers creative arts education for persons experiencing mental health issues across five domains (art, music, multimedia, horticulture and sport). Over 70 courses are run per week, with a monthly events programme and access to artistic and cultural opportunities offered as part of the membership. The Core Arts membership team offer support throughout membership and have a partnership with ELFT and the NHS to ensure members best outcomes, improved emotional wellbeing and increased self-management skills.

Core Arts has capacity for about 650 clients at any one time and sees about 1,200 per year. It is commissioned by the ICB and is a member of the WBN.

Clients stay with the service for a minimum of 12 weeks, up to a year. Core Arts eligibility criteria requires members to have a formal diagnosis. Of Core Arts members, 81% were experiencing severe mental illness, 5% first episode (early SMI), 11% personality disorders and 3% serious but common mental health conditions such as PTSD or OCD as their primary diagnosis when accessing support.

Of Core Arts clients, 51.2% have a diagnosed SMI, 11.0% a diagnosed common mental condition and 41.9% had a significant mental health need but no formal diagnosis, though many would meet the criteria.

Given its relative large size and considerable commissioned activity, Core Arts should potentially be considered under the main commissioned providers for future updates.

Residents can refer in to Core Arts through a number of pathways: https://www.corearts.co.uk/eligibility-referrals/.

Coffee Afrik

Coffee Afrik CIC is an experience-led community organisation working across East London. They work with women and young people from black and Global Majority communities, run community hubs, build knowledge, skills, and create connections. The service includes 28 projects, across seven community-led hubs, including a youth hub, two women's hubs, a problematic drug use safe space, a research lab, and a systemic litigation space.

Immediate Theatre

Immediate Theatre aims to work closely with local organisations and community groups to create performances that engage people in the process of change. They also provide one to one support, including employment support (including outreach at the Job Centre Plus), Immediate Theatre works with young adults (18-25) in particular young black men and Global Majority women (18+).

St Mary's Secret Garden

St Mary's Secret Garden was a community garden providing therapeutic and social horticulture opportunities in Hackney. Unfortunately this service has now closed, though may reopen in the future. Information from St Mary's Garden has still been included where available as it provides a useful perspective from a small local VCS service.

Mind in the City, Hackney and Waltham Forest

In addition to being the lead provider for the WBN and one of the community providers in TTAD, Mind in the City, Hackney and Waltham Forest (MindCHWF) offer a number of other services and in total support over 4,000 people in the City and Hackney, funded through a mixture of commissioned services, grants and donations. These include:

- IRIE Mind CIC - range of community based psychosocial support for the African Caribbean heritage community,
- Rainbow Mind - LGBTQIA+ service that provides a range of psychosocial support and partnerships with other LGBTQIA+ charities,
- Community Connectors (co-located in the community mental health teams in partnership with ELFT),
- Welfare Rights - supporting people flexibly to access and understand welfare benefits,
- Part of the Integrated Recovery service led by Turning Point.

Unfortunately some Mind CHWF have had to close a number of services recently due to funding cuts, including Supported Self Help, an education service and employment services.

Other services

The services listed above are those that provided data for this report. Further information on mental health and related services not covered in this report can be found at hackney.gov.uk/mental-health and https://www.cityoflondon.gov.uk/services/health-and-wellbeing/mental-health-and-wellbeing.

General Practitioners

GPs also play a crucial role in providing mental health support and treatment. They can diagnose and prescribe medication to people with mental health conditions, provide advice, as well as refer and signpost to specialised mental health services. Some residents will be treated solely by their GP, some just by mental health services and some by both. GPs can also help identify links where patients have coexisting mental and physical health conditions and how they might interact. Where patients do have multiple needs, GPs can play a role in bringing the various services and health professionals together.

At the time of writing, data on GP treatment of mental health was just in the process of being made available but had not been validated, so it was not possible to use for this report but this could potentially be included as a future update.

3. Service data

Data submitted from the different mental health support services are presented in this section. There are a number of points to note regarding these data which are described below.

For the quantitative analysis below, all service users were included in the overall totals. However, when the number of service users in a specific group was less than eight, these were combined into larger categories or excluded from that part of the analysis to protect the anonymity of individuals within datasets.

Rates have been used to present data in this report, rather than percentages, as this takes account of differences in the local population and makes it easier to identify areas of unmet needs. The calculation of rates was based solely on general population figures, meaning it does not take into account any specific differences in need. It may be possible to calculate this to account for local mental health needs when the second round of the 2023/24 Adult Psychiatric Morbidity Survey data are published, although this is likely to have its own limitations.

For the WBN, the data used are for people who have been assessed by the service, so will not include data on anyone who dropped out before this. This is because some clients referred to the service do not take up this referral until a later date, which would affect the data. For TTAD and ELFT, the data analysed were for people who were referred to the service and not those actually treated, so this should be kept in mind when interpreting the analysis.

WBN data mostly are for service users assessed by the service in 2024, because the service underwent significant changes in July 2023. This provided a whole year of data reflecting the current service, while avoiding the initial transition period. Individual level data are not collected for Open Access, to ensure it is as inclusive as possible, so was not available for the analysis.

The TTAD quantitative data are from 2021/22 to 2023/24. Each of the four organisations submitted their data separately and they were then combined. As

around 92% of service users are seen by Homerton, when data for the four organisations are combined, they predominantly reflect Homerton service users.

For ELFT, the quantitative data were analysed in three separate service groups, although these groupings include various distinct services within them:

- **Community services:** including community mental health teams, mental health care of older people, an early intervention service, perinatal mental health, a rehab and recovery service, an autism and ADHD diagnostic service and psychological therapy services.
- **Crisis services:** including a psychiatric liaison team in A&E, a home treatment team, a crisis assessment team, a crisis cafe and the City of London street triage service.
- **Inpatient services:** including an inpatient mother and baby unit, two female acute wards, three male acute wards, one male psychiatric integrated care unit and a health based place of safety (section 136).

Relevant population data are sometimes referenced in this section for context and comparison. A more detailed analysis of local population mental health data is available in City and Hackney Mental Health JSNA - Part 1: The Local Picture.

Unfortunately, there were insufficient data to carry out some of the detailed analysis as originally hoped, such as a more detailed breakdown of demographic characteristics (e.g. young black men) and clients journeys through services.

Mental health outcomes

Mental Health outcomes have been considered separately below for each service, as the type of data collected and submitted differs for each. Some consistency in measurement could be helpful in understanding the impact across the different services, although the different interventions used, as well as starting severity and complexity of need may also have to be taken into account.

Wellbeing Network

For the WBN outcome analyses, service users who were assessed on or after July 2023 and discharged in 2024 were included[6]. Out of these 470 service users, 284 (60%) had valid measures of the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) both before and after their treatment. Therefore, this does

[6] The short period of time was because the service changed significantly in July 2023 and using data from before this would not be reflective of the current service.

not include service users who had their initial assessment but are still in treatment or those who left treatment without completing the final assessment.

Overall there was a 4.6-point increase from the initial average score (16.6) to the final average score (21.1). An improvement of 3 points is considered a clinically significant change, so this is evidence that the service is effective at improving wellbeing. Given the service works with people with significant complex mental health needs and often challenging life circumstances, where improving mental health outcomes is particularly difficult, this is especially noteworthy.

Improvement was larger for:

- Women (5.7) compared to men (2.9),
- Non-African and Caribbean Heritage (ACH) (4.9) compared to ACH (3.7),
- Younger adults aged 18 to 39 (5.9) compared to adults 40 and over (3.2),
- Heterosexual/straight (5.0) compared to gay/lesbian, bi and other sexualities (3.5),
- Springfield Park (6.8) and Hackney Downs (6.1) compared to the average (4.6) Primary Care Network (PCN),
- No clear pattern was observed in relation to local deprivation,

More in depth analysis could be possible in the future when more clients have completed both assessments for the current service model.

In addition to SWEMWBS, the WBN data indicate that clients also experience notable improvements in social connectedness, physical health and unemployment between entering and exiting the WBN. In 2024/25, 42% of clients who reported smoking at service entry no longer reported smoking at service exit. For clients who reported being unemployed at service entry, only 31% still reported being unemployed at service exit. Between service entry and exit 65% of clients reported improvements in their physical health and 56% in their social connectedness.

WBN clients are also provided with a range of opportunities for learning and skills development, for example the service's Peer Pathway. The Peer Pathway provides opportunities for clients to take a next step in their recovery through building confidence and resilience by taking part in both practical and learning opportunities. The Pathway is fully lived experience led and offers continuous peer support spaces, building capacity within the system through strengthening a self-sustaining community. This also offers an alternative or additional type of support that is invaluable to many. A core offer is their Peer Leadership Programme where clients develop skills that foster their involvement in the service, such delivering groups or volunteering, and in the wider community such as moving towards employment or community activism. The Pathway has

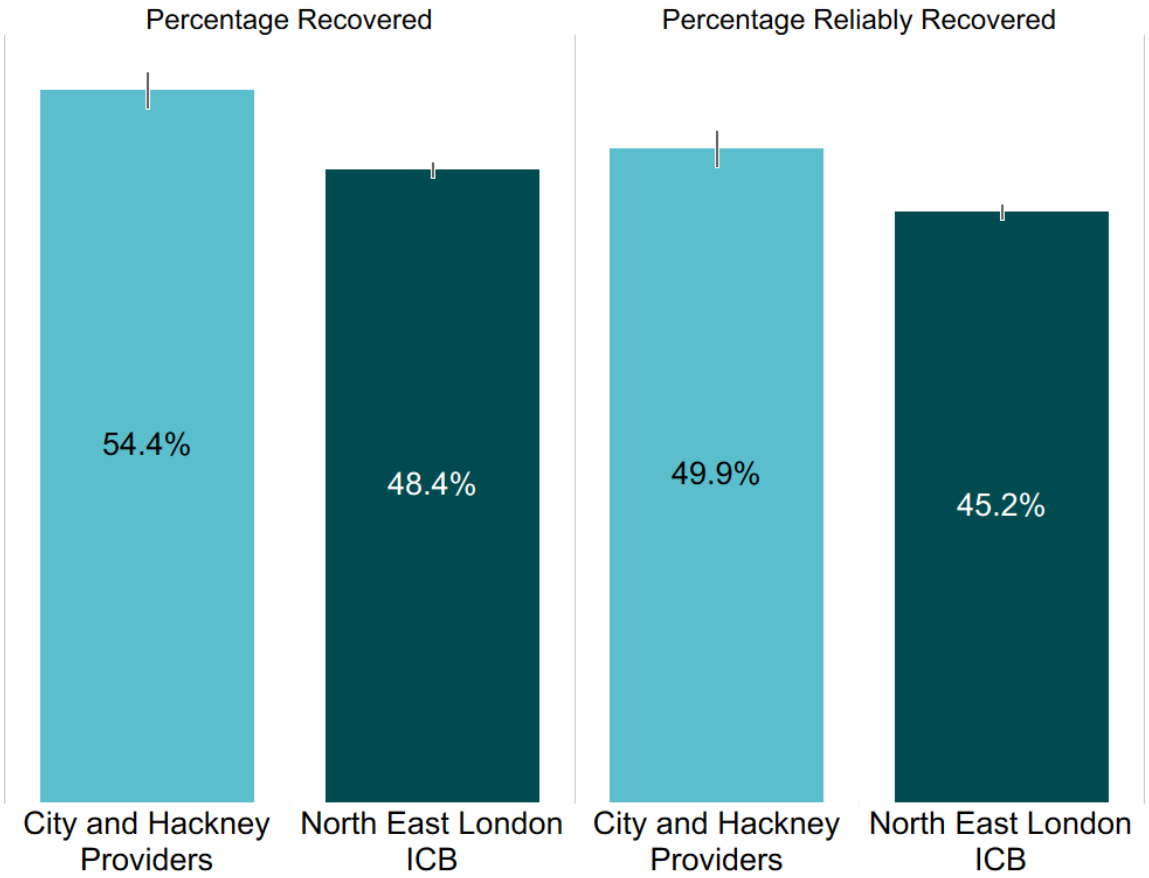
supported 49 people since its inception in 2023 with 36 people attending the leadership programme over 2024/2025 (Case studies available in Appendix 3).

In the WBN's newly developed Mind Forward (one at a time therapy) offer, 175 people had engaged with this intervention at the point of writing. Of these, 70% demonstrated improvement in symptoms after one session, 26% improvement after two and 100% improved after four sessions.

Talking Therapies for Anxiety and Depression

Of TTAD patients, 54.4% recovered and 49.9% were considered to have 'reliably recovered', meaning that their recovery is significant and lasting. This is in line with national standards and significantly above the outturn for the whole North East London Integrated Care Board area for 2024/25 (Figure 1). Differences in recovery rates across gender, age and ethnicity groups were mostly not significant, with the exception of the 'Asian or Asian British' ethnicity group having significantly lower overall recovery rates than average.

Figure 1: Recovery and Reliable Recovery outcomes from NHS Talking Therapy service, proportion of referrals that finished a course of treatment, 2024/25

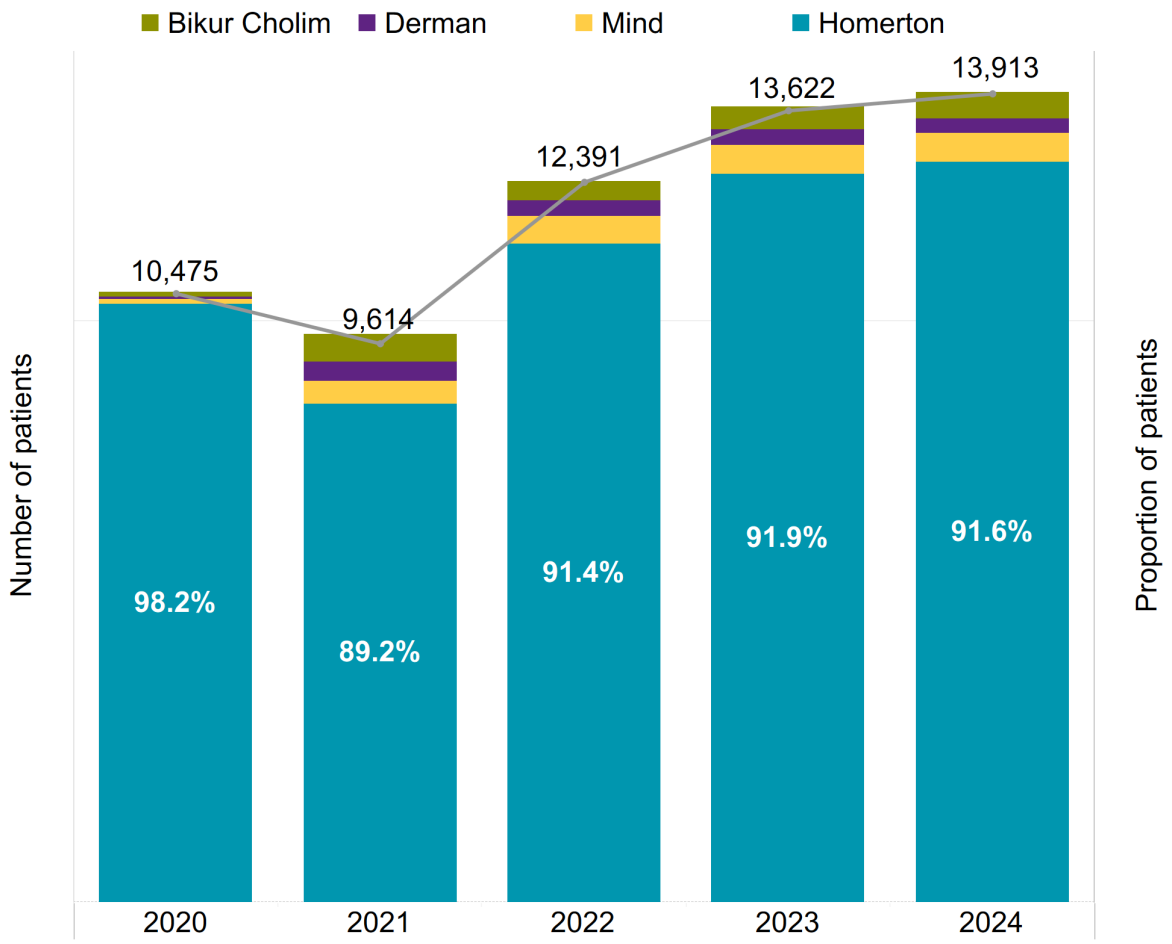


Source: NHS Talking Therapies, for anxiety and depression, annual report, 2024/25. Rates calculated using Census 2021 for the local population numbers.
Note: City and Hackney providers is a combination of the following providers' numbers from the annual report data: Mind in the City, Hackney and Waltham Forest, Derman, Bikur Cholim Ltd, Homerton Healthcare NHS Foundation Trust

At 36%, roughly a third of referrals accessed the service and received an assessment but no treatment. Reasons for this included TTAD not being the appropriate service for their mental health needs and patients declining treatment after referral (including self-referrals). Where patients are not suitable for TTAD, they are discharged following advice and support, and referred to other services where appropriate, by mutual agreement. This requires a lot of resources and reduces the amount of time the service can dedicate to treatment.

The number of service users seen by all the providers annually varied from around 9,600 in 2020/21 to almost 14,000 in 2023/24 (Figure 2). Homerton accounted for the largest number of service users, at around 90% or more each year.

Figure 2: Service users referred to NHS Talking Therapy service over time, number and proportion, 2019/20 to 2023/24

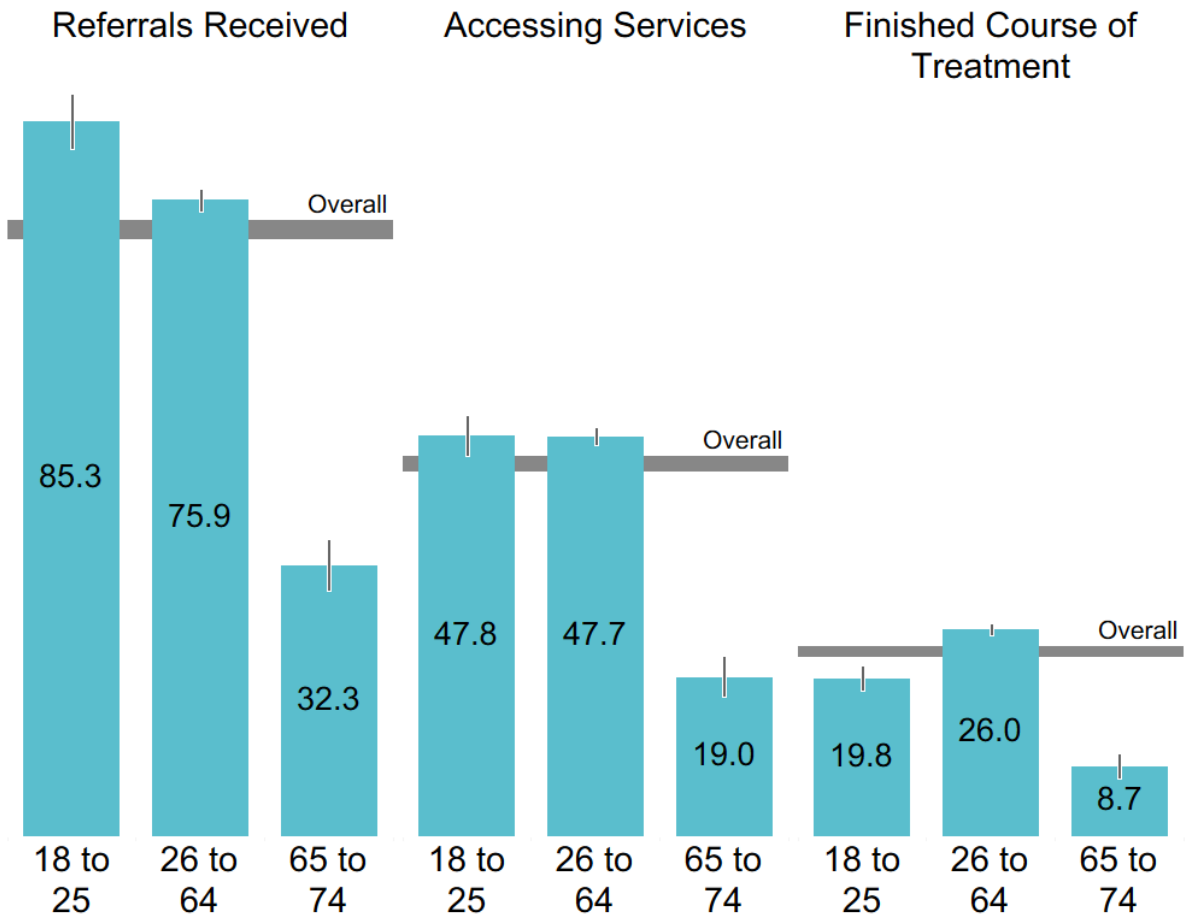


Source: Data sent individually by each provider.
Note: The year shown in the graph reflects the data at the end of the financial year. For example, the financial year from April 2019 to March 2020 is represented with 2020.

There was an overall 8% drop in service users referred to TTAD in 2020/21. Referrals to the Homerton reduced by around 1,700 during this period, likely due to people avoiding non-urgent NHS services around the coronavirus pandemic. The VCS providers experienced a combined increase of around 1,000 referrals in the same period due to an increase in funding. The overall increasing trend reflects the broader picture of increasing mental health needs in the population.

In 2024/25, the referral rate for service users aged 18–25 years in the City of London and Hackney (85 per 1,000) was statistically higher compared with the overall rate (72 per 1,000). However, the rate for those completing a course of treatment, which is defined as attending at least two treatment sessions, was only 20 per 1,000. This is statistically lower compared with the overall rate of 23 per 1,000. This suggests that this age group fails to access services or complete treatment compared to the larger 26 to 64 age group.

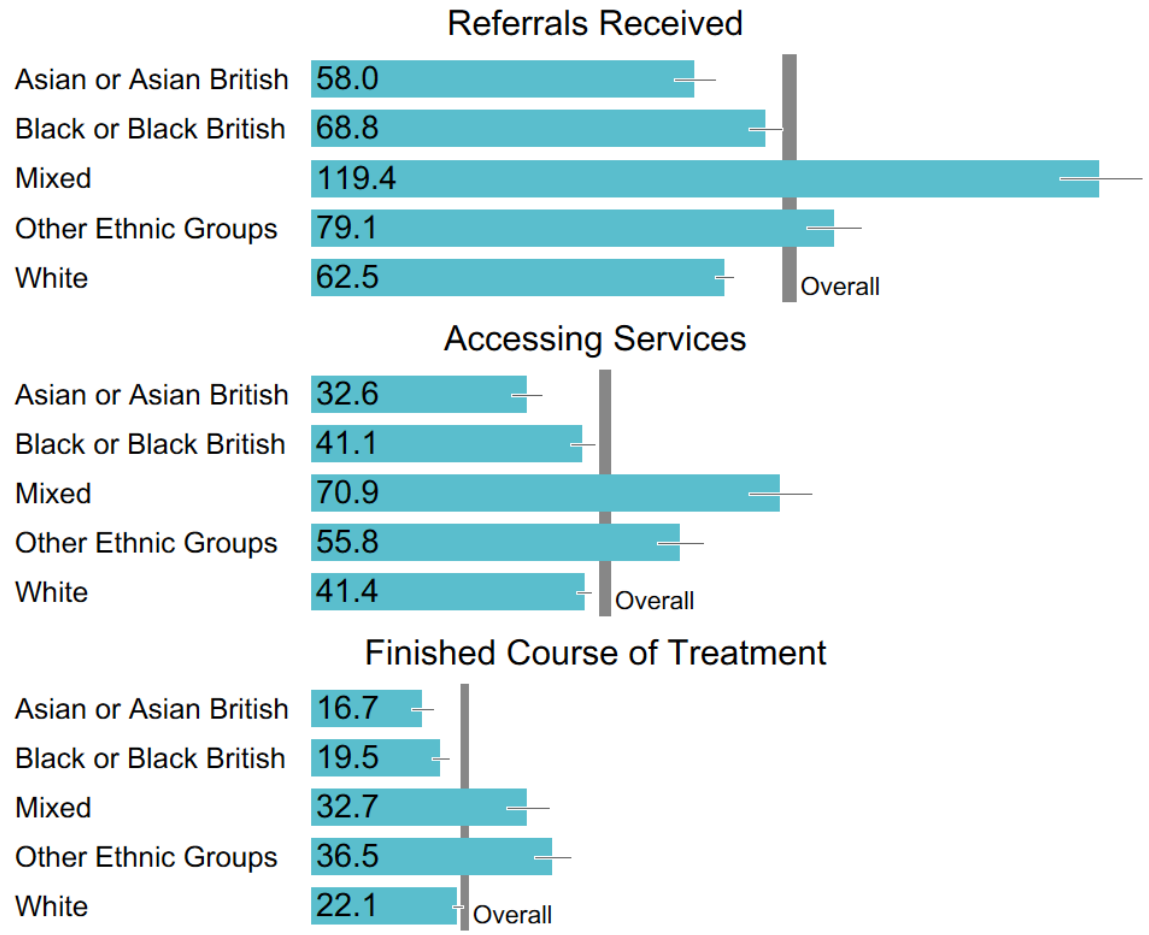
Figure 3: Rate per 1,000 of referral received, accessing services and finishing a course of treatment from NHS Talking Therapy service, by age group, City of London and Hackney providers*, 2024/25



Source: NHS Talking Therapies, for anxiety and depression, annual report, 2024/25. Rates calculated using Census 2021 for the local population numbers.
Note*: City and Hackney providers is a combination of the following providers' numbers from the annual report data: Mind in the City, Hackney and Waltham Forest, Derman, Bikur Cholim Ltd, Homerton Healthcare NHS Foundation Trust

The same rates also vary by ethnicity when compared to the overall rate. The rate for the Asian or Asian British group remained consistently below the overall average across all three stages, with 58 per 1,000 for referrals, 32.6 per 1,000 for accessing services and 16.7 per 1,000 for finishing treatment. While the white group initially showed a referral rate (62.5) below the average, this gap narrowed, resulting in a completion rate (22.1) similar to the overall figure. Conversely, the black or black British group began with a referral rate (68.8) broadly similar to the average, but fell below the overall rate for both accessing services (41.1) and finishing a course of treatment (19.5).

Figure 4: Rate per 1,000 of referral received, accessing services and finishing a course of treatment from NHS Talking Therapy service, by ethnic group, City of London and Hackney providers*, 2024/25



Source: NHS Talking Therapies, for anxiety and depression, annual report, 2024/25. Rates calculated using Census 2021 for the local population numbers.
Note*: City and Hackney providers is a combination of the following providers' numbers from the annual report data: Mind in the City, Hackney and Waltham Forest, Derman, Bikur Cholim Ltd, Homerton Healthcare NHS Foundation Trust

ELFT

In the data provided by ELFT only 5% of City and Hackney residents had patient-reported outcome measures recorded, at the start of treatment. These are insufficient data to analyse mental health outcomes for ELFT. The service is now using Dialog and is encouraging it to be used systematically, so better outcomes data may be available in the future.

Core Arts

Following Core Arts interventions, over 80% of clients have a meaningful improvement in their wellbeing, measured using the Warwick-Edinburgh Mental

Wellbeing Scale. Core Arts also reports a 96% non-addmission rate to inpatient services over a 3-6 month placement timeframe.

Service waiting lists

Waiting times

The average waiting time is 22 days for the WBN and 14 days from referral to treatment for TTAD. Some independent VCS services reported having virtually no waiting list, which may reflect the more flexible way in which they work. For example, Core Arts usually respond and invite clients to start within a week but at times have had to close to new referrals to manage demand. There is also some variation in how 'waiting' is defined, for example waiting to be accepted to the service, for an assessment, or for the main interventions to begin. ELFT did not provide updated waiting times data for this report but have previously reported wait times of over a year for some ELFT services, which unfortunately is not unusual for secondary care services nationally.

Waiting times for mental health services is something that is frequently brought up by resident representatives and stakeholders as a concern locally, with ELFT and TTAD referenced specifically. Some local support services reported not making referrals because of the waiting times. Anecdotally, Mind and Derman noted that a few service users complain about the waiting times for TTAD services. This feedback does not appear entirely consistent with the data for non-ELFT services at least, so it would be useful to understand more detail behind this. It may be that long wait times for certain people are obscured by the average or that specific pathways within services require a longer wait, for example the VCS pathways in TTAD are often accessed by clients with more complex life circumstances. It would also be useful to understand what the expectation of residents is and what is deemed a 'long' or unreasonable wait.

Waiting lists are a concern as mental health problems can continue to worsen without intervention, may be time sensitive, or, for some, the window where they are open to accepting support can be limited. To minimise these risks TTAD offers Silver Cloud, a digital mental health support platform, to those appropriate on their waiting list. The WBN encourages clients on its waiting list to attend its Open Access interventions and, as these are open to all residents, they can be utilised by those on any waiting list. The WBN also has introduced Mind Forward (one at a time therapy) sessions, which are available to all core clients. Clients can be seen on the same day as their consultation with the psychological therapies team, minimising waiting times for therapy specifically. ELFT did not provide information on support available while waiting.

Services will also often prioritise certain clients, for example those with the most urgent needs. TTAD prioritises perinatal, armed forces, healthcare professionals and parents of children under Child and Adolescent Mental Health Services (CAMHS). The WBN uses a triage system to prioritise those waiting for its services. Both services also regularly review capacity and demand. ELFT did not provide this information.

Lost referrals

For the WBN, TTAD and Core Arts 25%-35% of people dropped off waiting lists or from the service either before assessment or before starting the main interventions. Not much is known about these people and why they dropped off but it does indicate a high number of people who reach out for help but do not receive it. For the smaller VCS organisations who provided these data, drop outs tended to be much lower, under 5%. ELFT did not provide these data.

Derman, Bikur Cholim and Core Arts did provide some anecdotal insight into why some prospective clients may drop out, the extent of each issue is not known and there are likely other reasons too:

- Due to mental health needs or additional complexities being too great,
- Some residents need more support and encouragement to overcome initial hesitancy,
- They want to be seen sooner and choose a private therapist instead,
- They were referred by their GPs/professionals but don't actually want therapy or think it will help,

Services reported turning clients away for a number of reasons relating to contractual requirements. Several reported not being able to support clients due to their level of complexity, including cooccurring problematic drug and alcohol use, making them unsuitable for the interventions offered. Conversely the WBN had to turn down people who were not complex enough. Prospective TTAD clients not registered with a GP were also turned away. ELFT did not provide this information.

Decreasing the number of clients who are referred to the inappropriate service could improve client experience and overall system efficiency.

Demographic data

Gender

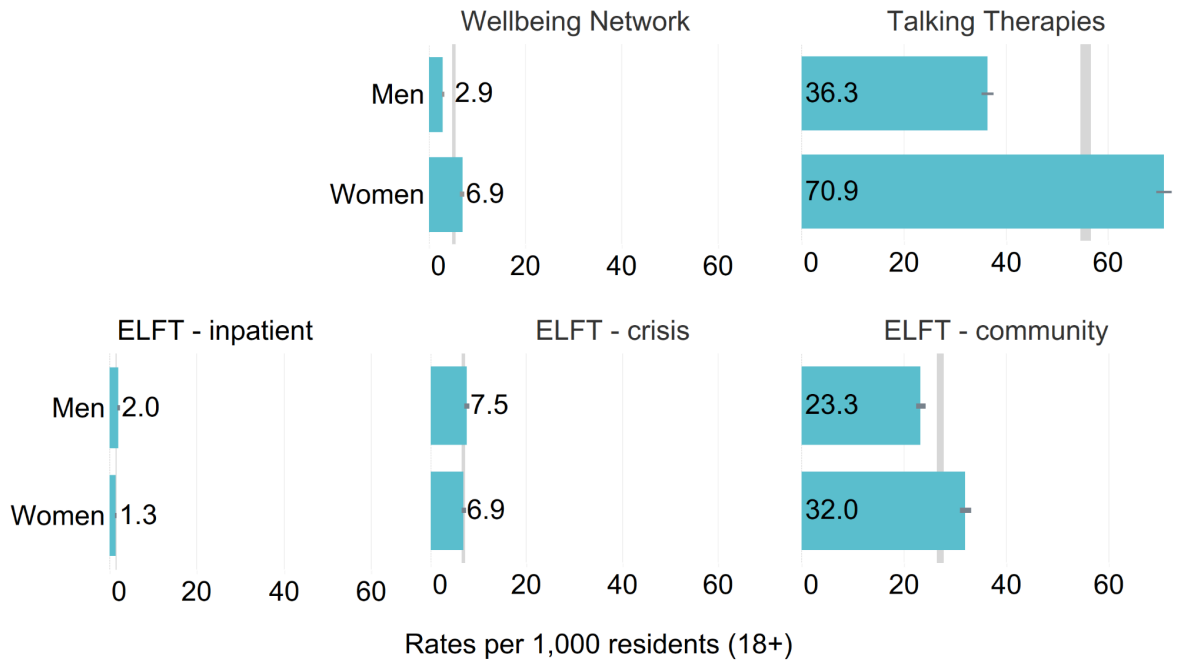
Even taking into account differences in the prevalence of mental health conditions, men are underrepresented in most of the large commissioned services locally.

In TTAD, the number of men referring to the service was 36.3 out of 1,000 about 50% of the rate for women of 70.9 per 1,000. In the local population, the number of men diagnosed with common mental health conditions is about 60% of the number of women.

The WBN had the highest relative rate of women in comparison to men, with 2.9 men per 1,000, which was 42% of the 6.9 per 1,000 population women. Local rates on prevalence of complex mental health needs are not collected, so it is not possible to determine what the comparative need is in this group. Some relevant factors, such as poverty and challenges associated with being a single parent are more common in women, but others, such as substance, are more common for men.

ELFT services had the lowest proportionate difference in rates. In ELFT community services 30.7 women per 1,000 population were seen, compared to 22.8 per 1,000 men However, as rates of SMI are actually higher in men locally than for women, this is still a notable underrepresentation of men. A higher rate of men than women accessed ELFT crisis services, although the difference is not statistically significant and a significantly higher proportion of ELFT inpatients were men.

Figure 5: Service users assessed by/referred to the WBN, TTAD and ELFT inpatient, crisis, and community services, by gender, rate per 1,000, 2024



Source: WBN: Mind. TTAD: Bikur Cholim, Derman, Mind, and Homerton. ELFT: North East London Integrated Care Board, 2025 (numerator of the rates, number of service users). Office for National Statistics, Census 2021 (denominator of the rates).
Notes: Rates were calculated by dividing the number of service users in a certain sex by the total number of residents in City and Hackney in the same sex.
Non-binary and other genders were suppressed from this analysis due to numbers being under eight.
WBN data refers to people assessed by the service in 2024. TTAD data refer to people whose referral was received by the service from 2021/22 to 2023/24. ELFT data for inpatient, crisis and community services refer to people whose referrals were received by the service in 2024. People without information of sex were included in the total, despite not being shown on the graph.

There was also variation within TTAD, which varied from 64% women in MIND and Homerton to 84% in Bikur Cholim. It is very likely that there will also be variation between the different WBN providers and the different ELFT services, though these data were unavailable for this report.

It is not clear from the data whether social issues, such as stigma relating to mental health are disproportionately affecting men and therefore making them less likely to attend services, or attend later. It could also be that services and interventions offered are less inclusive or acceptable to men than women. The latter is supported by Samaritans research, which found men gravitate towards hobby-based activities focused on meeting general wellbeing needs, rather than formal mental health or crisis services. (1)

Most City and Hackney mental health services record more genders than men and women but for confidentiality reasons, due to small numbers, these figures cannot be reported here. However, wider data show that non-binary and transgender individuals can experience unique mental health challenges and higher rates of some mental illness, so it is important that services consider how their offer can be inclusive of all genders.

Coffee Arik reported that over 90% of their clients were women. However, Core Arts, St Mary's Secret Garden and Immediate Theatre all reported close to a 50-50 split of men and women, as well as a small proportion of non-binary, transgender and other genders. This is interesting considering the above mentioned Samaritans research and does give some indication that underrepresentation of men in some of the larger services may not solely be due to an absence of need or willingness to seek support. It would be useful to get further insight into the gender distribution across more of the VCS services providing mental health support, to see if this trend persists more widely.

In the WBN and TTAD, a significant majority of staff were women, whereas in Core Arts there was a roughly an even split between men and women in their staff[7]. It is potentially interesting that in these cases staff and client gender composition roughly correlate, though more information would be needed to ascertain whether there is any causal connection. ELFT did not provide data on staff gender composition.

Age

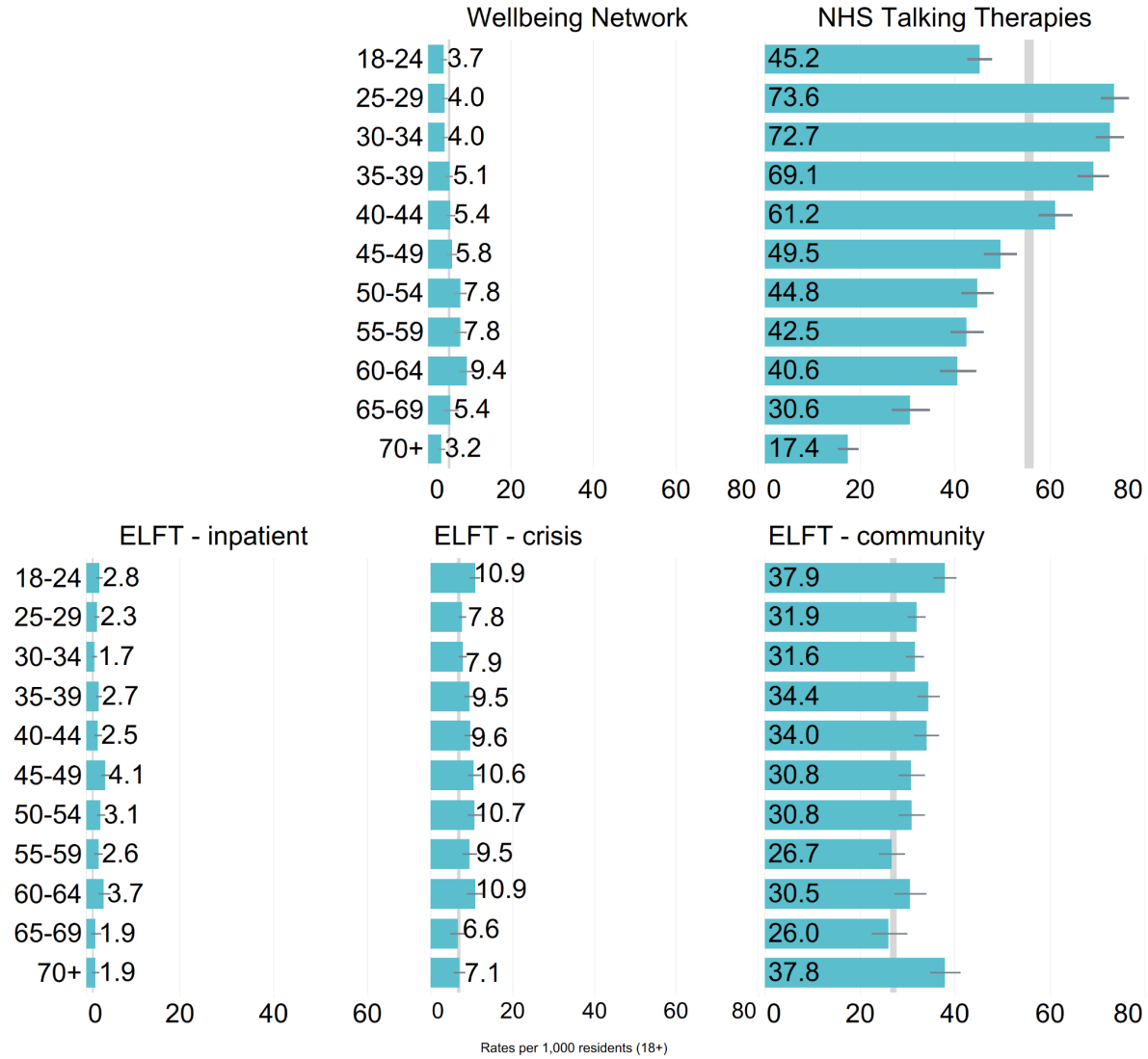
The age distribution across all three services is quite different. Broadly, rates of patients in TTAD get lower as age patients get older. Rates of patients in the service are below population estimates for those aged over 45, although the 18-24 age band is also lower than expected. Prevalence of anxiety locally is highest in the 25-39 age bands, which roughly correlates with TTAD demand. However, prevalence of depression is highest in the 50-64 age group locally and lowest for the 75+ and 18-24 age groups. Overall the evidence indicates that there is an overrepresentation of younger age groups in TTAD locally, especially as prevalence of depression is much higher than anxiety.

The ELFT community services patient age distribution is more even across all age groups, although there are still lower rates in age groups above 45, apart from the 70+ age group, which is significantly higher. The local population data show that rates of SMI are higher in age groups over 40, so this would indicate that older residents are underrepresented in ELFT community services. For ELFT crisis care, the 45-49 to 60-64 age groups had above average attendance rates and most of the younger age groups had below or similar to average attendance rates, with the exception of the 18-24 age group. ELFT inpatient age distribution was quite varied, with the highest rates in the 45-49 and 60-64 age groups.

[7] Immediate Theatre also submitted these data but the numbers were unfortunately too small to interpret meaningfully

In the WBN, rates of clients in the service increased with age up to the 60-64 age group, after which they fell again. The largest *number* of service users in the WBN is actually the young adult population, which is likely a reflection of City and Hackney's relatively young demographic (Figure 6). As information on complex mental health needs is not available for the population, it is not possible to comment on how well the age range in the service reflects the local need.

Figure 6: Service users assessed by/referred to the WBN, TTAD and ELFT inpatient, crisis, and community services, by age band, rate per 1,000, 2024

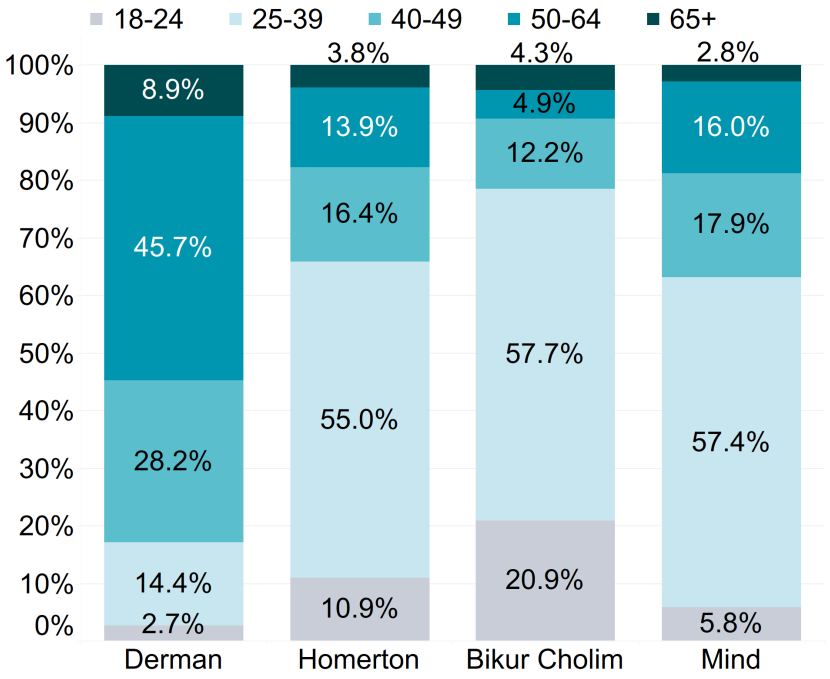


Source: WBN: Mind. TTAD: Bikur Cholim, Derman, Mind, and Homerton. ELFT: North East London Integrated Care Board, 2025 (numerator of the rates, number of service users). Office for National Statistics, Census 2021 (denominator of the rates).
Notes: Rates were calculated by dividing the number of service users in a certain age group by the total number of residents in City and Hackney in the same age group.

WBN data refers to people assessed by the service in 2024. TTAD data refer to people whose referral was received by the service from 2021/22 to 2023/24. ELFT data for inpatient, crisis and community services refer to people whose referrals were received by the service in 2024.

In TTAD, the age distribution differed across the providers. Derman had a noticeably older cohort of patients, whereas Bikur Cholim's was slightly younger (Figure 7).

Figure 7: Service users referred to NHS Talking Therapy service by age group and provider, proportion, 2021/22 to 2023/24

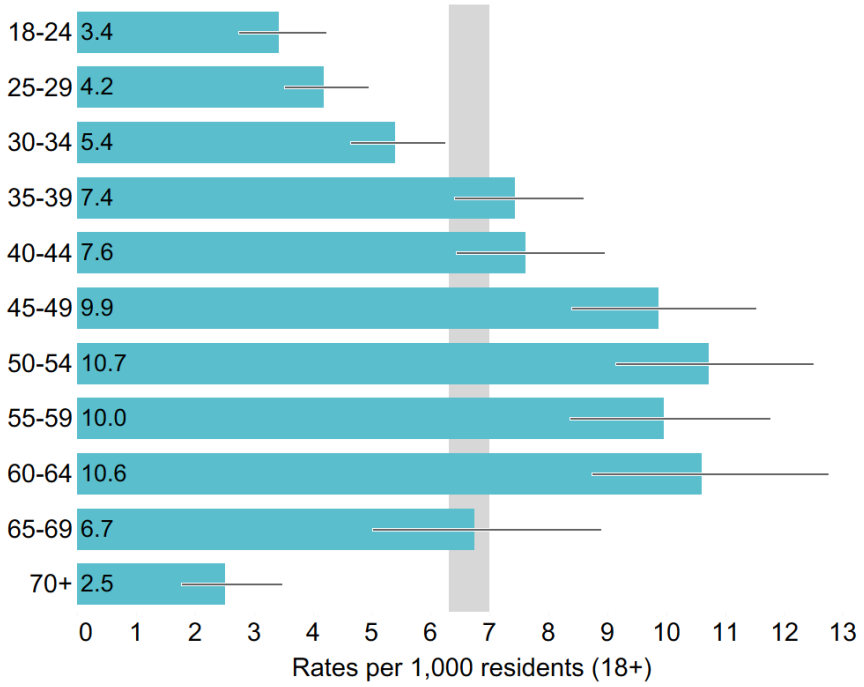


Source: Each provider Bikur Cholim, Derman, Homerton and Mind sent their data, 2025 (number of service users).

It is not clear what the reasons for the difference in age distribution at the different services are. It could be related to how they are promoted, or perhaps some interventions are more acceptable to younger people, such as talking therapies, while older people may prefer alternative interventions or community based providers.

In St Mary's Secret Garden, the majority of clients were 45 years and older. In Core Arts, rates for 35-64 year olds in the service were higher than average, with the highest rates in the 45-64 age range. Residents aged under 34 and over 70 appear under represented within Core Arts.

Figure 8: Service users referred to Core Arts, by age band, rate per 1,000, 2018-2023



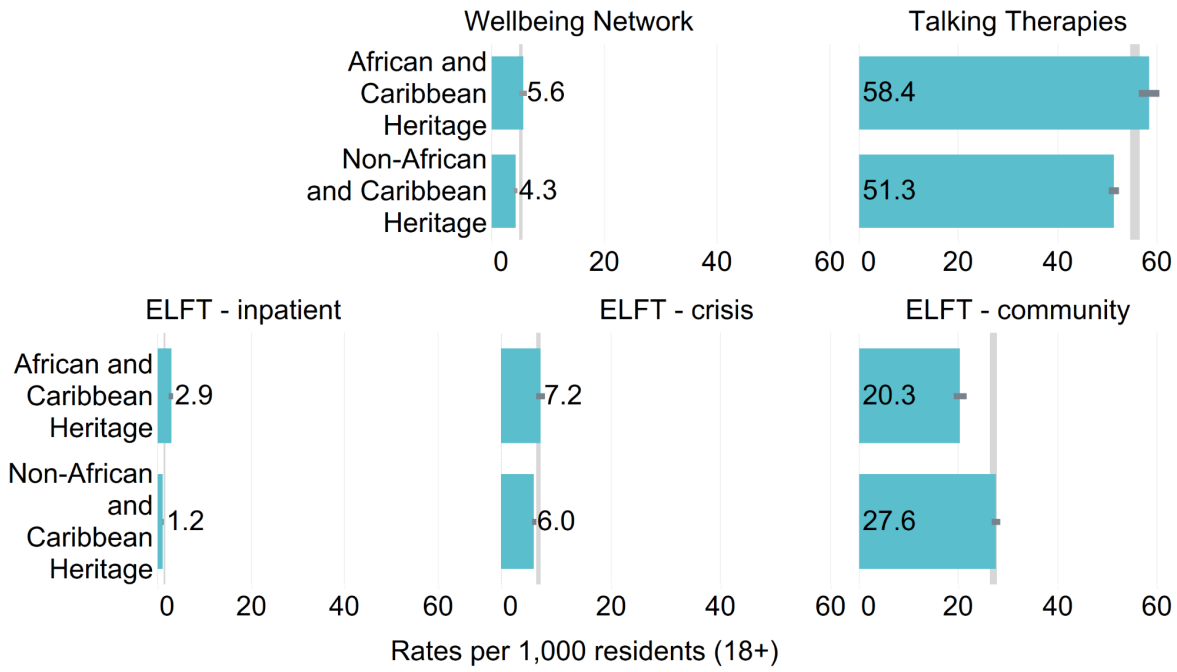
Source: Core Arts, Office for National Statistics, Census 2021 (denominator of the rates).
Notes: Rates were calculated by dividing the number of service users in a certain age group by the total number of residents in City and Hackney in the same age group.

Ethnicity

In both the WBN and TTAD, the rate of people from African and Caribbean heritage communities (ACH)[8] was similar to the rate of people from other ethnicities (Figure 9). In ELFT community services, the proportion of patients from ACH communities were lower than what would be expected based on the local population numbers but higher in inpatient services. The rates for crisis services were not significantly different.

Figure 9: Service users assessed by/referred to the WBN, TTAD and ELFT inpatient, crisis, and community services, by ethnicity, rate per 1,000, 2024

[8] ACH communities include: black African, black Caribbean, black other, mixed white and black African, mixed white and black Caribbean, mixed any other. This was based on advice from providers



Source: WBN: Mind. TTAD: Bikur Cholim, Derman, Mind, and Homerton. ELFT: North East London Integrated Care Board, 2025 (numerator of the rates, number of service users). Office for National Statistics, Census 2021 (denominator of the rates).
Notes: Rates were calculated by dividing the number of service users in a certain ethnicity grouping by the total number of residents in City and Hackney in the same ethnicity grouping.
WBN data refers to people assessed by the service in 2024. TTAD data refer to people whose referral was received by the service from 2021/22 to 2023/24. ELFT data for inpatient, crisis and community services refer to people whose referrals were received by the service in 2024. People without information of ethnicity were included in the total, despite not being shown on the graph.
African and Caribbean heritage is composed by black African, black Caribbean, any other black ethnicities, mixed white and black African, mixed white and black Caribbean, any other mixed ethnicities.

The comparatively low rate of ACH patients in ELFT community services is potentially concerning, as locally the highest rates of diagnosed SMI are in Caribbean and other non-African black ethnicity groups. black African, white and black African and white and black Caribbean ethnicity groups also have above average rates of SMI locally. As a proportion of ACH inpatients, 37% were black African, 29% black Caribbean, 24% other black ethnicity groups and 10% mixed white and black. However, completion rates for inpatient ethnicity was only 65%.

The high rate of ACH inpatients in the City and Hackney corresponds to national trends and also reflects the higher rates of diagnosed SMI in these population groups locally. However, this does not explain why there is such a marked difference between inpatient and community services. Additionally, diagnosis rates can be influenced by social factors as well as actual prevalence, so more detailed research in this area could be useful to ensure resulting actions are set correctly.

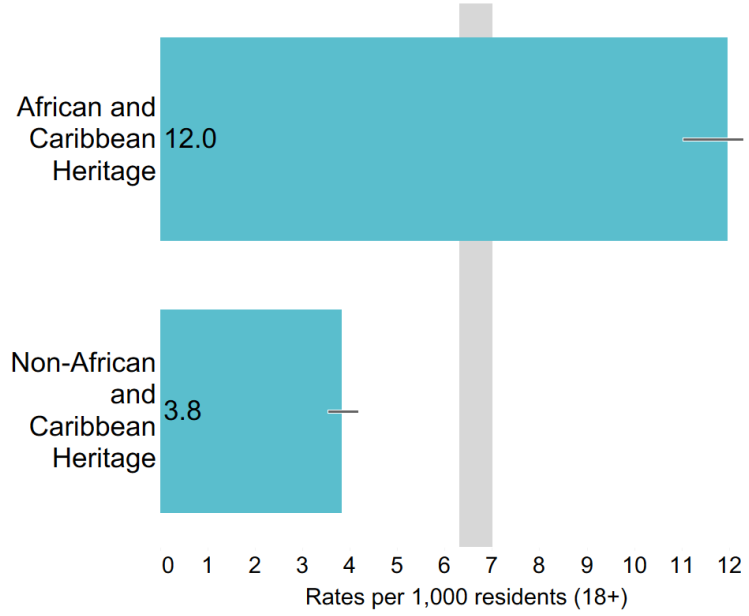
In both the WBN and TTAD, there has been a seemingly successful focus on improving representation from these previously underserved ACH communities.

In the WBN, including organisations and interventions that specifically focus on ACH population groups has played a big role in increasing representation, as has introducing a more streamlined pathway into the service for ACH clients. TTAD includes a specific pathway provided by MindCHWF.

There are notable differences in the ethnic backgrounds of service users across the different TTAD providers, with Derman and Bikur Cholim patients reflecting their Turkish/Kurdish and Orthodox Jewish focus respectively. MindCHWF clients were also comparatively diverse, including a relatively high proportion from ACH communities. This is perhaps unsurprising as a key reason for including community providers in TTAD was to increase engagement from underserved communities.

In Core Arts, ACH communities are significantly overrepresented. This may be related to a number of factors including that Core Arts sees a high proportion of residents who are diagnosed with SMI, which is higher than average in ACH communities. It may also be that some ACH residents prefer the less medicalised approach offered by Core Arts, or that this service is considered more inclusive.

Figure 10: Service users referred to Core Arts , by ethnicity, rate per 1,000, 2018-2023



Source: Core Arts, Office for National Statistics, Census 2021 (denominator of the rates).
Notes: Rates were calculated by dividing the number of service users in a certain ethnicity grouping by the total number of residents in City and Hackney in the same ethnicity grouping.
African and Caribbean heritage is composed by black African, black Caribbean, any other black ethnicities, mixed white and black African, mixed white and black Caribbean, any other mixed ethnicities.

The data is presented in just these two ethnicity categories because:

- a detailed breakdown results in some small numbers for the smaller services,
- splitting by the traditional asian, black, mixed and white is not particularly meaningful due to the diversity within these groups,
- providers requested the ACH focus due to this being a priority area of work.

It would be possible to split these ethnicity data into more categories in the future but this may need some discussion/agreement around how to categorise these data meaningfully, For example, Orthodox Jewish and Turkish/Kurdish populations are significant locally and there are specific providers for them in some of the services but these groups are often not well captured in ethnicity data, making it difficult to understand need.

Client feedback about what could increase inclusivity of mental health services often includes the importance of having staff that look like, or have similar social experiences to them. Of the services that provided this data, the WBN had the most diverse staff in terms of ethnicity, even more diverse than the local population. TTAD staff were less diverse than the local population.

Table 2: Staff ethnicity group by service[9]

	Local Population	**WBN**	**TTAD**	**Core Arts**
Global Majority	46.2%	48.6%	31.5%	33.3%
White British	34.3%	22.9%	47.7	33.3%
Other white ethnicities	19.5%	28.6%	20.8%	33.3%

Deprivation

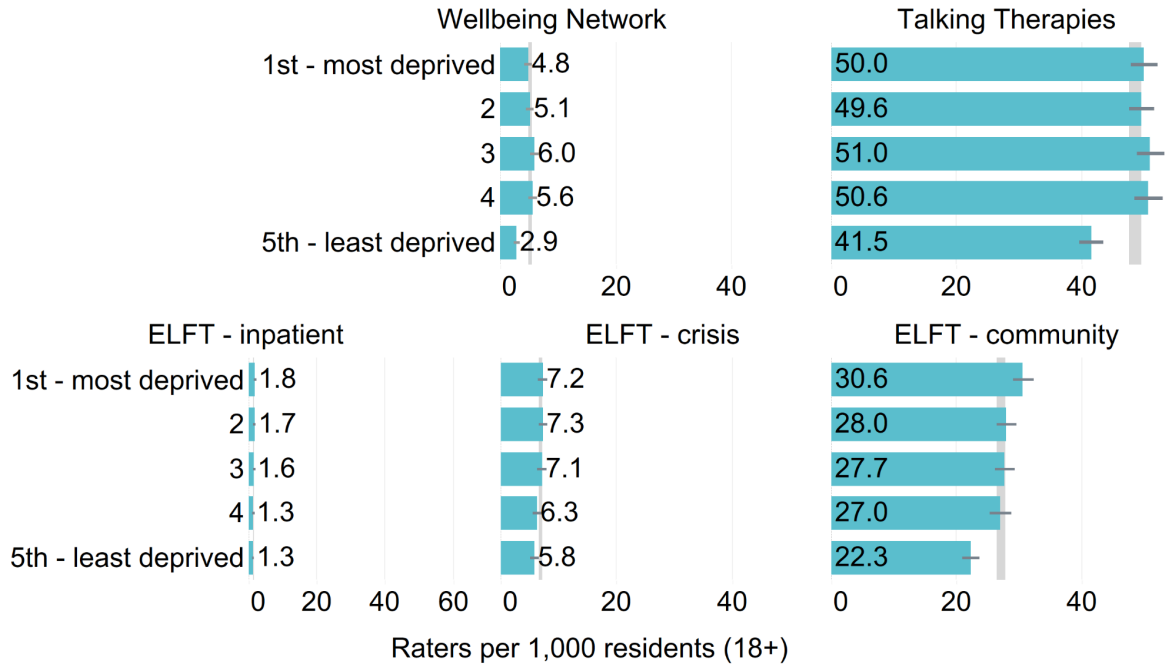
The rate of people diagnosed with mental health conditions in the City and Hackney is significantly higher among those from the most deprived areas and lower in those from the least deprived areas. Patients seen in all three ELFT services did follow a similar trend, although some differences were less marked than might be expected and many were not significant.

In TTAD there appears to be broadly similar rates of people in mental health services across all the deprivation quintiles apart from the least deprived

[9] Staff ethnicity groups were limited to these three categories due to small numbers.

quintile, for which the rate was notably lower[10]. In the WBN, the most deprived quintile had the second lowest rate of clients, with the third and fourth least deprived quartiles having the highest rates. These data suggest that people from the most deprived areas are underrepresented in the WBN and TTAD.

Figure 11: Service users assessed by/referred to the WBN, TTAD and ELFT inpatient, crisis, and community services, by local deprivation quintile, rate per 1,000, 2024



Source: WBN: Mind. TTAD: Bikur Cholim, Derman, Mind, and Homerton. ELFT: North East London Integrated Care Board, 2025 (numerator of the rates, number of service users). Office for National Statistics, Census 2021 (denominator of the rates).
Notes: Rates were calculated by dividing the number of service users in a certain sex by the total number of residents in City and Hackney in the same sex.
Non-binary and other genders were suppressed from this analysis due to numbers being under eight.
WBN data refers to people assessed by the service in 2024. TTAD data refer to people whose referral was received by the service from 2021/22 to 2023/24. ELFT data for inpatient, crisis and community services refer to people whose referrals were received by the service in 2024. People without information of local deprivation quintiles were included in the total, despite not being shown on the graph.

For the WBN, it is perhaps especially surprising that the rate is not higher in the most deprived groups, given that deprivation is often a factor in mental health complexity, which in turn contributes towards service eligibility. However, it is possible that for residents in this group, other issues, such as housing and low income are so pressing that they do not always have the time or head space to

[10] It is possible that a greater proportion of people from the least deprived group get mental healthcare privately. Similarly they may be less likely to have a diagnosis recorded with their GP, which is what is used for the local population comparator. There is, however, no evidence to show this, and practically, the impact on demand for locally commissioned services remains as reported. .

prioritise mental health or are not presenting until their mental health deteriorates further. Stakeholders have suggested that lowering barriers to entry for this group by offering more outreach/inreach may increase representation from people living in the most deprived areas.

Location (Primary Care Networks)

All three services serve residents across all the primary care networks (PCNs) in the City and Hackney. There are some similarities across services. For example, all services, apart from ELFT crisis services where the rate is still below average, see the lowest rate of people from the Shoreditch Park and City PCN. This PCN also has a lower than average prevalence of mental health conditions locally and the lowest prevalence of SMI. Hackney Marshes is in the top two PCNs seen by all three organisations, despite being more middling in terms of prevalence of mental health conditions.

Well Street Common has the highest rates of all three mental health condition categories locally and its residents have some of the highest attendance rates for all services, apart from the WBN, where the attendance rate is below average. Conversely the highest rate of clients in the WBN came from Springfield Park, whereas for all ELFT services the rates are below average for this area and about average for TTAD. The distance of this PCN from ELFT services and comparatively low rates of mental health conditions may at least partly explain this low uptake. The presence of Bikur Cholim in this PCN, a key partner in the WBN and smaller partner in TTAD, is likely also impacting uptake in the area, both because of its proximity and culturally tailored service.

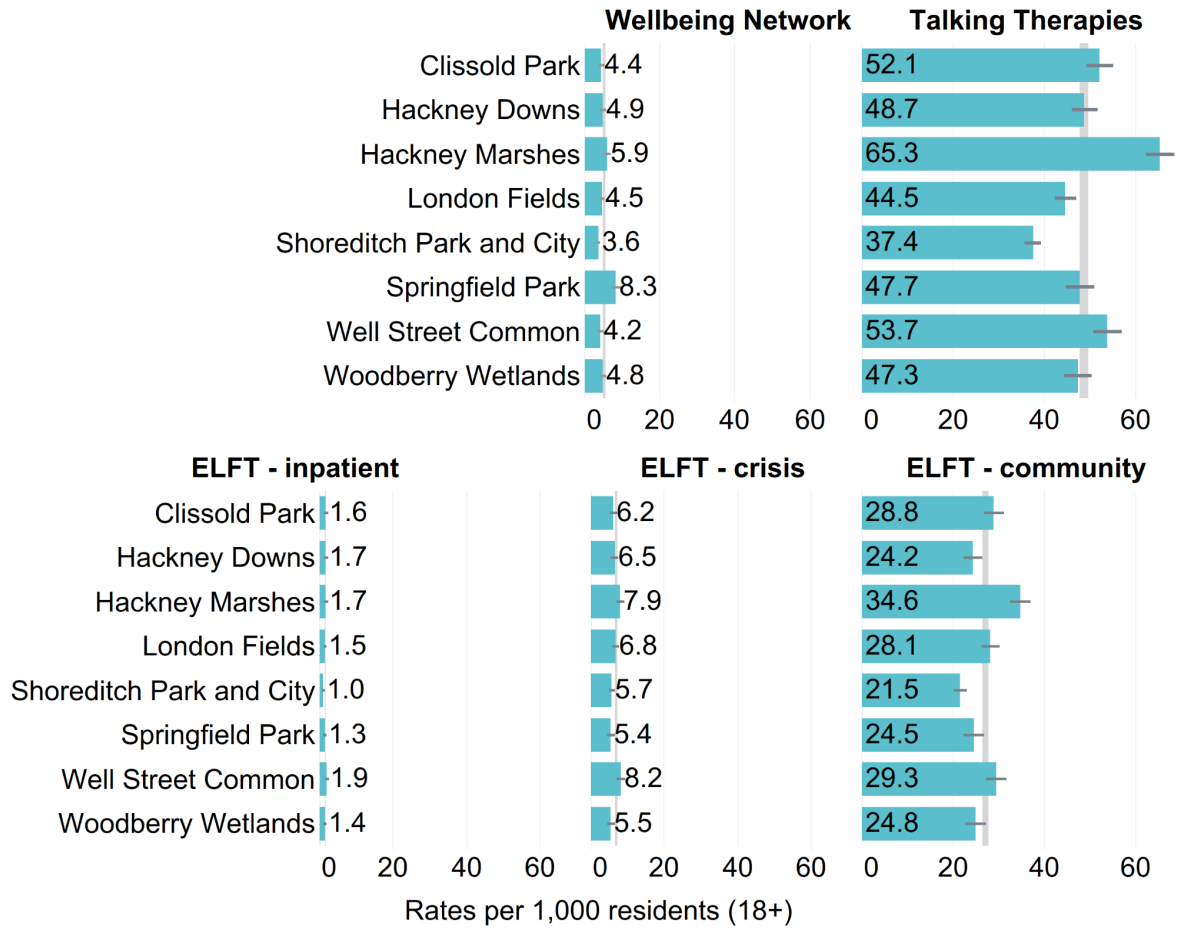
Rates for Clissold Park are neither particularly high nor low for any of the services, which is also true for SMI rates in this PCN, although common mental health condition prevalence is above average. Rates of patients were about average or a little below for Woodberry Wetlands PCN, compared to an above average rate of depression locally and roughly average rates of anxiety and SMI.

In Hackney Downs rates varied from below average for ELFT inpatient services, to above average for ELFT community services and about average for TTAD, WBN and ELFT Crisis services. Rates for London Fields were about average for all services apart from ELFT community services, where rates were above average.

Uptake from different PCNs will be influenced by a range of factors, including proximity to services (despite some virtual options being offered), local

population demographics and relative mental health needs, so fully understanding the differences and causality in uptake will be difficult.

Figure 12: Service users assessed by/referred to the WBN, TTAD and ELFT inpatient, crisis, and community services, by primary care network, rate per 1,000, 2024



Source: WBN: Mind. TTAD: Bikur Cholim, Derman, Mind, and Homerton. ELFT: North East London Integrated Care Board, 2025 (numerator of the rates, number of service users). Office for National Statistics, Census 2021 (denominator of the rates).
Notes: rates were calculated by dividing the number of service users in a certain sex by the total number of residents in City and Hackney in the same sex.
Non-binary and other genders were suppressed from this analysis due to numbers being under eight.
WBN data refers to people assessed by the service in 2024. TTAD data refer to people whose referral was received by the service from 2021/22 to 2023/24. ELFT data for inpatient, crisis and community services refer to people whose referrals were received by the service in 2024. People without information on primary care networks were included in the total, despite not being shown on the graph.

Within TTAD, the different providers reached different areas. There was a concentration of people referred to the Bikur Cholim service in the North of Hackney, aligning with the usual residence of the Charedi community. Derman referrals were spread throughout Hackney but not in the City of London. Both Homerton and Mind had service users living in Hackney and in the City of London, but Homerton service users represented 96% of the service users living

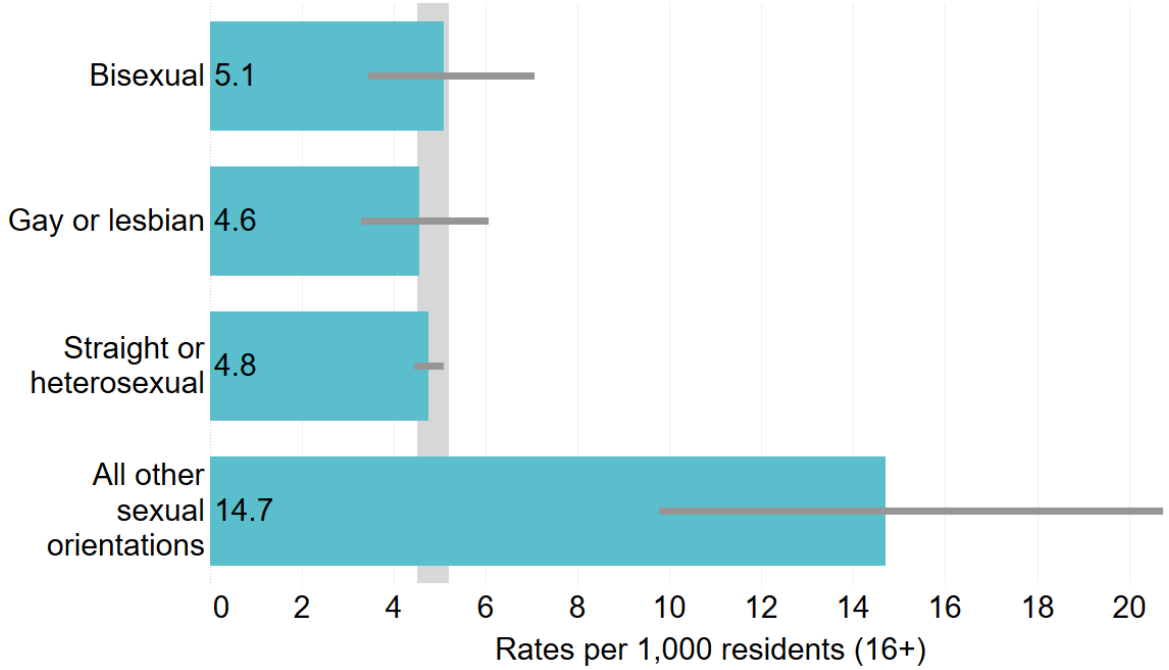
in the Square Mile referred to TTAD. Anecdotally, City of London residents are very reluctant to travel outside of the City of London for services.

Sexual orientation

In the WBN, sexual orientation was recorded for 85% of service users and of these 89% were heterosexual, 4% were gay or lesbian, 4% bisexual and 3% self-described. Where sexual orientation wasn't recorded, this was mostly due to service users actively choosing not to disclose the information (80%).

For service users identifying as gay or lesbian, straight or heterosexual, and bisexual, the rates in the WBNs reflected the relative proportion of local residents in each group. The rate of WBN service users who self-described as any other sexual orientation not previously mentioned was much higher than in the local population. While the numbers in this group were small, the difference was significant.

Figure 13: Service users assessed by the WBN by sexual orientation, rate per 100,000 adult population, 2024



Source: Mind, WBN service data, 2025 (number of service users). Office for National Statistics, Census 2021 (denominator of the rates).
Note: The average for City and Hackney band is different from the other band shown in the other WBN graphs because in this one the resident population includes people aged 16 and over due to data availability.

The representative rates of LGBTQIA+ residents in the WBN is positive, as this group is often underrepresented in services. The service has worked to improve

inclusivity for the LGBTQIA+ community, including having a specialist provider for this group (Rainbow Mind). However, given research consistently shows that LGBTQIA+ individuals in the UK experience comparatively higher rates of mental health problems, it might be expected that the rates of residents in services would actually be higher than average. Local data on mental health conditions by sexual orientation are not available.

Unfortunately it was not possible to report sexual orientation data for the other mental health services, as while TTAD and ELFT collect this, completion rates are below 20%, and 1% respectively, so insufficient for valid analysis. This is concerning as LGBTQIA+ communities report a number of issues in accessing mainstream mental health support services, such as discrimination and not feeling understood, so understanding how much this is an issue with local services is important.

Other characteristics

The WBN, TTAD and ELFT do collect other data, which would be useful for understanding local mental health needs, such as marital status, employment status, accommodation status and religion. However, completion rates were below 20% and so insufficient for a representative sample. Completion of disability status was better for the WBN and TTAD but this was not recorded consistently, e.g. different definitions were used, meaning accurate analysis could not be carried out. Similarly language data for TTAD were recorded but inconsistent.

The majority of clients working with Core Arts, Immediate Theatre, Coffee Afrik and St Mary's Secret Garden were not in work. Data on sexual orientation, housing tenure, learning disability and long term physical health conditions were also provided by Core Arts, Coffee Afrik and St Mary's Secret Garden but either completion rates were too low or insufficient information was provided to include in this report.

Unavailable data

While available mental health service data provides useful indications into where unmet needs are locally, there are also some notable gaps in the information. As a result, a full picture of local mental health needs for services is not possible.

- Data are not routinely gathered by services for all relevant population groups. For example, asylum seekers, people living in temporary accommodation, gypsy and traveller communities and people using food banks repeatedly come up as having high unmet mental health needs but these are not well captured in data, so cannot be quantified.
- Most of the data available are from services, including GPs. Residents who do not access mental health services or are not registered with a GP will not be included. It is known that some communities do not trust mainstream services and can be unwilling to share their personal details, so these communities may be underrepresented in services.
- Even if residents are registered with a service and that service does record the relevant information, residents may not disclose key details due to stigma or privacy concerns. For example, residents from Gypsy and Traveller communities often do not disclose this.
- The data available do not really account for complexities and intersecting needs, which is often where the greatest levels of support needs arise.
- Due to the amount and sometimes the completeness of data available, the analysis of subgroups for the purpose of this report was limited.

Challenges in data collection

There are a number of challenges that organisations face in relation to data collection. These include:

- Service user **privacy concerns,** especially regarding what may seem to be unrelated issues, such as relationships, housing status or employment.
- Service users' **lack of understanding of how their data would be used**.
- Limited organisational **resources and capabilities to support data collection,** especially in VCS organisations. Access to data systems, training and expertise can also be particularly challenging for VCS services.
- **Identifying measures for effectiveness of interventions is often not straightforward.** For example the WBN uses SWEMWBS but this is better suited to psychological interventions than for the more holistic wellbeing support such as advocacy education, and social inclusion. Comparing outcomes across different intervention types and for residents with different starting levels of needs is a further challenge.
- **Getting clients to complete follow up questionnaires**, so that change can be measured, is difficult as they often express frustration about the amount of questionnaires and many don't complete exit interviews or drop out before this can take place.

More positively, data collection on a number of measures, such as ethnicity, has really improved within the WBN over the last few years. This reflects huge efforts from the team to improve this, partly in response to new reporting requirements around key demographic data. There is potential learning here on how to improve completion rates for data fields.

4. Service User Experience

Service data

Satisfaction with both the WBN and TTAD is high, based on data collected by the services. Overall satisfaction rates in TTAD varied from 95%-100% each month. In the WBN 92% of service users 'strongly agreed' that they were happy with the service in 2023/24, although the numbers completing this feedback were small. ELFT did not provide service user feedback data.

Within TTAD confidence and trust in the staff, feeling involved in their care, feeling listened to and being helped to deal with their health or condition better were some of the frequent top rated areas. Similarly in the WBN, being listened to, treated with respect, skill and knowledge of staff, being helped with their difficulties and receiving the help that mattered to them were some of clients' top rated feedback.

Core Arts did not report quantitative data but themes from feedback comments include: increased confidence, improved happiness and wellbeing, being treated with respect and skills development.

While these are all undoubtedly positive results, it must be acknowledged that there may be biases in these data, such as those who are happy with the service may perhaps be more likely to stay long enough to provide feedback and perhaps be more willing to do so. It also cannot be assumed that people dropping out of services are dissatisfied, as they may do so for many reasons, including that they felt better, changes in circumstances prevented them from attending more sessions, lack of time etc. However, it would be really beneficial if there were a mechanism for capturing their data.

Wider feedback

Feedback on services was also provided by patient and resident representatives, including from other support services, as well as via various stakeholder engagement activities. Many were invited to do so anonymously

hence further details not being included. The term resident representatives will be used here to refer to all of these collectively.

Navigating the system

One of the biggest issues raised was difficulty navigating the numerous services, their different criteria, referral pathways and processes. Resident representatives highlighted ELFT services as being especially opaque and hard to navigate. Additionally some residents did not understand their offer, for example what the neighbourhood teams are, do or who they are for. Where residents have complex and intersecting needs, stakeholders reported that it is especially difficult to identify a suitable service.

The WBN and TTAD both offer a self-referral option, which can simplify the pathway in. In TTAD, 90% of patients are self-referrals, highlighting how important this option can be. In the WBN roughly a third of clients self-refer, with the rest being referred via a range of internal and external organisations. In ELFT crisis services residents can self-refer but for many of its community and inpatient services, referrals must come via GPs, which may contribute to the difficulties residents report accessing it. ELFT are currently exploring increasing the number of services to which self-referrals can be made. A benefit of GP referrals is that they can briefly assess need first and this may reduce the number of ineligible referrals and therefore people bouncing around the system.

Referral forms often rely on a level of input and proactivity from residents or referrers that is not always easy for people with complex or severe mental health conditions, or for support staff with limited time/capacity. Furthermore, referrers reported that they often did not get a response or follow up after making a referral, including to crisis services, or in some instances were turned away from ELFT due to the service being too busy.

Most providers report having significant numbers of people refer to their services where it is not actually the most suitable service for that person's needs, which is likely a reflection of the difficulties residents and referrers have identifying the right service. These residents may be referred on to a more appropriate service but there is not always capacity to do this and some people are just declined. While there are no robust data on this, anecdotally many people do not take up onward referrals and drop out of the system.

Where residents do take up onward referrals, they often report frustration at having to repeat the same information to different services, which can also be retraumatising for them, as well as increasing the time before they can get treatment.

As a result of these various difficulties, some staff from wider support services report not making referrals, especially if help is needed sooner than the system allows, or if they fear doing so will cause more harm than good in terms of future resident acceptability of support services. Some don't make referrals at all and just call the police if somebody presents with significant mental health needs.

It is worth noting that the difficulties navigating mental health services are not replicated with other support needs. Various stakeholders commented how referrals for other services like smoking cessation, substance use, employment support, housing etc. are much more straightforward. A number of stakeholders specifically requested a much simpler referral pathway for mental health.

It was acknowledged that there are a range of navigator services locally, though they often have their own criteria and usually do not specialise in mental health and may even face similar difficulties in knowing what service is most appropriate, as they are not trained to assess the different types of mental health need. It was also acknowledged that even where navigation services do work, they are only as good as the intervention they have to navigate to and rely on there being adequate capacity.

Length of support offer

Another frequently reported concern for service users is the length of support. Residents representatives and several local mental health support services (WBN, Bikur Cholim, Derman, Core Arts and Immediate Theatre) all confirmed a need for longer-term mental health support for some individuals, while acknowledging funding limitations.

How long support can be offered for is often predetermined by services, perhaps with some limited flexibility, and not based on individual resident needs. Resident representatives noted how some people move from service to service once they have used up their limits of the previous one, but this means they often run out of options and the support they do get is fragmented and is not always best suited to their needs. If residents run out of support and continue to deteriorate they can be at risk of more serious illness or crisis. While this issue was widely acknowledged, data are not available on how many residents this impacts.

Some residents also may prefer and/or benefit from a shorter course of treatment. In the WBN's Mind Forward one at a time therapy clients can choose to end or continue with treatment after each session. Interestingly 60% of clients elected to have just one session, 27% had two sessions and 13% had three or four

sessions. All these clients had requested 1:1 talking therapies as part of their care plan. These figures are also potentially interesting when considering the high drop out rates from traditional talking therapies.

In a landscape of ever more stretched budgets, providing longer-term support will be a huge challenge but not doing so may cost even more in the long run.

Insufficient or inappropriate support

Resident representatives have not only raised concerns about the insufficient capacity of local mental services but that the current support offer is not right for everyone, especially for certain population groups. Some of the most common complaints included how mental health support has been over medicalised and that it focuses too much on talking therapies. Some commented that this is a very white or western approach to mental health and that it lacks important social, activity and spiritual based support. Various stakeholders suggested more mental health support needs to be provided by VCS organisations, in addition to NHS services. Many also called for more informal support options, including safe spaces where people can go to just socialise, connect and be out, as well as more outreach into local communities.

Relatedly, the Better Mental Health fund local evaluation found that some residents with mental health needs do not want to attend interventions specifically labeled as being for mental health, often due to associated stigma or previous negative experiences. However, these residents were often open to opportunities to build skills, learn and socialise, which evidence shows improve mental health. The evaluation also noted that for some residents, trust needs to be built slowly and they will not benefit from going straight into a 6 week course of treatment with a stranger. However, once a trusting relationship is built, for example through the aforementioned activities, clients often become receptive to conversations about wellbeing and mental health support. Having staff who have a deep understanding of the challenges and stigma specific communities face also was found to strongly support the development of trust.

Many mental health service providers acknowledge the importance of more holistic and community based interventions, however, there is a tension around who should be providing these. Most mental health services are commissioned to provide therapeutic mental health support and their targets and service design reflect this. Most are NHS services, so the more clinical focus is perhaps unsurprising. Each service has specific requirements (e.g. providing talking therapies for common mental health conditions) and none have responsibility for all mental health locally or overall improvements in mental health outcomes. Even if every existing service performed perfectly, there would still be gaps

between the services, for support needs, such as more holistic mental health support. However, if not mental health services, it is not clear who should be responsible for funding or providing this.

Governance and accountability

Beyond services, there also does not appear to be an overall functioning authority structure with responsibility for mental health in totality across the City and Hackney. The closest is perhaps the Mental Health Integration Coordinating Committee (MHIC), which is made up of a number of key stakeholders and providers, though at the time of writing it has temporarily been disbanded. While this committee could potentially provide some accountability, it is not clear how it can compel action or funding decisions beyond those that individual providers or commissioners choose to make. To illustrate the issue, a collaboration of stakeholders, including MHIC members, agreed the data that should be collected for this report. However, this did not prove sufficient authority to compel all providers to share their data, despite them being among MHIC members. Many of the key MHIC members are service leads or commissioners, so there is arguably an issue of 'marking one's own homework'.

The current underlying governance structure makes it nearly impossible for a person or service to be held accountable for issues, such as many of the unmet needs identified in this report and the lack of integration between services, which causes negative resident experiences. Currently each service reports to its own commissioner and gaps in provision tend to be managed within services rather than between them. The lack of a joined up and overarching approach to mental health provision or responsible authority means that it is almost inevitable that services will not meet the needs of many residents.

Delivery channels

The way in which services are provided was also commonly raised as an issue, with services users usually having to attend the provider's location. Some population groups will be less likely to attend these locations, for reasons including, lack of time and affordability of travel. Some residents also have significant, complex needs and sometimes chaotic or difficult lives that can make attending appointments difficult. For others, they may have to prioritise certain practical needs above attending mental health support.

While some services do offer online or telephone support options, there were concerns this was not suitable for everyone, especially where social isolation was already an issue.

Many stakeholders advocated for more outreach and in-reach services, including targeting people using food banks, asylum seekers, refugees and people living in temporary accommodation, who are not well served by current services. Citizens Advice and warm hubs were also suggested for in-reach locations, with reportedly many clients with unmet mental health needs.

Cultural competency

Beneficiaries across the vast majority of the Better Mental Health funded interventions, cited feeling subject to prejudice and discrimination from public services in the borough, as well as the lack of diversity and inclusion in these services and a deep lack of cultural understanding and competency. A number of resident representatives also noted how many residents opt out of specialist mental health support due to feeling discriminated against, a lack of cultural understanding or feeling a general distrust toward mainstream health services. Some residents are reluctant to formally register with services due to concerns around how their personal details will be used.

5. Prevention

There are a wide range of individual, social and environmental factors that can help protect good mental health and prevent the development or worsening of mental health conditions. Many of these are largely beyond the remit of mental health services, including housing, income, employment, education, social inclusion, substance use, family and relationships, physical health, sleep, nutrition and experience of trauma. While very important, these are beyond the scope of this report, although there is a brief description of how some of these intersect with mental health in Section 6: 'Local Context' of City and Hackney Mental Health JSNA - Part 1: The Local Picture.

Individual behaviours and resources

There are a wide range of resources available to support individuals to build resilience and maintain good mental health, such as Five to Thrive/Five Ways to Wellbeing, Good Thinking, Every Mind Matters and Mind. Additionally there are many tailored resources for specific population groups. City and Hackney Public Health maintain a page on the Hackney Council website (hackney.gov.uk/mental-health), which provides links to many of these, as well as signposting to other relevant support. Partners also promote these resources to residents, for example on recognised mental health days.

VCS organisations provide a wide range of preventative activities, for example lunch clubs, exercise sessions, social and skills based events. Many of these offers are at risk, due to reductions in VCS funding both from voluntary contributions and commissioned services.

Early intervention

Early intervention can prevent many mental health problems from worsening and improve chances of recovery. GPs and other health professionals play a vital role in identifying potential issues as they emerge and signposting or referring residents to support services. Issues navigating mental health services, as discussed above, can make this difficult and can mean that residents may not end up seeking support until their condition has deteriorated. Feedback from services indicates that there is an increase in the number of people presenting only once their mental health problems have become more serious.

Wider support services, beyond mental and physical health, can also play a key role in prevention and early intervention and this is covered in more detail in the section below.

Wider local support

Wider local support services include those with a specific focus, such as substance use, as well as those offering more general support, such as libraries and front of house council staff. Many mental health stakeholders agreed that these services should be familiar with mental health problems, be able to provide basic mental health advice, make referrals to relevant services where appropriate and be trauma informed. However, the extent to which local support services agree with and do this at the moment varies significantly.

Some services reported their staff being skilled in identifying mental health issues and responding to them and a few even have mental health specialists within their service, which they found very helpful. Other services acknowledged that competence in this area varied across their staff, often dependent on the individual's previous experience or training. Some services reported that this wasn't something that their staff do, or that they didn't want them to. Reasons for not offering basic mental health advice or signposting include:

- Believing it is beyond the scope of their role to do so,
- Concerns it may disrupt the support they are trying to provide,

- Not knowing how or not feeling confident to bring up a conversation around mental health,
- Not knowing what basic advice/tips to provide
- Not wanting to give advice in something they are not trained in,
- Believing only mental health professionals should offer advice regarding mental health,
- Concerns that residents may react negatively or even with hostility to the subject of their mental health being raised,
- Not wanting to risk harming a positive relationship they have built with residents,
- Not having sufficient time/capacity to have the conversation, with many services already struggling to meet demand for their services' primary purposes,
- High staff turnover (trained staff and knowledge are lost)
- The person does not meet mental health service referral thresholds or eligibility criteria,
- Believing mental health waiting times are too long/that there is insufficient capacity,
- Not knowing when, how or where to refer residents to for mental health support.

It is possible a few respondents misunderstood the type of mental health support they were being asked to provide as being clinical support, perhaps reflected by comments such as procedures being to call emergency services when somebody presents with mental health needs. However, this could also suggest a lack of understanding as to how mental health needs present in many different ways and severities.

Staff training in identifying mental health issues, providing basic advice and signpositing could help overcome some of the concerns listed above. A few services do ensure that all their staff receive mental health training as standard, however, most do not see it as their responsibility to provide or fund this. These services will usually allow staff to attend externally funded courses, often resulting in just a few staff being trained. While many of these services could see the benefits of universal staff mental health training, they believe it is the responsibility of mental health services to provide. Use of online training resources was rarely considered. It was also noted that training on bringing up difficult conversations, in particular how to raise mental health in a discussion without it being taken the wrong way, would be especially useful.

City and Hackney Public Health did fund mental health training for resident facing staff, as described above, for a number of years. However, this recently ended due to funding cuts.

The extent to which wider support services interact with mental health services varies considerably, some of which will be due to the nature of the different services. Some services reported positive partnerships, regular meetings and well utilised referral pathways with both NHS and VCS mental health providers. In a minority of cases colocation occurred, which was regarded as very positive and several services expressed a desire for more of this. They felt this would help capitalise on the key moments when residents are already open to mental health support and to minimise barriers to engagement. Other services reported challenges in getting engagement from mental health services, including mental health services saying that they don't have capacity/are too busy or making referrals but not getting a response. Furthermore, even some that had established relationships felt the pathways and ways of working could be streamlined, as well as that the partnerships needed to be much wider than mental health.

Many wider support services record data on mental health for their clients. How it is recorded varies between different services from a yes/no option, to details of diagnosis. For most it is not a mandatory field to complete, so data are often quite incomplete. At present, these data are only used internally. However, if the data were sufficiently complete and reliable, getting regular updates on the mental health trend data from some of these organisations could offer potentially very interesting insight into prevalence of mental health needs locally, both generally and in specific communities.

6. Partnership Working

For the most part, each local mental health service works broadly independently from one another, with their own priorities and reporting requirements. In some ways this makes sense with the way the different mental health services are set up to treat different levels of need. However, this likely contributes to the resident experience of a complex system that is hard to navigate, with no real system or coordination between mental health services. As noted above, it is also a problem for residents whose needs do not fit well with any of the main services and fall through the gaps.

Furthermore, stakeholders and resident representatives note the frustration of residents with multiple or complex mental health needs who are supported by multiple services for different aspects of their needs with little coordination between mental health services and their other support providers. Various stakeholders also called for much more integration between mental health and

substance use services, noting how currently residents are often passed back and forth between these services, with both refusing to help until the person's other issue is resolved.

Partly in response to these challenges, services have taken a number of actions to improve client experience through improved partnership working. All the services who provided information on partnership working reported having positive relationships with other service providers and having developed referral pathways to other services. These pathways tend to be informal, rely on individual services to cultivate them and vary between services. Some services, such as Bikur Cholim have a specific member of the team responsible for developing partnerships.

The WBN has brought together a number of providers in order to provide a single integrated mental health service. The service uses shared data processing systems, implements agreed standards across providers and provides opportunities for information sharing for member organisations. The WBN also introduced an 'independent access' option, which allows clients who already have a keyworker with another service to access the Network's interventions without needing a keyworker within the service itself. This is being piloted within the Integrated Recovery Service (substance use) and ELFT Community Connectors, which is a blended VCS and NHS service. It has also developed delivery partnerships with external partners including Heads Up (ELFT), Carers First, Community Connectors, Pause/Steps, TTAD, Off Centre, Acorn House under Spitalfields Crypt Trust Hackney Recovery Service and City Libraries. The WBN is required to report on its success in developing partnerships and delivering shared services as part of its formal contract monitoring and KPIs.

TTAD works closely with CAMHS and GPs, with information sharing processes in place and also has links with secondary care and the voluntary sector.

ELFT did not provide any information on partnership working.

There are also a number of forums, such as the Psychological Therapies and Wellbeing Alliance, that bring together different mental health service providers, for a number of purposes, including information sharing, joint problem solving and decision making. However, the reach and authority of these forums have a number of challenges and limitations and there is no single board to which all services are accountable nor which is fully responsible for their combined strategic direction. The TTAD agenda is largely set nationally by NHS England, North East London ICB commission ELFT and the WBN is for City and Hackney only, commissioned by City and Hackney Public Health. Each service has its own

targets and priorities and some stakeholders have commented that some KPIs can even discourage partnership working.

These problems are exacerbated by the fact each service also uses its own data processing systems and collects data differently. There recently was an attempt to create a single shared referral form but the issues proved insurmountable.

GPs can be a valuable asset in helping to ensure a person's care is coordinated when they have multiple needs. However, GPs are not always aware when somebody is accessing mental health support in specialist services, especially those provided by VCS organisations. While it is not always possible, e.g. if the client refuses consent, notifying a person's GP can support their overall care.

GPs don't need the detail of a person's clinical notes, they just need to know:

- What services that person is accessing and broadly what interventions they are being provided with,
- Ideally contact details (named person) in case they need to speak to somebody or escalate an issue,
- How long they are receiving support with that service/how many sessions etc.,
- Any key messages or actions the person needs to take or that the GP can help support,
- Knowing high level goals would also be helpful.

7. Trauma Informed Services

Core Arts, Immediate Theatre, the WBN and all four TTAD providers all confirmed that their staff are trained in trauma informed approaches. Additionally, all TTAD high intensity therapists are trained to treat post-traumatic stress disorder and the service recently introduced a new pathway for complex post-traumatic stress disorder. In the WBN, every step of the client journey is designed to be trauma informed, including consideration of how to make the delivery environments more trauma informed. ELFT did not provide any information on this.

8. Section 117 Aftercare

Section 117 aftercare is free, ongoing support for people who have been detained in hospital under certain sections 3 and above of the Mental Health

Act. Once they leave hospital, the NHS and local council must jointly provide care and support to help them stay well and avoid going back into hospital. City and Hackney's section 117 aftercare system faces growing cost pressures that affect the whole system. With some of the highest rates of serious mental illness in the country, the borough naturally supports a large number of people under section 117, many with complex, long-term needs. However, costs are rising due to a combination of factors: very few people are discharged from section 117 (even when stable), care packages often include high levels of support to manage risk, and there is limited general needs housing or flexible community support available.

For service users, the implications are profound. Extended stays in institutional or distant settings can disrupt connections with family, peers, and local support networks; key elements of recovery. Personalised, recovery-oriented pathways risk being constrained by placement availability rather than individual need. These challenges are particularly acute for communities experiencing health inequalities, including ACH residents and other minoritised communities who are over-represented in secure care pathways. From a system perspective, the current trajectory is not financially sustainable and diverts resources from broader population mental health priorities. Strong joint working is already in place across partners, but the scale of the challenge calls for renewed focus on collaborative solutions.

The system as a whole would benefit from stronger joint governance, clearer discharge pathways, more balanced risk-sharing in the community, and better use of existing services, all working together to keep care effective, person-centred, and financially sustainable.

9. Support of Carers

Carers are people of any age who look after a friend or relative who needs support because of:

- a physical or learning disability,
- mental health problems or illness,
- impaired health due to sickness or old age,
- substance use or addiction.

Many people with mental health problems are also carers or have carers themselves and being a carer can put a lot of pressure on people's mental health. The WBN has been building partnerships with carers' organisations since the new service commenced in 2023. TTAD prioritises parents whose children are being seen in CAMHS, some of whom are carers, Bikur Cholim offer peer

support groups for carers and Derman provide counselling/group activities for them.

Recently ELFT launched a support offer for carers of their mental health patients, which aims to ensure that carers are recognised, supported and included in all aspects of mental health care. The offer includes:

- **Dedicated Carer Support Roles:** funded by the London Borough of Hackney, delivering statutory carers assessments, ongoing emotional support and coaching. 1:1 support (about 50-60 carers at any one time), a six-week strengths-based coaching course, and group programmes such as boundary setting and communication skills.
- **Education and Peer Support:** monthly psychoeducation sessions, providing carers with clinical insight and space for discussion, support for carers of adults experiencing psychosis and monthly wellbeing and peer support groups delivered in partnership with the Hackney Carers Centre.
- **Family, Friends and Carers Hub:** brings together ELFT, the Hackney Carers Centre, Turning Point and the Young Carers Service to provide a coordinated response for carers. Carers of adults admitted to hospital following mental health act assessments are proactively contacted within 48 hours and a new self referral option has recently been introduced. The hub also offers follow-up for carers linked to safeguarding enquiries and is developing a pathway to support carers who experience abuse from the person they care for.
- **Partnership and Community Offer:** carers can access counselling, grants, wellbeing activities and peer opportunities offered by voluntary sector partners, supporting both emotional resilience and social inclusion.

Of ELFT service users admitted to hospital or assessed by AMHP, 100% were screened for carers. Over the past three years, the carers service in ELFT have provided information, advice, support or assessment to approximately 950 informal carers and the service is currently on target to meet a new target of 278 assessments per year.

In order to develop workforce capacity and embed carer awareness and good practice across ELFT services, ELFT has a specific Senior Carers Lead post, who is a member of the Community Services management team. The Senior Carers Lead also sits on the ELFT Carers Strategy Implementation Group and the Hackney Carers Partnership Board, ensuring strong alignment between NHS, local authority and voluntary sector priorities for carers.

ELFT social care staff receive annual carer-focused supervision and regular training on carers' rights, duties under the Care Act, and best practice in supporting families and friends. This sustained emphasis on workforce

development ensures that carer needs are considered at every level of service delivery.

The carer support offer is still relatively new and is being continually developed and improved following stakeholder feedback.

Data on the mental health needs of Hackney carers are currently not available and this may be an area for further investigation going forwards

10. Service Response

Much of the data presented in this report will not be new or surprising to services and in many cases work is already taking place to address some of the challenges identified. This section provides an opportunity for services to share how they have been doing this and anything they plan to do as a result of this report.

The Wellbeing Network

Service flexibility and data requirements

A defining characteristic of the Wellbeing Network is its ability to adapt service delivery arrangements in response to feedback, real-time intelligence, ongoing development, and cross-service learning. The service is subject to rigorous administrative and data reporting requirements, which have presented challenges for smaller voluntary and community sector (VCS) organisations. Nevertheless, these high expectations have resulted in a wealth of data that are available for analysis, with the potential to generate valuable insights at both local and national levels.

Innovation and service delivery

The Wellbeing Network has supported and cultivated a range of innovative approaches. Notable examples include Mind Forward, which offers one session or more of therapeutic support at the point of need to address lengthy waiting times for clients with complex needs or circumstances. The service has also introduced increased digital automation for data entry and intervention registration following participation in interventions. The shared care pathway is another key innovation, strengthening collaboration between the Integrated Recovery Service (Turning Point) and Community Connectors (ELFT), ultimately enhancing the client experience and achieving system-wide cost savings.

Additionally, the Wellbeing Network provides a drop-in, open-access offer to all residents of City and Hackney. This initiative delivers effective aftercare and maintenance following discharge, community-based preventative support, and acts as a gateway for clients who may be uncertain about making a longer-term commitment to the service.

Community engagement and inclusion

Historically, engagement from the African and Caribbean Heritage communities was lower prior to 2020. In response, pilot projects were launched, subsequently leading to the integration of African Community School, Immediate Theatre, and IRIE Mind into service delivery. This inclusive approach has resulted in engagement levels among African Heritage and Caribbean Heritage populations now exceeding established service targets. The specific engagement of young black men aged 18-24 remains below target, whereas targets for young black men aged 25-30 are being met.

Data capture and inequalities analysis

The Wellbeing Network currently collects and reports data to commissioners on more than 20 inequalities categories, with a focus on intervention engagement rather than outcomes, which are presented in aggregate form. There is an aspiration to explore where improvements in outcomes for specific demographic groups are strongest, and to understand whether these improvements are linked to particular service journeys, wider structural inequalities, or a combination of factors. Such analysis would inform future resource allocation and decisions regarding the adaptation of interventions, as well as the division of funding between general and specialist providers. The infrastructure to analyse and respond to these data trends is invaluable.

We are proud of our diverse and talented staffing that constitute the integrated service.

We would encourage commissioners commissioning services across the mental health system to adapt similar frameworks for capturing inequalities KPIs both for active engagement in service and outcomes. This will ensure fairer allocation of resources based on local need, population health information and shared learning between statutory and VCS where providers are excelling in certain areas.

Enhancing service provision for men

The service is committed to improving data capture and reporting. With regard to poorer outcomes and engagement among men, consideration is being given

to the integration of more male-focused groups. In 2015, MindCHWF piloted male-specific groups with positive results, though this initiative was supported by a dedicated budget. Pilot projects that feature homogeneity in protected characteristics within groups have often yielded positive outcomes. Given the current funding constraints, careful thought is required before progressing with further targeted provision. Demand for the Wellbeing Network continues to exceed capacity across all characteristics and demographics KPIs (for which there is evidence of poorer mental health outcomes throughout the lifespan).

Decisions must be made about balancing the response to those seeking support through the Wellbeing Network against allocating specific resources to targeted audiences.

Collaboration and future funding

The Wellbeing Network remains committed to ongoing collaboration with the eight Voluntary and Community Sector providers who make up the Wellbeing Network (African Community School, Bikur Cholim, Centre for Better Health, Core Arts, Derman, IRIE Mind, MindCHWF, Shoreditch Trust) and the broader mental health system, with the aim of learning from one another and improving support for local people. The enormous amount of service re-design and adaptation that has occurred in the last 3 years has been a testament to the ingenuity, flexibility and resilience within the voluntary sector. To cost effectively sustain and build upon this community offer and the learning, talent, and service structures established, sustainability of funding beyond 2027 is required.

Talking Therapies for Anxiety and Depression

TTAD did not provide a full response but work to address some of the challenges raised in this report includes:

- Closer work with VCS providers to help the service to reach previously underrepresented groups
- Expanding the range of support offers the service can provide (e.g. to include support for complex PTSD)
- The new physical activity pilot, meaning the service will be offering a more whole person approach
- Trialing new days of delivering therapy, including digital therapies.

East London Foundation Trust

ELFT did not provide a response but work to address some of the challenges raised in this report includes:

- The Service User Network group, allowing service users to access peer support following discharge
- CIty Street Triage and Right care right person, supporting people to get the appropriate support in response to crisis
- Improvements to the crisis response offer, including the crisis line, to ensure that patients are able to speak to somebody more quickly and that they get the appropriate support they need.

=

References

1. Samaritans [Internet]. [cited 2025 Oct 2]. Engaging men earlier. Available from: https://www.samaritans.org/about-samaritans/research-policy/middle-aged-men-suicide/engaging-men-earlier/

Appendix 1: Data completeness

	Completeness of recording				
Service	**Gender**	**Age**	**Ethnicity**	**Deprivation**	**PCN**
Wellbeing Network	98%	99%	88%	100%	100%
TTAD	98%	100%	95%	100%	100%
ELFT community services	100%	100%	92%	100%	100%
ELFT Crisis services	100%	100%	86%	100%	100%
ELFT Inpatient services	100%	100%	97%	100%	100%

Source: WBN: Mind. TTAD: Bikur Cholim, Derman, Mind, and Homerton. ELFT: North East London Integrated Care Board, 2025 (numerator of the rates, number of service users). Office for National Statistics, Census 2021 (denominator of the rates).
Note: The proportions have been rounded to whole numbers.

Completeness for deprivation or PCN fields will always be 100%, as they are calculated using postcode data. As postcodes are what was used to select the data in the first place, in order to identify somebody as living in the CIty or Hackney, every record must include one. If any records do not include postcode data, these will not be included in the analysis.

Appendix 2: Wellbeing Network Providers

The Wellbeing Network is a service delivered by a range of voluntary and community sector partners, as described in the report. Below is a short summary about each of the providers. Further information can also be found on their respective websites.

Mind City, Hackney and Waltham Forest
MindCHWF are an independent local charity who are community rooted: most staff are local, have lived experience and every year work with 4,000 people within City and Hackney. MindCHWF's holistic services are funded by contracts, grants and donations. They provide general and specialist support. The service offer includes psychoeducation groups, 1:1 psychological therapies and peer support alongside welfare and benefits support service. MindCHWF are community minded with a focus on reducing isolation and health inequalities and creating connections. They have a specialist LGBTQIA+ offer through Rainbow Mind and a specialist ACH offer through IRIE Mind. They lead a suicide bereavement postvention service for adults, children and young people and contribute to suicide prevention initiatives across North East London. MindCHWF offers mental health training and bespoke employee support for organisations and community groups. They respond to local needs and innovate new ways to deliver services. MindCHWF strives to improve the local health system through thought leadership and collaboration with partners.

Derman
Since its inception in Hackney in 1991, Derman has been offering health and social care services to all Kurdish and Turkish speaking communities irrespective of their ethnic, religious and political backgrounds. Services are offered freely reaching thousands of residents each year. Derman's recovery rates are high (consistently around 60%) and it engages very well with Kurdish and Turkish communities. Derman is also BACP accredited, annually passes NHS digital's Data Protection Toolkit, is a Trusted Charity of NCVO and is Advice Quality Standard accredited to provide Welfare Advice.

Core Arts
Core Arts enriches the lives of socially excluded people with severe mental health issues through creative education and emotional support, helping individuals realise their artistic potential. Based in Hackney, Core Arts is an award-winning mental health creative education centre that has delivered user-led services since 1992. We offer courses in arts, music, horticulture, multimedia and sport. Core Arts promotes positive mental health through the arts in a supportive, college-like community that empowers members to overcome

barriers, lead fulfilling lives and experience social inclusion. With a 96% non-readmission rate, many members break the cycle of hospitalisation. In partnership with the NHS, its programme offers intensive wraparound support for clinically referred individuals. Core Arts welcomes people from marginalised and minority communities, especially those who may not feel able to engage with traditional services or mainstream arts opportunities. Our mission is to promote recovery, social inclusion and wellbeing through the use of arts.

IRIE Mind CIC
IRIE Mind is a community-led, culturally specific black, African, and Caribbean mental health and wellbeing service, for the people, by the people. Operating across the City of London and Hackney, the service supports adults (18+) through culturally grounded talking therapies, psychosocial groups, and 1:1 community-based support. IRIE Mind addresses racial trauma, systemic inequity, and the impact of severe mental illness (SMI) and chronic health conditions that are particularly common within these communities, While also supporting the "worried well" – individuals experiencing early signs of emotional distress or seeking to maintain positive mental wellbeing.

Culturally specific Mental Health First Aiders (MHFAiders) provide Mental Health First Aid support, outreach, and signposting to raise awareness, reduce stigma, and promote early engagement with services, including culturally specific support. Programmes such as Black Men's Support Group, MADE, ACT for Racial Trauma, Nyam Well 4 Better Health, and the Front Room Drop-in Space promote healing, resilience, and community connection. IRIE Mind is a BACP-accredited service and supports the principles of the Patient and Carer Race Equality Framework (PCREF) and the wider health equity agenda.

Shoreditch Trust
Shoreditch Trust is a community-rooted anchor organisation with over 25 years' experience in delivering civic, health, and wellbeing programmes across Hackney and the City. It supports those most likely to experience health, social and economic inequalities, including isolated older adults, people with long-term health conditions, vulnerable young people, and women facing multiple disadvantages during pregnancy and early parenthood.

Shoreditch Trust's work is grounded in lived experience, peer support, and strong local partnerships. It delivers holistic, person-centred services through outreach, 1:1 support, and group activities. The We Connect programme includes coaching, mental health support, community meals, volunteering and peer facilitated groups, that build resilience and connection through creative group activities.

Shoreditch Trust supports people at community hubs across Shoreditch Park and the City, and actively collaborates with statutory services, schools, and voluntary sector partners to ensure inclusive, coordinated support that strengthens individual wellbeing and community resilience.

Centre for Better Health
The Centre for Better Health is a registered charity that supports wellbeing and recovery from mental ill health. It provides a range of services in a trusted, community-based, non-clinical setting: low-cost counselling; low-cost creative, movement and therapeutic groups; as well as work-skills training placements to help provide in-roads into employment for those who are out of work and struggle with their mental health.

Each of the services provided places an emphasis on developing supportive and therapeutic relationships with clients, in order to effectively support wellbeing and recovery from long-term mental ill health. The service supports individuals to achieve personal growth, improve wellbeing and quality of life, and make employment progression where relevant. Centre for Better Health's vision is for individuals to lead satisfying and hopeful lives in a society without any stigma around mental ill health.

African Community School
African Community School works with children and families in need to build their confidence, learn new skills and empower them to gain employment. They conduct flexible and affordable, OCR and NCFE accredited educational and training sessions. African Community School promotes community cohesion by ensuring their services are accessible to all ethnic groups in the community.

Bikur Cholim
Bikur Cholim provides a wide range of practical and emotional support services, with an emphasis on empowering people no matter their situation. They provide personalised support according to each person's individual needs with sensitivity, compassion and confidentiality. Bikur Cholim's dedicated team of 45 staff members and over 400 volunteers are trained to deliver person centred support 24/7, 365 days a year.

Appendix 3: The Wellbeing Network Peer Pathway Case Studies 2024-25

Case Study 1:

"I officially became a Peer and felt embraced"

"I have 'climbed' in my journey to becoming a more self-confident individual. This is primarily due to the course sessions of the Peers Leadership Programme. It has positively impacted my confidence, management skills and public speaking skills"

"The peers pathway opens opportunities for people in recovery, to be a part of a network of supportive peers. For them to take ownership of their recovery. For them to utilize their lived experiences and to be a source of encouragement and empowerment to others."

What led you to the WBN?
I went through nineteen years of a bad and controlled marriage and lost almost all that strong independent female I used to be. I was suffering with depression and high anxiety where my mouth and body began shaking. I called the GP for more anti-depressants but was refused. I was referred to Talk Therapy instead, then to Irie Mind.

How did you discover the Peer Pathway?
I was introduced to the Peers Leadership program via IRIE Mind who assessed me and, as a result of completing this, I officially became a Peer and felt embraced.

What accomplishments are you most proud of during your time in the programme?
I now have the opportunity and support to run my own group within the wellbeing network. I must say that I have 'climbed' in my journey to becoming a more self-confident individual. This is primarily due to the course sessions of the Peers Leadership Programme. It has positively impacted my confidence, management skills and public speaking skills, as I had to prepare a speech (with complete and non-forcible support), and present it in front of a large audience.

What are your next steps in the Peer Pathway and beyond?
My plan is to deliver a group to encourage others to communicate their emotions, feelings, thoughts and expressions without judgement. Let them know that creative techniques can release anxiety and pent-up emotions and stress. There is no right or wrong way to be. Mistakes are allowed. Perfection is not allowed. The point of the group is to give acknowledgement to each person,

to give the drive and determination to carry onward and above. It will make them feel as if they are somebody, if others made them feel otherwise.

Any additional comments or suggestions for the team or other peers?
The peers pathway opens opportunities for people in recovery, to be a part of a network of supportive peers. For them to take ownership of their recovery. For them to utilize their lived experiences and to be a source of encouragement and empowerment to others. I was at a point of low and desperation. I did something about it. I continued to be supported. Now I am planning on running my own group, with continued support.

Case study 2:

"One of my main motivations for joining was to overcome my fear of speaking in groups."

"The exchange of ideas was both refreshing and inspiring, offering me new ways of thinking and problem-solving."

"My next goal is to build on the skills and confidence I have gained and apply them to future leadership and community projects."

How did you discover the Peer Pathway?
A friend recommended the Peer Pathway programme for its focus on leadership development. Having already taken part in leadership roles elsewhere, I saw this as an opportunity to expand my knowledge and strengthen my skills.

I have always believed that learning is a continuous process, and that there is always room to grow. One of my main motivations for joining was to overcome my fear of speaking in groups. In the past, I often went blank or became overwhelmed when addressing others. That anxiety made me rush through what I wanted to say, simply to get it over with.

Through the Peer Pathway, I wanted to build confidence, manage my nerves, and learn to communicate more clearly and effectively. I also wanted to develop my ability to speak from the perspective of others, to engage with people in a way that is understanding and empathetic. My goal was to move beyond speaking just for myself and instead communicate in a way that connects with and resonates with others.

What accomplishments are you most proud of during your time in the programme?

Throughout my time in the programme, I have achieved real personal and professional growth. I am proud of how much I have developed my confidence and communication skills, especially my ability to help others by speaking openly and honestly. That was something I used to find very difficult. I have really valued working alongside peers who brought such diverse experiences and perspectives. The exchange of ideas was both refreshing and inspiring, offering me new ways of thinking and problem-solving. Each person's input contributed to a richer, more dynamic learning experience, and that collaboration became one of the highlights of my journey.

What are your next steps in the Peer Pathway and beyond?
Although I have recently been unwell, I remain committed to continuing my journey within the Peer Pathway. My next goal is to build on the skills and confidence I have gained and apply them to future leadership and community projects. I am determined to keep improving my communication abilities and to use my lived experience to support and uplift others.

Any additional comments or suggestions for the team or other peers?
I want to express my deep appreciation for the entire team behind the programme and the dedication they show to every participant. The Peer Pathway has been delivered with care and professionalism and has provided a truly empowering and inclusive environment for everyone involved.

Appendix 4: Services in the City and Hackney Public Health team that influence mental health of our residents

Community Wellbeing Team

The City and Hackney Community Wellbeing Team is a collaborative effort that brings together local support services for residents who traditionally do not access conventional settings.

All residents are welcome, but especially those who are:

- rough sleepers.
- struggling with alcohol and substance use,
- asylum seekers.
- sex workers.
- members of the Gypsy Roma Traveller community,
- in contact with the justice system,
- other socially excluded groups,

The team parks in various locations across Hackney and the Square Mile. They offer different services and information on different days, from Monday to Friday.

PAUSE

PAUSE provides a psychologically informed, bespoke 18-month programme of interventions for women who have had children removed from their care. Each programme is developed around the goals and aspirations women have for themselves and aims that no woman should ever have to experience the removal of a child more than once.

STEPS

STEPS provides a specialist, intensive outreach programme, delivering relationship-based, trauma-informed practice to a population of adults in the City of London and Hackney. To be eligible, the person would have experienced three or more disadvantages, these include: substance use, enduring psychological distress and trauma histories, homelessness, and involvement in the criminal justice system. STEPS supports these adults to gain greater control over their lives and to improve their health and wellbeing.

Gambling harm

City and Jackney Public Health arranged for frontline staff to be trained in gambling harm with Gamcare in 2024. The frontline staff were representative of various services such as customer service, housing needs and benefits, Turning Point, and the City Police. The aim is that these staff can support people, and

avoid gambling harmful effects such as low self-esteem, addiction, poor sleep and appetite, stress related or mood disorders like depression and anxiety, and even suicidal thoughts, as well as impacting relationships, employment, and overall wellbeing.

Substance use

The City and Hackney Recovery Service, run by Turning Point, is the service commissioned by the City and Hackney Public Health Team to support people with substance use needs in the local area. It is the main service in the area, delivering individual and group support. It has subcontractual agreements with Mind.

As part of its support offer, professionals work with individuals to develop a long-term personalised care plan to reduce harms from substance use and improve their mental health. This plan is agreed with a key worker, and supported by them, using a motivational approach in the sessions. The group-based psychosocial interventions combine different talking therapy approaches to develop motivation to modify their substance use behaviour, manage feelings that can trigger it, and build skills to regulate their emotions and be more mindful. These groups are delivered by a licensed psychologist. This supports long-term recovery and resilience.
Turning Point also has a subcontractual agreement with Mind, which supports them to work together on cases and easily refer people who have both ongoing mental health and substance use needs. In the UK, 72% of adults who started treatment for substance use in the UK between 2023 and 2024 reported a mental health treatment need.

As part of the work of the City & Hackney Combating Drugs Partnership (CDP), Turning Point is currently working together with the East London Foundation Trust, Mind, and TTAD to improve integrated support for people with cooccurring mental health and substance use needs. These efforts include:

- Improving communication and information sharing systems and protocols between services,
- Upskilling the mental health and substance use workforce to deliver effective interventions for people with cooccurring mental health and substance use needs,
- Piloting care teams that integrate mental health and substance use professionals,
- Streamlining referral, assessment, and triage pathways to ensure appropriate access to support.

Support When It Matters (SWIM) is also commissioned to provide mental health and substance use support both for individuals and groups-based support focused on substance use. The service uses similar motivational techniques, but is specifically for people from African and Caribbean heritage who are registered at a GP within four of Hackney neighbourhoods and experience complex needs. In addition to the service users, SWIM supports professionals through cultural competence awareness training.

Lastly, the East London Foundation Trust has just been commissioned to provide more integrated support for people with cooccurring mental health and substance use needs. As part of this service, mental health nurses work within the City & Hackney Recovery Service to deliver sessions jointly with Turning Point staff focused on improving their mental health in line with their substance use. They will also lead on case management to ensure that service users receive appropriate and coordinated support between other mental health and substance use professionals.

Domestic violence

The Domestic Abuse Intervention Service (DAIS) is jointly commissioned by City and Hackney Public Health and the North East London Integrated Care Board (ICB). From April 2023, the service has been delivering training to increase the early identification of domestic abuse cases and case consultations to discuss cases of individuals identified as being at risk of serious harm. The service aims to support practitioners working directly with residents in City and Hackney by increasing:

- awareness and understanding of the different types of domestic violence and abuse among frontline practitioners, and the referral pathways within City and Hackney,
- referrals from frontline practitioners to domestic violence and abuse services,
- prevention and early identification of domestic violence by frontline practitioners.

DAIS focuses on staff working within NHS and local authority services (including Hackney Council and the City of London Corporation), the voluntary and charity sector (VCS) and external agencies such as the Metropolitan and City of London Police and the London Fire Brigade. The service is a way of improving access to domestic abuse support agencies and therefore, promoting access to mental health services to these victims with high mental health needs.

Further information is available in the Early Identification Domestic Abuse Needs Assessment (2022).

Stop smoking service

Smokefree City and Hackney is the local stop smoking service for adults and children (12+ years) who live, work, study or have a GP in Hackney or in the City of London. They offer 12 weeks of support to help you quit, with your own dedicated stop smoking advisor and easy access to stop smoking medication. Further information regarding smoking in City and Hackney is available in the Tobacco Needs Assessment for City and Hackney (2024).

Physical activity

There are some initiatives promoted by City and Hackney to encourage people to move. Further information is available in the Healthy Weight Needs Assessment for City and Hackney (2024).

City and Hackney Adult Mental Health Joint Strategic Needs Assessment

Part 3: Local Challenges and Recommendations

2025

Authors
This report was written by: Jennifer Millmore (Senior Public Health Specialist), Mariana Autran (Public Health Analyst) and Tom Moore (Public Health Analyst)

Report Approvers
This report was approved by Andrew Trathen

Acknowledgements
We would like to sincerely thank everyone who has contributed towards the production of this report, including our commissioned providers and wider system partners, colleagues in the Public Health team and wider Council colleagues and City of London Corporation colleagues.

Cite this report as:
City and Hackney Public Health. City and Hackney Adult Mental Health Joint Strategic Needs Assessment, Part 3: Local Challenges and Recommendations. (December 2025)

Contents

Abbreviations and acronyms 4
1. Introduction 5
2. Navigating and Accessing Services 6
Recommendations - navigating and accessing services 8
3. Inequalities and Inclusivity 9
Sexual orientation 10
Ethnicity 10
Deprivation 10
Gender 11
Age 11
Complex mental health needs 11
Residents living in temporary accommodation 12
Residents experiencing rough sleeping 12
Gypsy and traveller communities 12
Refugees and asylum seekers 12
Recommendations - inequalities and inclusivity 13
4. Data 14
Insufficient data available or shared 15
No overall oversight and accountability 15
Different Data Systems 15
Additional data challenges 15
Recommendations - data 17
5. Governance and Accountability 18
Recommendations - governance and accountability 20

Abbreviations and acronyms

ACH:	African Caribbean Heritage
ELFT:	East London Foundation Trust
GP:	General Practitioner
LGBTQIA+:	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and all other related identities
NHS:	National Health Service
SMI:	Severe Mental Illness
TTAD:	Talking Therapies of Anxiety and Depression
VCS:	Voluntary and Community Sector
WBN:	Wellbeing Network

1. Introduction

This report summarises the challenges identified in the City and Hackney Mental Health JSNA - Part 1: The Local Picture and Part 2: Local Services and makes recommendations for how to address these. Four main themes emerged:

- Difficulties experienced by residents in accessing and navigating local mental health services,
- Inequalities in mental health need and how inclusive services are,
- Gaps in the quality of insight, driven by fragmented data and inconsistent approaches, limiting effective decision-making,
- The underlying accountability and governance structures for mental health.

While discussed the least in the reports, the accountability and governance issues appear to underpin the other three and their success is likely to be limited if these governance and accountability issues cannot be solved.

Also underlying all of the challenges outlined below are high levels of mental health needs in the City and Hackney.

- Rates of common mental health conditions have been increasing in the City and Hackney over the last decade, reflecting national trends.
- Hackney's rates of common mental health conditions are higher than the London average, though similar to England.
- Rates of severe mental illness (SMI) have remained relatively stable in the last decade but Hackney's rates are about 50% higher than the London and national averages.
- While the City of London's rates of SMI and common mental health conditions are lower than the national and London averages, there are still some communities with high levels of mental health needs.
- Often some of the greatest levels of need are found where mental health intersects other areas of need.
- Despite the increasing mental health need, there is already insufficient funding to meet demand. This is likely to be a challenge for the foreseeable future.

2. Navigating and Accessing Services

One of the most common complaints from stakeholders and residents is that mental health services are complicated to navigate.

The challenges raised include:

- There are a **number of different services** and it is **difficult for residents and support workers to know which is most appropriate for who.** Support workers report that they often make a referral to a general practitioner (GP) or emergency services, rather than to the correct service due to this.
- Staff from wider support services can be valuable in helping residents to navigate systems. However, it is arguably **not realistic to expect them to have in-depth knowledge of all mental health services, the types of mental health and other relevant intersecting factors, in order to know which service to recommend** in each case. Mental health is just one of many issues resident-facing staff frequently encounter and some of these staff have requested a single point of referral for mental health.
- **Many residents are initially referred to the wrong service**. Some are then referred on to a more appropriate service and others are told they are not eligible and perhaps given some generic information on other support available. This can all be time consuming and therefore costly to the original service, as well as a negative experience for the resident, who may not persist with help seeking.
- **When residents do move between services they get frustrated repeating themselves multiple times**. Work was undertaken a few years ago to try and design a shared referral form but the challenges around different data systems, different collection requirements and information governance proved insurmountable at the time.
- **Some services require a GP referral** and do not have a self-referral option, including many East London Foundation Trust (ELFT) services. **This can add extra steps for residents in getting support** and **excludes anyone not registered with a GP**. It may also put off anyone who does not have a good relationship with their GP or struggles to get GP appointments. While Talking Therapies for Anxiety and Depression (TTAD) allows self-referrals, it does require GP registration.

- **Long waiting times** are one of the most frequently raised concerns and can mean that **by the time a resident is seen by services their condition has deteriorated or their willingness to engage and trust services has been eroded**. Many services do have fairly low average waiting times, so more information on where the issues are occurring would be helpful to understand where action is needed.

- **A high proportion of residents drop out of larger commissioned services** (It is unknown whether this includes ELFT as their data were not made available). Very little is known about why these residents drop out having asked for help, or who they are (e.g. whether some population groups are more likely to drop out).

- Even when residents are accepted into a service, **the support may not last long enough or lead to recovery,** and their condition may deteriorate. They may keep seeking help from other services or present again in a more serious state, e.g. crisis. Ensuring residents get the right care earlier could lead to better outcomes and experiences, as well as save resources.

- **Some residents require ongoing support** as a result of their condition but there is very limited ongoing provision available.

- **Residents with complex needs often need to go to a different service for each of their needs**. This can be very difficult for people who may already be experiencing chaotic and challenging lives. Residents report wanting to be able to go to one place (or at least fewer places) for all their needs and **many support services and resident representatives advocate for more mental health outreach/in-reach.**

- **Some residents are excluded from mental health services due to co-occurring needs,** such as substance misuse. They often do not have the option to be supported for multiple needs by one service (or by organisations working in partnership).

- While for many they are effective, **some residents don't feel the mental health interventions available are well suited to their needs.** Some feel that they have a Western or white bias and focus too much on talking therapies, when there are other ways to support mental health.

- **Even when signposted to mental health services, many residents will not follow through**, sometimes because that key moment of help-seeking has passed or because they do not trust the signposted services. Therefore, capitalising on when and where residents are receptive could be beneficial. This could include in-reach to other services or upskilling staff from wider services.

- **There are currently limited external opportunities for resident-facing staff from wider support services to train in mental health awareness**, signposting, starting conversations and giving basic advice, **meaning many staff lack these key skills**. It could be argued that for many staff this training is essential to their role and therefore should be funded internally but most wider services believe mental health services should provide this training.

Recommendations - navigating and accessing services

- "A single point of coordination/hub for all local mental health services. Exactly what this involves would need to be worked up.
- Consider how best to help residents and support services identify the most appropriate mental health support. This could involve:
    - creating a flowchart/pathways diagram (acknowledging previous attempts at this have gone out of date very quickly and still been very complicated),
    - visiting external services to explain the different options available, who is most suitable for which service etc.,
    - adopt an AI tool to help residents identify the best support for them.

  (This recommendation may be superseded by a single point of coordination if that could be established).
- Introduce more in-reach and outreach options, especially in services where there are many people with high and complex mental health needs.
- A piece of work to look in more detail into waiting times and delays and make specific recommendations based on findings.
- A further joint piece of work to look into how many residents require longer term or ongoing support, what sort of support they need (also taking into account the evidence base in terms of effectiveness). Longer term support could include community activities and peer support.
- Create a training offer for resident facing (non-mental health) staff on mental health awareness and how to offer basic advice and signposting. Perhaps pre-recorded/online.
- Services to do warm referrals where possible, prioritising population groups who are most excluded from mental health services.

- ELFT to look into whether more self referral options could be introduced for their services where this is possible and appropriate.
- Monitor what is happening in other areas and nationally in terms of shared referral forms and related technological developments that we might be able to implement in the City and Hackney.

3. Inequalities and Inclusivity

While important improvements have been made in relation to inequalities in some areas, many still persist, This section covers some of these by theme or population group, with some overarching themes listed below.

- **Some residents are not easily able to attend services at the main location(s), due to factors such as travel costs and time.** Some residents have difficult and complex lives and may need to prioritise practical issues over attending mental health services. These issues affect certain population groups more and often those that most need the support, such as those living in deprivation and asylum seekers. Outreach and in-reach services can be effective for improving accessibility for these groups but there are limited options for mental health.

- **Some residents are reluctant to attend mainstream NHS services, often lacking trust, fearing discrimination or a lack of cultural sensitivity and worrying how their personal details will be used.** Some have had previous negative experiences. These concerns are more prevalent in certain population groups, including Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and all other related identities (LGBTQIA+) residents and some global majority communities. Alternative community based support is often highly valued by these groups, though funding for this is comparatively limited and often more at risk of funding cuts.

- **Voluntary and community sector organisations play an important role** in supporting some of City and Hackney's diverse communities, especially where communities are reluctant to attend mainstream services. **However, these organisations have recently experienced significant cuts** to their already comparatively limited funding, against the backdrop of increased need.

Sexual orientation

- There is a lack of local data on mental health needs for LGBTQIA+ communities in the City.
- Most services, including ELFT and TTAD, either do not collect data on sexual orientation or do not collect it routinely enough for analysis to be meaningful, so it is not possible to know how well services are meeting the needs of LGBTQIA+ populations.
- Stakeholders and resident representatives report that LGBTQIA+ communities can be reluctant to access mainstream services due to concerns such as fear of discrimination and not being understood.
- The Wellbeing Network (WBN) and TTAD (via Mind in the City, Hackney and Waltham Forest) do include a specific LGBTQIA+ pathway, although funding for the WBN is currently due to end by July 2027.
- In the WBN, the only service where sexual orientation data was available, LGBTQIA+ groups had lower improvements than heterosexual/straight residents, following interventions, although in both groups improvements were clinically significant.

Ethnicity

- SMI rates for black ethnicity groups and the mixed white and black Caribbean ethnicity group are the highest locally. However, African and Caribbean heritage (ACH) groups are significantly underrepresented in ELFT's community services.
- The mixed white and black Caribbean ethnic group has the highest rates of depression and anxiety in the City and Hackney, followed by white British and white Irish ethnic groups.
- Stakeholders and resident representatives report that some global majority communities can be reluctant to access mainstream NHS services due to concerns such as fear of discrimination and a lack of cultural competency.
- In some organisations, such as TTAD, staff are disproportionately white British, compared to the local population. This may partly be a reflection of wider issues, such as diversity in those pursuing careers in psychotherapy.
- In the WBN, ACH ethnicity groups had lower improvements than non-ACH residents, following interventions, although improvements for both groups were clinically significant. In TTAD the 'Asian or Asian British' ethnicity group had significantly lower overall recovery rates than average.

Deprivation

- People living in the most deprived areas of the City and Hackney have the highest rates of common mental health conditions and SMI. However, they appear underrepresented in TTAD, the WBN and to a lesser extent ELFT.

- People from the most deprived neighbourhoods are disproportionately likely to have complex lives and multiple needs, meaning they may be less likely to be able to attend mental health services.

Gender

- In the City and Hackney women have higher rates of common mental illness than men but men have higher rates of SMI. It is not clear how much of these differences are due to genuine differences in prevalence and how much is due to other factors, such as lower awareness and acceptability in men and possible overdiagnosis of common mental health conditions in women.
- Even taking into account their differing prevalence of mental health conditions, men are underrepresented in TTAD, the WBN and ELFT community services. It is not clear how much of this underrepresentation of men reflects social factors and how much it is that services and the interventions offered are not sufficiently inclusive to men.
- In the WBN, the data indicate that men on average have lower wellbeing improvements following intervention than women. In TTAD there was no significant difference in recovery rates by gender.

Age

- Residents aged 40-74 had the highest rates of depression, those aged 25-39 had the highest rates of anxiety and 50-74 year olds had the highest rates of SMI in the City and Hackney.
- Residents aged over 45 appear underrepresented in ELFT community services and TTAD, with the exception of the 70+ age group in ELFT.
- In the WBN, the reverse trend is true, with age groups up to 34 being underrepresented.

Complex mental health needs

Many stakeholders continue to raise concerns about the increasing number of residents with complex mental health needs and how it is especially difficult for them to get mental health support. The situation is only likely to get worse with services aimed at supporting this population group ending. PCPCS recently lost its funding and the current WBN is due to end in July 2027.

Complex needs clients often are not well suited to traditional mental health services and due to the nature of their complexity. Supporting them requires proportionately more resources than average. Due to their negatively reinforcing complexities, without the right support these residents are likely to deteriorate

and be at high risk of needing even more expensive support, such as crisis or inpatient services. However, the WBN model has shown that it is possible to get good outcomes from these clients, not just on wellbeing measures but also around other factors such as employment, physical health and isolation.

Residents living in temporary accommodation

- Residents living in temporary accommodation have high levels of mental health needs and these are usually complex needs. The number of households in temporary accommodation is rising, with Hackney ranking among the highest.
- Primary care and some mental health services do not routinely record a person's accommodation status. Completion rates are low for those that do.

Residents experiencing rough sleeping

- The City of London has the third highest rate of rough sleeping in London and the majority of rough sleepers have mental health problems and for many this is a factor in their becoming homeless.
- Traditional services are often not well suited to rough sleeping populations.
- People rough sleeping usually have complex and intersecting needs. Once they are at the point of sleeping rough, it can be very difficult to deliver successful interventions, so earlier intervention is key.

Gypsy and traveller communities

- There is high unmet mental health need in the local gypsy and traveller communities.
- Gypsy and traveller status is not systematically recorded by many health services and some residents also choose not to disclose this, so data are limited.
- Outreach is vital for engaging with these communities but there is little available for mental health.

Refugees and asylum seekers

- While there are no quantitative data available, professionals working with refugees and asylum seekers report a high prevalence of mental health conditions in this group
- Traditional mental health services are unlikely to be well suited to this group. In-reach and outreach services are likely to be the most beneficial.

Recommendations - inequalities and inclusivity

- Further work to look in more detail about how services can be more inclusive for underrepresented population groups, including:
    - LGBTQIA+ communities,
    - Men,
    - Global majority ethnicity groups, where they are underrepresented,
    - Residents living in most deprived areas,
    - Gypsy and traveller communities.

  Perhaps including specific interventions or pathways and learning from good practice where services already have representative uptake from these population groups.
- Use outcomes data across all services to study in more detail the difference in outcomes for different population groups. Where one group is getting poorer outcomes, investigate what may be causing this.
- Define, record and if possible quantify complex mental health needs across services, so that the extent of this need can be better quantified and understood. It may be that this is defined using more than one category, such as 'complex' and 'significantly complex' needs. It is also acknowledged that any definition or classification will be imperfect but even a proxy could help to quantify and understand the extent of this issue.
- Ensure there are services in place and appropriate pathways for people with significant complex mental needs to access the support they need, in a joined up and holistic approach, keeping in mind local authority funding for the WBN, which currently provides this, has significantly decreased and will end in July 2027, so this service will cease unless alternative funding can be secured.
- Offer more community based and in-reach/outreach interventions, including at locations where people with multiple needs will already be attending and areas of high deprivation.
- Invest in more alternative interventions, including culturally appropriate interventions and interventions more suited to men, to complement the clinical/therapeutic offer. There is currently a lot happening in this space but it is underfunded and more is needed.
- Provide early, seamless mental health support that prevent escalations to secondary care, reduce service fragmentation and alleviates pressure on hospital beds, improving residents' care journey.

- Services to improve recording of sexual orientation, accommodation status and any other agreed metrics (see data) so we can better understand any unmet need.
- Review how best to offer mental health support to asylum seeker and refugee populations groups, including how to ensure an inclusive offer and to take into account their concerns around information sharing and their relatively transient nature.
- Ensure residents with learning disabilities and autism experience minimal inpatient delays, faster discharges, with enhanced care quality, and better access to mainstream services, especially from marginalised groups.
- Work with housing, homeless and temporary accommodation services to understand how mental health services can be more inclusive to these populations and take action on this. including targeting this work where it is most needed, for example families living in temporary accommodation.
- In partnership with other services, ensure that people who are at risk of homelessness get the support they need urgently for their complex mental health needs and ADHD to prevent them becoming homeless in the first place.
- Ensure there is support in place to access training and qualifications in psychotherapy, or other roles within mental health, with a specific focus on population groups that are underrepresented in current staffing. Good practice already in place by organisations such as Mind in the CIty, Hackney and Waltham Forest should be built upon and shared.
- Continue to monitor national research and best practice to better understand high rates for SMI diagnosis and inpatient admissions for ACH population groups. ELFT to continue work to ensure ACH patients are correctly allocated to community or inpatient services, acknowledging the underpresentative and overrepresentative rates of ACH patients in these services respectively.

4. Knowledge, Insight and Decision-Making

Services and wider stakeholders broadly agree that better mental data and more transparency and sharing of these data would be hugely beneficial. However, there are a range of challenges related to this.

Insufficient data available or shared

While the JSNA highlights many important key insights, there are gaps in the available mental health data that limit full understanding of local mental health needs, how well services are performing and for which communities. This can make it more difficult for decision makers and commissioners to make evidence-based decisions, on a strategic, system wide level and possibly even within services. These gaps arise because some data are not routinely collected, limited sharing and transparency.

No overall oversight and accountability

Data requirements and reporting for each service are governed by different responsible authorities, on different geographical footprints. Data tend to be reviewed on an individual service basis, with no whole system view. This makes it very difficult to use data to inform strategic decision making for City and Hackney as a whole. The City and Hackney Mental Health JSNA - Part 1: The Local Picture and Part 2: Local Services reports aimed to change this and bring together all local mental health data. However, obtaining the data proved difficult and prolonged and there are still some gaps, because data did not exist or was not provided, including demographic data, such as sexuality, some outcomes data and information on complexity of needs. Obtaining data from ELFT was especially difficult. Getting data from voluntary and community sector (VCS) organisations is also a significant challenge for different reasons and the lack of this means that their contribution to the system is not as visible or recognised.

Different Data Systems

A contributing factor to the problem of sharing data is that each mental health service uses its own system for collecting and processing data. There is some linkage between the NHS services but it is limited and VCS organisation systems are completely separate. Even the VCS TTAD providers use a different system to submit their data to NHS England from the Homerton and these two data systems do not connect to each other. An additional related challenge is that the small size of VCS organisations can make obtaining high quality data systems difficult, which can lead to challenges in data management and increase the amount of staff time required to process it.

Additional data challenges

More specific data related challenges are listed below.

- Primary care data suggest that recorded rates of common mental health conditions in Hackney have been broadly similar to those seen nationally

over the past decade. In contrast, **the Adult Mental Health Population Survey (AMPS) conducted in 2014 indicated much higher levels of self-reported mental health problems locally**. These findings are not directly comparable, as population surveys and primary care records use different definitions, thresholds, and methods for identifying mental health needs. However, they point to **the likelihood that more people are experiencing mental health difficulties than are currently diagnosed in primary care**. This suggests a level of unmet need in the local population and warrants further investigation to better understand its scale and nature.

- **Data on outcomes, such as overall improvements in wellbeing, as a result of interventions, are not well collected by some services**, or not in a way that is useful in terms of understanding the effectiveness of interventions. This includes ELFT services.
- **Completeness of data for end of treatment measures (to allow beggining/end comparisons) are often limited** due to people dropping out or not completing this. Without these data, it is difficult to understand treatment effectiveness and acceptability across a range of measures. improving wellbeing for different population groups.
- Current understanding of mental health needs is largely shaped by people who use services, meaning **less is known about those who never seek help or who disengage once support has started.** Improving insight into the experiences, barriers, and reasons for non-attendance or drop-out would help inform more accessible and effective mental health support.
- **There is a lack of data available from VCS organisations**, despite the significant role they play in providing mental health support locally. Access to quality data systems, capacity and in some cases expertise, contribute towards this problem.
- **Recording of some demographic and social characteristics is often incomplete**, particularly for sexual orientation, marital status, employment, accommodation status, disability, and physical health. This limits how confidently patterns can be explored across these groups.
- **Ethnicity is not categorised in a consistent or sufficiently meaningful way in local mental health data.** For example, some key local population groups, such as Turkish/Kurdish and Orthodox Jewish are not well captured in most datasets but are significant locally and local mental health services include specific provision for them.

- **There is no formal way for services, including GPs, to record or report complex needs**. This is despite it repeatedly coming up as an area of increasing and unmet need. Not being able to quantify or track this need across services and the local population makes it difficult to make evidenced-based decisions.
- **Data are often not comparable across services**. Some of this is due to mental health services recording different metrics depending on their service design. However, they also sometimes use different formats to record the same metrics (e.g. different ways of categorising ethnicity) and use different methods to measure the similar things, such as wellbeing improvement. Even the definition of a 'referral' can vary across services.
- **Many patients have privacy concerns** and do not understand how services will use their data. Additionally **not all resident-facing staff understand or are not able to explain how patient data will be used.**
- A number of **non-mental health support services** collect data on mental health (or could), **which could provide an estimate of changing mental health trends locally.** However, this is not always well completed, shared or reported in a way that would allow it to be used this way.

Recommendations - Knowledge, Insight and Decision-Making

- Consider whether a coordinated approach to data management systems and recording would be possible for VCS organisations, which may create efficiencies for them and support recognition and visibility. For example, investigate whether a shared data management system could be commissioned across a range of VCS organisations, to enable them to access a higher quality system than would be possible individually.
- Agree a proportionate minimum dataset that should be collected consistently across mental health services, to be shared with key strategic stakeholders. The purpose of a minimum dataset is to ensure that a basic, shared evidence base exists to support system-wide insight, equity analysis, and strategic planning across different types of mental health provision. It would not replace existing service monitoring and performance management mechanisms. This minimum dataset should focus on a number of core measures that enable meaningful analysis across population mental health and mental health services (for example, rates of mental illness, demographic information, waiting times, and broad

outcomes). Any agreed dataset should be developed collaboratively with providers to ensure feasibility and relevance, and reviewed periodically as services and priorities evolve. This should include VCS organisations where possible, to ensure they and their contribution is visible and valued within the system. Residents should also be engaged to understand what measures are most important to them about mental health services.. While data will be considered across the system, it will be against a background of understanding that different service data will not always be comparable, For example outcomes data will not be directly comparable due to different starting types of mental health condition, variations in severity and complexity, different types of interventions and different lengths of care provided.

- Agree and develop a mechanism for sharing and using the minimum dataset, such as a data dashboard. This could be local or it may be possible to advocate for this at an ICB, national or regional level.
- Where possible and reasonable to do so, standardise the collection of the agreed demographic and inequalities measures across all mental health services and put in place processes to ensure high completion rates for these. This includes what measures are collected, how questions are asked and the response option categories (e.g. ethnicity categories). The response options should take into consideration national norms as well as the local population, e.g. recording of Turkish/Kurdish and Charedi Jewish identities.
- Investigate whether it is possible or beneficial to align the data management systems of the various services at all, to support integration of the system and improved patient experience. .
- Improve the recording and understanding of people's journeys through mental health services, including engagement, non-attendance, drop-out points and outcomes following contact with services. This should cover people who disengage at different stages of the pathway, as well as those who never attend or do not progress to treatment, and capture (where appropriate) the reasons for this. Better information on engagement patterns, alongside demographic characteristics, would support a clearer understanding of where and for whom services may not be working as intended, and whether some population groups are disproportionately affected.

- Develop more proactive, partnership-based approaches to identify and respond to mental health needs among people who do not access, disengage from, or are not currently known to mental health services. This includes working with wider system partners such as primary care,

education, housing, employment, community and voluntary sector organisations to recognise mental health needs that may present indirectly or alongside other issues. Responses should not rely solely on clinical pathways, but include social, community-based and preventative support where appropriate, recognising the role of factors such as loneliness, isolation, insecurity and wider life pressures in shaping mental health and wellbeing.

- Improve how information about data use is communicated and understood by both staff and residents. This includes supporting resident-facing staff with clear, consistent messages and practical guidance so they feel confident explaining why data are collected, how they are used, and how privacy is protected. Alongside this, develop simple, consistent communications for residents that show how shared data contribute to better understanding of need, fairer decision-making, and service improvement. Over time, this should help build trust, support informed engagement with services, and improve the quality and usefulness of data collected.

- Consider how data from non-mental health support services could be used to monitor trends in prevalence and demand and work with these services to ensure this is included in MH data oversight and strategic planning.

5. Governance and Accountability

Many of the challenges outlined in this report are underpinned by the underlying governance, accountability and structure of local mental health services and systems. Some of the main factors are outlined below:

- **Each service is accountable to a different organisation, often with different geographical footprints.** The WBN reports to City and Hackney Public Health, TTAD to NHS England and ELFT to North East London Integrated Care Board. VCS organisations report to their own boards for self-funded activity and external commissioners for external contracts.

- **Each service has its own remit, objectives and targets, with each working to make their own service better,** which to a degree makes sense. However, as no service is responsible for the whole population's mental health, this can create gaps in provision and responsibilities. Even if every service performs perfectly, gaps would remain.

The two largest local services, ELFT and NHS Talking Therapies, broadly treat people with SMI and common mental health conditions respectively[1], and do so with a clinical approach, centered around talking therapies. While this can be effective for many patients, it can exclude those with needs that do not fall under these categories or services, for example:

- Residents with complex mental health needs where they are are too complex for TTAD but don't have an SMI or otherwise meet the thresholds for ELFT. These residents often need a whole person, holistic approach to care.
- Where a medicalised or therapeutic approach does not meet residents' needs. Some people respond better to or are more willing to engage with activity, social or skill-based interventions.
- For some, cultural acceptability or stigma may make them reluctant to attend NHS mental services. Trust concerns regarding NHS services, sometimes because of previous experience of discrimination, or a lack of cultural competency.

- **No single body, service or commissioner has overall responsibility or accountability for mental health in its totality** for City and Hackney. As a result there is no overarching authority to determine who should be accountable for what, or who should meet gaps in provision, Therefore inequality of mental health needs will inevitably persist.

- The NHS commissions these more clinical services and its responsibility in doing so is fairly clear. **However, there appears to be less agreement on who should fund or deliver more holistic and activity based mental health interventions**. Despite this, most stakeholders do support and recognise the importance of this type of care in principle.

- There are a number of boards that try to bring together different stakeholders and services, such as The Mental Health Coordinating Committee, Psychological Therapies and Wellbeing Alliance and the Mental Health Strategic Group. However, **there is no one board that all services are truly accountable to, has responsibility for the strategic direction for all mental health services or has the authority to define who is responsible for the gaps in provision.**

[1] At the moment some residents with complex needs can be seen in the WBN, a community service offering a holistic approach. However, funding for this service has just been significantly reduced and will end entirely in 2027. PCPCS, an NHS service for residents with complex needs, was also recently decommissioned. Some non-clinical and/or community based provision is offered but it is a small proportion and much of this funding is uncertain.

- While theoretically commissioners and providers could agree additional responsibilities among themselves, in an environment of ever tightening budgets and already insufficient resources, this will be very difficult to achieve.

- While there are a number of roles that have system level responsibilities across the sector, including in the Integrated Care Board, ELFT, public health and the voluntary sector, the exact overall strategic responsibilities of these roles and how they interact is unclear.

- **Service targets rarely encourage integration or accountability to the system as a whole and can actually discourage partnership working.** For example, ensuring that residents receive a warm referral to a more suitable service takes significant resources, which could otherwise be used to help meet KPIs. Sometimes different mental health services even have to compete for funding, further discouraging collaborative working.

- **Improved integration of services and partnership working** could potentially help but with the current system of services and without well functioning governance underlying it, the impact of this is likely to be limited.

- **The system is predominantly designed around services and how they work, not around residents and how they need support,** especially not more marginalised residents.

Recommendations - governance and accountability

- Establish a governance and accountability structure, that has the authority to hold organisations to account, set priorities and determine responsibilities. This structure should be able to agree and delegate responsibility where gaps are identified. It should include VCS representation and resident representatives. This is about redesigning and improving the current governance, not just adding something new.
- Use the agreed minimum dataset to provide oversight and inform system level actions and strategic planning and if necessary to hold mental health services and the system overall to account

- Have shared, cross service objectives and agreements, and/or include partnership working as a core part of service design and monitoring.
- Agree who should fund and provide less clinical and more holistic elements of mental health support, as this is currently not clear or well defined.

Committee(s): Health & Wellbeing Board – For information	**Dated:** 04/02/2026
Subject: Update on the progress towards heat and water stress climate adaptation actions in relation to health and wellbeing	**Public report:** For Information
This proposal: Delivers Corporate Plan 2024-29 outcomes	• Leading Sustainable Environments • Providing Excellent Services • Diverse Engaged Communities
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 Director of Public Health Katie Stewart Executive Director Environment
Report author:	Ratidzo Chinyuku Senior Public Health Specialist, CCS Tim Munday Lead Environmental Resilience Officer, Environment Sam Murphy Environmental Resilience Officer, Environment

Summary

The Health and Wellbeing Board was presented with two climate-focused reports, specifically on overheating (November 2024) and water stress (July 2025).

This paper provides a progress update on actions taken by the Corporation to address these climate-related risks in the City.

Progress has been made in improving resilience to heat and water stress, including expanding the Cool Spaces network from 3 to 16 locations, planting new street trees, completing an internal heatwave exercise, and maintaining 18 active public drinking water fountains.

Further action is needed to strengthen health service preparedness, expand access to drinking water in high-footfall and greenspace areas, engage communities in resilience planning and improve data sharing on health impacts during extreme weather events.

Continued collaboration across system partners is essential to embed climate risks into public health planning and ensure the Square Mile remains resilient to future challenges.

Recommendation

Members are asked to:

- Note the progress update provided in this report.

Main Report

Background

1. At the November 2024 meeting of the Health and Wellbeing Board, a paper was presented outlining the impact to public health arising from overheating, and the potential opportunities and risks of acting.
2. A related paper, focusing on water stress and drought as a health-related climate risk, was subsequently presented to the board in July 2025.
3. The Square Mile faces an increasing risk of overheating and water stress driven by climate change. Rising temperatures, compounded by the Urban Heat Island effect, are expected to have significant public health implications, including risks to the resilience and operational viability of healthcare and social care infrastructure.
4. Wider determinants of health will also be affected, with impacts on education settings, housing quality, workplace productivity, and access to safe public spaces, disproportionately affecting vulnerable populations and exacerbating existing health inequalities.
5. Water stress, including the risks of regional drought and localised disruption from burst water mains, is an increasing challenge for London and the South-East of England. Existing pressures on water supply are expected to be exacerbated by climate change, population growth, and ageing infrastructure. Over time, these pressures are likely to intensify impacts on public health, including risks to

hygiene and sanitation, healthcare delivery, heat-related illness, and the resilience of critical services, with disproportionate effects on vulnerable populations.

6. At previous Board meetings, members requested further detail on the actions being taken across the City Corporation to address overheating and other climate-related risks.
7. This paper responds to that request and provides an update on additional actions implemented since. For clarity, actions are presented in two categories: **preparatory responses**, undertaken in advance of heatwaves and drought, and **incident responses**, implemented during periods of extreme heat or water supply disruption.

Current Position

Preparatory activity

8. The London Risk Register (2025) identifies extreme heat as a major and growing risk, with impacts on population health, critical infrastructure, and the power grid[1].
9. While the City Corporation's **Corporate Risk Register** recognises climate change as a risk, overheating is not currently articulated as a distinct risk. Notwithstanding this, there continues to be a growing Corporate awareness of the impacts and opportunities associated with climate change, which is increasingly reflected through climate considerations embedded within relevant strategies, resilience planning, and preparatory activity across the organisation and partner-systems.
10. The **Climate Action Strategy** (CAS) has four core aims. One of these is to increase resilience to climate change in our buildings, public space and infrastructure. This includes resilience to overheating and extreme weather events including heatwaves and drought.
11. The **Resilient Buildings workstream** of the CAS is focused on strengthening the resilience of City Corporation–owned buildings. Detailed assessments of overheating risks across the estate have been completed, and pilot schemes for physical resilience interventions are now being progressed.
12. The **Mainstreaming Climate Resilience** workstream, part of the CAS, is responsible for enhancing preparedness across the City Corporation in key operational areas. Specifically, the Environmental Resilience Team collaborates with colleagues to determine how overheating and water stress affect their respective services and to develop mitigating actions. A core component of this workstream is the strengthening of our public health programme.
13. The **Cool Streets and Greening** workstream is focused on enhancing climate resilience within the public realm. Key initiatives include planting 100 new street trees for shade and improving both the quantity and quality of green spaces, which will help mitigate the urban heat island effect. Furthermore, an assessment of the impact on road surfaces was conducted, with the results being integrated into the climate materials catalogue.
14. Policy CR1 of the draft **City Plan 2040** aims to address the reduction of risks related to overheating and the urban heat island effect. To comply with this policy,

[1] Greater London Authority. London Risk Register. 2025.

developers must demonstrate how they will mitigate overheating both within their developments and in the surrounding areas. Furthermore, major developments must meet the BREEAM sustainability standard[2] for climate adaptation. Compliance is then reviewed by the Sustainability and Environmental Resilience Teams.

15. Since 15 June 2022, **Building Regulation Part O** has been in force, requiring new residential developments to limit unwanted solar gains during summer and to provide adequate means for removing excess heat from indoor living spaces. Where the City Corporation acts as the **building control body,** the district surveyor assesses compliance with these requirements. District surveyors also enforce **Building Regulation G2**, which aims to prevent the undue consumption of water.
16. The **Transport Strategy** sits alongside the City Corporation's City Plan 2040. The strategy aims to create a more climate-resilient street network and public realm through use of materials, and planting more trees and greenery across the schemes[3]. These opportunities and interventions also deliver co-benefits for reducing overheating risk and strengthening climate resilience.
17. The **Natural Environments** division leads the Nature Conservation and Resilience Strategy. The strategy aims to protect biodiversity and ecosystems while increasing their ability to withstand and recover from environmental stresses like climate change[4]. The strategy includes a core objective to strengthen climate resilience across the Corporation's open spaces, including reducing overheating risks through improved land management, greening, and shading. In addition, through the CAS Carbon Removals workstream, work is underway to strengthen wildfire prevention protocols, including convening a cross-departmental group of internal experts to share best practice, improve preparedness, and reduce the risk of heat-related incidents.

Incident responses

18. **City Operations and Preparedness:**
    a. Staff safety: City Corporation employees engaged in outdoor and/or physical labour are especially at risk during periods of extreme heat. To mitigate the risk of adverse health due to overheating, guidance is issued by the Health and Safety executive.
    b. Water stress and drought: Measures to address water stress include the water fountain programme, the public refill scheme, and the introduction of drought-resilient planting across City gardens.
    c. Cooling and access to drinking water: Access to public drinking water can support individual cooling during periods of extreme heat. There are a number of disused water fountains across the City, including one in the recently reopened Finsbury Circus Gardens. While GLA mapping currently shows two public drinking water fountains within the Square Mile, City of London

[2] BREEAM (Building Research Establishment Environmental Assessment Method) provides a sustainability assessment method for the built environment.
[3] City of London Corporation. Transport Strategy. 2024.
[4] Natural Environment - City of London Corporation. Nature Conservation and Resilience Strategy. 2024.

mapping indicates that additional fountains are available across the City, with 18 locations identified.

d. Emergency planning:

- Emergency Planning Teams are intensifying their focus on climate risks, including heatwaves. Following the unprecedented 40°C temperatures recorded in London in the 2022 heatwaves, a pan-London exercise, *Exercise Helios*, was conducted in 2024 (which involved participation from the City Corporation) to assess preparedness and response to extreme heat.
- More recently, the City Corporation's Resilience and Environmental Resilience teams led an internal heatwave exercise in May 2025. The exercise considered local risks associated with a prolonged period of extreme heat and included an assessment of public health preparedness and potential impacts.
- Planning is underway to deliver a water stress/drought exercise specific to the City for 2026.

19. **Port Health & Public Protection** is particularly susceptible to climate-related impacts, where service disruption could result in significant downstream consequences. Critical services, such as the Heathrow Animal Reception Centre, already include extreme heat scenarios in their annual business continuity plans, specifically addressing staff levels and operational delivery.
20. **Cool Spaces network**. Cool spaces are indoor spaces for Londoners to shelter from the sun, cool down, rest and take respite on hot days[5]. Cool spaces are suggested by boroughs, community groups, faith-based or cultural organisations and others, and validated based on specific criteria. Cool spaces are vital for critical areas like the Square Mile; in 2025, the number of cool spaces there grew from 3 to 16.
21. The **Planning for Sustainability Supplementary Planning Document (SPD)** was officially adopted in 2025. The SPD provides guidance on how developers should address environmental sustainability, including measures to tackle the Urban Heat Island effect and manage overheating risk, as part of the planning application process. Planning applications are required to demonstrate how these considerations have been integrated into design and delivery, supporting climate resilience and improved environmental outcomes across the City.
22. The SPD also sets planning policy requirements for residential developments to meet a water efficiency standard of 110 litres per person per day, alongside guidance on water use in commercial developments. Planning applications are required to demonstrate how these considerations have been integrated into design and delivery, supporting climate resilience and improved environmental outcomes across the City.

[5] Greater London Authority. Cool Spaces. 2025.

Current progress and further opportunities

23. Actions proposed to the Health and Wellbeing Board to address overheating included: strengthening place-based partnerships, promoting cooling-focused roof design; undertaking or participating in overheating exercises; developing a network of cool spaces; and expanding the role of community champions to support residents most vulnerable to climate change impacts.

24. While several of the actions detailed above have been progressed, further opportunities remain to strengthen and embed this work (potentially as part of the pending refreshed Climate Action Strategy). There are further opportunities to improve adaptation to heat and water stress. For overheating these include the following:

    a. Improving understanding of heat risk within the Square Mile, including the recording, management, and adaptation of housing and other critical buildings such as community centres and libraries.

    b. Continued promotion of the Cool Spaces scheme, and ensuring existing sites continue to meet scheme requirements.

    c. Enhancing workforce safety through appropriate heat-related guidance.

    d. Improving data sharing, including healthcare utilisation during periods of extreme heat, to better understand impacts and inform future adaptation.

    e. Working with health system partners to understand readiness for extreme heat scenarios and identify priorities for preventative measures in buildings and service delivery work.

25. The Board was also presented with several actions to mitigate water stress including:

    a. Reviewing existing drought preparedness plans.

    b. Promoting the registration of vulnerable residents and communities with the (utilities) priority services registers.

    c. Organising a drought emergency exercise.

    d. Disseminating best practices for water efficiency measures.

    e. Ensuring clear public communication about drought impacts and opportunities for residents to take action.

26. For water stress, additional potential actions are detailed below:

    a. Incorporate water stress scenarios into Business Continuity Planning.

    b. Expand public drinking water fountains, focusing on City Gardens and other high footfall areas.

    c. Monitor and share data on health impacts and healthcare service utilisation during periods of water stress.

    d. Facilitate knowledge exchange and sharing of best practices on water efficiency and management strategies across all sites and services by bringing together asset and facilities managers.

e. Raise awareness of water use, conservation and safe drinking practices during droughts.

Proposals

27. Further climate-related topics will be brought as appropriate. It is proposed to continue to report ongoing activities related to this series of topics on an annual basis to the Health and Wellbeing Board.

Key Data

28. Impact of rising temperatures and heat:
    - London's heat-related mortality rates are projected to double by 2030 and quadruple by 2050 across all age groups.
    - In 2024, the global temperature surpassed 1.5°C for the first time. Current policies suggest a trajectory towards 2.6°C warming.
    - For the Square Mile, the Met Office forecasts that a 2°C warming scenario would lead to summer maximum temperatures approximately 3.6°C higher, coupled with a 9% reduction in summer rainfall.
    - Temperature increases will manifest as more frequent days above 35°C. Health consequences include heat-related illnesses, increased hospital admissions, or death. Wider sector impacts (e.g., transport disruptions, due to track buckling on railways and road melt).
    - Tropical nights (above 20°C) will become more common, causing heat stress and putting vulnerable people at greater risk of hospitalisation or death.
29. Water stress and demand:
    - In 2024, London's water demand was 2,104 million litres per day (ML/d), with a deficit of 143 ML/d.
    - By 2024, demand is anticipated to rise to 2,246 ML/d (an increase of 104 ML/d). The projected deficit is expected to increase significantly to 362 ML/d, representing 16% of the total anticipated demand.
    - The Square Mile currently consumes 9.42 ML/d of water, with 8.17 ML/d supplied to commercial premises, and the remainder to residential users. Without intervention, this consumption is modelled to increase by 14% by 2050. However, high-ambition water saving measures, including retrofitting and new building development, could reduce consumption to 9.12 ML/d while still accommodating anticipated growth.
    - East London presently experiences 88 days of water stress annually (where water usage exceeds the system's intake). This is projected to increase to 234 days per year under a scenario of high population growth and high investment. Under a lower population growth (and thus limited investment) scenario, water stress is expected to rise to 363 days, virtually every day of the year.

Strategic implications

Aligns with Corporate Plan 2024-2029 outcomes such as Leading Sustainable Environment and Providing Excellent services, by improving climate resilience and protecting public health.

Financial implications

No additional revenue or spending required for this report. Continuing actions largely involve coordination and engagement.

Resource implications

Resources for most actions are covered by the Public Health team and the Environmental Resilience Team, working as part of the Climate Action Strategy. Collaboration across teams and organisations will require staff resources for needs such as planning, training and exercising.

Legal implications

Aligns with statutory duties under the Civil Contingencies Act 2004 by planning, exercising and updating Business Continuity plans.

Risk implications

Addresses ‘very high’ risk of heatwaves and drought as scored in the London Risk Register, and City of London Corporation Borough Risk Register. Actions potentially reduce health risks and operational risks. Failure to act could lead to cascading risks, including reputational.

Equalities implications

Positive impact: interventions protect vulnerable groups who are disproportionately affected by heat and water stress. Actions such as cool spaces specifically consider accessibility and inclusion in the criteria for spaces.

Climate implications

Directly addresses climate risks through climate adaptation actions. Supports resilience objectives under CAS and Corporate Plan.

Security implications

None.

Conclusion

30. Both extreme heat and water stress pose serious risks to the Square Mile and there are significant public health impacts that need to be addressed. Significant progress has been made to date, with key achievements including increasing the number of registered ‘cool spaces’ from 3 to 16, undertaking an internal heatwave exercise and planning for a drought exercise in 2026. Many other actions have been taken as described in this report, and there is support for further actions to continue.
31. Embedding climate risks into public health planning and policy is an integral part of improving the resilience of the Square Mile and the health of its residents, workers, and visitors. Continued actions are needed to: expand access to drinking fountains; strengthen health service preparedness; develop

community engagement on these issues; and improve data sharing with health partners. Continued support from the Health and Wellbeing Board and endorsement of ongoing actions and future proposals is important to maintain momentum.

Appendices

None

Background Papers

2023-11-24 - Climate & Health – Opportunities for Collaboration

2024-11-15 - Health and Wellbeing Board - Overheating and Health

2025-07-11 - Health and Wellbeing Board - Health and Water Stress (1)

Authors

Tim Munday

Lead Environmental Resilience Officer

E: tim.munday@cityoflondon.gov.uk

Ratidzo Chinyuku

Senior Public Health Specialist

E: Ratidzo.chinyuku@cityandhackneyph.hackney.gov.uk

Sam Murphy

Environmental Resilience Officer

E: sam.murphy@cityoflondon.gov.uk

This page is intentionally left blank

Committee(s): Health & Wellbeing Board – For Decision	**Dated:** 04/02/2026
Subject: Climate Driven Health Risks: Vectors & Vector Borne Diseases	**Public report:** For Decision
This proposal: Delivers Corporate Plan 2024-29 outcomes	• Leading Sustainable Environments • Providing Excellent Services • Diverse Engaged Communities
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 Director of Public Health
Report author:	Tim Munday Lead Environmental Resilience Officer, Environment (Presenter) Ratidzo Chinyuku Senior Public Health Specialist, CCS (Presenter) Sam Murphy Environmental Resilience Officer, Environment

Summary

Climate change is increasingly affecting public health, with disproportionate impacts on vulnerable groups, requiring a Just Transition[1] approach. Building on previous Board reports on overheating (November 2024) and water stress (July 2025), this paper focuses on the emerging risks associated with pests and vector borne diseases (VBDs). Appendix 1 provides a progress update on actions taken by the Corporation to address climate-related water stress and overheating risks.

Climate change and rising temperatures are altering the ecology of non-native and invasive pests and vectors. VBD risks are particularly relevant to the City of London due to its dense daytime and working population, high visitor footfall, extensive transport links, and role as a global financial hub.

The City of London Corporation also has a unique role through its management of extensive open spaces, port health responsibilities, and statutory health protection functions.

Horizon scanning through the City Climate Action Strategy has identified four priority vectors posing the greatest risk to human health, including invasive mosquitoes and ticks associated with dengue, West Nile virus, Lyme disease, and other serious infections.

The mitigations proposed in this report include staff training, resilience planning, continued support for national surveillance programmes, and the establishment of a biosecurity working group to strengthen horizon scanning and local monitoring of climate-related health risks, recognising that a One Health approach is crucial to addressing these complex and interrelated issues.

A related paper will be taken to the Port Health and Environmental Services Committee, tailored to its specific focus.

Recommendations

Members are asked to:

1. note the report
2. approve and actively support enhanced collaboration between system partners on the issues outlined in paragraph 26.
3. agree to receive annual updates on related actions taken forward through the City of London Climate Action Strategy.

Main Report

Definitions

1. A **One Health Approach** recognises that the health of humans, animals, and the environment are closely interlinked. One Health is an internationally recognised

[1] Source: UNECE. Guiding Principles for Just Transition. 2025.
The Just Transition approach is a framework that seeks to balance environmental sustainability with social and economic justice. It aims to ensure that workers, communities and marginalised groups are actively supported in the shift toward a low-carbon future.

approach to tackling issues such antimicrobial resistance, and impacts of climate change on public health.

2. **Biosecurity** refers to precautions that aim to prevent the introduction and spread of harmful organisms, disease or infection. This includes emerging and re-emerging infectious diseases, vectors, vector borne diseases and invasive non-native species. Biosecurity prevents harmful impacts to human, animal, and plant health.

Background

3. Vector borne diseases (VBDs) are infections transmitted by arthropods such as mosquitoes and ticks, whose distribution and activity are strongly influenced by climate, alongside global travel, trade and urbanisation, and growing interconnections between human, animal and environmental health.
4. The Climate Change Risk Assessment has given the risk from VBDs in the UK as "more action needed"[2], and primary vectors are ticks and mosquitoes. Horizon scanning for the City Corporation has identified emerging infections, climate-sensitive diseases, plant pests and diseases, and invasive species as key risk categories.
5. VBD risks have increased following the first detection of West Nile virus genetic material in the UK in May 2025, alongside the northward spread of invasive mosquito vectors such as the *Aedes albopictus* (tiger mosquito) from Europe, including Italy and Croatia[3], which have already experienced dengue and other VBD outbreaks.
6. London already has a suitable climate for *Aedes albopictus*, with detections in Kent (2016) and West London. It is predicted that most of England will become suitable for its establishment by the 2040s and 2050s[4].
7. While sustained transmission of West Nile Virus and dengue is not yet established in England, climate change is expected to increase future outbreak risk in the South East of England from 2050. Climate change is also expected to drive Lyme disease through longer transmission seasons and increased human-and-tick contact.
8. Once a vector species is established, it is extremely difficult to eliminate and is likely to be associated with substantial public health impacts, alongside wider economic costs affecting leisure, travel and tourism. As a result, national policy prioritises early detection and control, with enhanced vector surveillance, alongside field-based studies to understand ecological drivers of changes in vectors and VBDs nationally.
9. The UK Health Security Agency[5] leads the national strategy and contingency planning for invasive mosquitoes, and implements rapid control measures when invasive species are detected (e.g., reducing breeding sites). The UK Department for Environment, Food & Rural Affairs has included biosecurity as one of its

[2] UK Climate Risk. Summary for England (CCRA3 - IA). 2021.
[3] UKHSA. Invasive mosquito surveillance: Information for local authorities. 2025.
[4] HECC. Direct and indirect effects of climate change on vectors and vector borne diseases, 2023.
[5] UKHSA. UKHSA Advisory Board: Preparedness for Environmental Hazards. 2025.

national goals amongst its Environmental Improvement Plan 2025[6]. This states that biosecurity will be enhanced to protect our natural environment and boost the health and resilience of plants, animals, ecosystems and people.

Risks Associated with Vectors and Vector Borne Disease City of London

10. VBD risks are particularly relevant to the Square Mile due to its dense daytime and working population, high visitor numbers, and its role as a global financial hub.
11. Vulnerable and disadvantaged groups are likely to be disproportionately affected by VBDs due to differences in exposure, underlying health conditions and capacity to adapt, with the potential to widen existing health inequalities if risks are not effectively addressed.
12. Horizon scanning through the City Climate Action Strategy has identified four priority vectors that pose the greatest risk to human health:
    a. *Aedes albopictus* (associated with dengue, chikungunya and Zika viruses)
    b. *Culex modestus mosquito* (associated with West Nile Virus)
    c. Native tick species (linked to Lyme disease)
    d. Non-native tick species (with the potential to transmit Crimean–Congo haemorrhagic fever and tick-borne encephalitis)
13. The horizon scan has identified the need for increased resourcing to enhance health protection training, capability and capacity within Public Protection in response to increased demand and the ongoing and growing risk of vectors and VBDs.
14. Climate change impacts, including flooding, and associated adaptation measures (e.g., land-use change for flood control) may alter native mosquito populations or create additional habitat for invasive species.

Current Position

15. The City Corporation manages vector and VBD risk through its Category 1 responder role[7], local authority functions, port health and public protection responsibilities, and land management activities. The climate and health agenda is also being progressed through the Climate Action Strategy (CAS).
16. The CAS aims to enhance the resilience of infrastructure, public spaces and services to climate change, including preparedness for new and emerging pests and diseases.
17. As part of the Strategy, the Mainstreaming Climate Resilience workstream focuses on enhancing organisational preparedness across key functional areas. In this capacity, the Environmental Resilience Team works with departments across the City Corporation to assess risks from pests and diseases, their

[6] DEFRA Environmental Improvement Plan (EIP) 2025

[7] Category 1 responders under the Civil Contingencies Act 2004 have statutory duties to assess risk, plan for emergencies and coordinate responses to incidents that may pose a serious risk to public health, including VBDs.

potential service impacts and appropriate preventative measures. This has included the production of a horizon scanning report setting out the current position across the organisation, and informing some of the recommendations in the Proposals section of this report.

18. As the Port Health Authority for the London Port Health District[8], the City Corporation is responsible for monitoring food and feed imports that may introduce pests, pathogens or vectors. In addition, port health responsibilities include inspections of vessels, ports and businesses (in the port district), and wider environmental health regulation and enforcement, all of which address other potential routes of introduction. These responsibilities sit alongside managing biosecurity pressures at Heathrow's Animal Reception Centre, where imported animals may carry vectors and VBDs.
19. The Public Protection team also oversees key environmental health responsibilities, including air and water quality, pollution control, licensing, pest control, and management of the Coroner's service, all of which support early detection, prevention and response to vector and VBD risks.
20. In addition, the City Corporation is the sole charity trustee for nine charities that manage large areas of open space and through the Natural Environment division, is responsible for around 4,400 hectares of land. Habitat management influences vector ecology and disease risk, with habitat change and biodiversity loss increasing the likelihood of pests, invasive species and VBDs becoming established, reinforcing the need for early detection through partnership working.
21. Overall, the increasing interconnections between human, animal, plant and environmental health may create complex biosecurity risks that require coordinated, system-wide responses as part of a One Health approach. This approach emphasises equity across sectors, as well as recognising the importance of biodiversity, natural space, and animal health and wellbeing alongside human health.
22. VBD risks have significant implications for all Member partners of the Health and Wellbeing Board, given their roles in public health, emergency preparedness, commissioning, patient advocacy, and health service delivery.
23. Addressing vector-associated risks therefore supports national biosecurity and broader health protection objectives, whilst helping to mitigate local public health impacts, health system pressures, and the risk of widening health inequalities.
24. To further mitigate risks associated with climate change and vector-associated risks, additional work is needed to strengthen joint surveillance and intelligence, risk planning, and system-wide preparedness and coordination. This will enable earlier identification and more effective management of emerging vector risks (as well as other climate-related risks beyond the scope of this report), within the context of a robust biosecurity framework.

[8] Constituted under section 7 of the Public Health (Control of Disease) Act 1984.

Options

25. **Option 1 (not recommended)**: Maintain the current level of engagement between partners, collaborating on a case-by-case basis where shared climate-related interests align in specific projects.
26. **Option 2 (recommended)**: Health and Wellbeing Board as a collective body, and within their member organisations, use its influence to strengthen local partnership to address the health impacts of climate-driven pests and diseases, as outlined in the Proposals section below.

Proposals

27. The Board is asked to:

    i. Approve and actively support stronger collaboration to identify and implement shared actions that prevent and reduce the harms caused by cascading climate impacts, including those related to vectors, pests, and diseases.

    ii. Recognise and integrate a One Health approach into future public health strategies for addressing climate-sensitive or associated diseases, including VBDs, through cross-sector collaboration, capacity building, and recognition of the interdependence of human, animal, and environmental health.

    iii. Consider and advise on the following proposed public health-related actions:

        b. **Risk Assessments:** Members are asked to review their respective organisational risks related to vectors and VBDs.

        c. **Training**: For City Corporation and Member partners, improve staff training on climate-sensitive pests, invasive species, and VBD pathways, including early identification, reporting, and response.

        d. **Capacity building:** Within City Corporation, address challenges identified through horizon scanning ensuring operational readiness to pest and vector pressures, as they potentially increase with warming temperatures.

        e. **Resilience planning**: Embed climate-driven pest, vector, and disease risks into long-term corporate resilience and adaptation planning. Assess how replacement strategies (e.g. tree replacement or green infrastructure) may influence exposure to pests and vectors (e.g. mosquitoes, ticks) under current and future climate conditions, to inform future action and mitigation.

        f. **Stakeholder engagement**: Build relationships with neighbouring local authorities, UKHSA, and community groups to foster collaborative biosecurity efforts and public awareness of climate-sensitive pests, invasive species, and vector borne disease pathways.

        g. **Surveillance and coordination**: Continue to support national surveillance programmes and establish a City Corporation biosecurity working group to align efforts, improve horizon scanning, and enhance local monitoring and communication of climate-related health risks to

partners through appropriate channels such as the City & Hackney Health Protection Forum.

h. **Policy and strategy development**: All organisations to refresh and expand biosecurity policies (e.g., plant, habitat and animal health policies). For the City of London Corporation to adopt a comprehensive biosecurity strategy that integrates divisional priorities and ensures coordinated action. Green infrastructure, and environmental health policies to explicitly address climate change, pests, and vector borne disease risks. Apply a formal Health Impact Assessment framework to tree and green infrastructure replacement strategies to assess potential health impacts before implementation.

28. It is recommended that these actions are taken forward through the City of London CAS and proposed biosecurity working group, and that progress is reported back to the Health and Wellbeing Board annually.

29. A related paper, which will include aligned recommendations, will be taken to the Port Health and Environmental Services committee in due course.

Corporate Implications

Strategic implications

Aligns with Corporate Plan 2024-2029 outcomes such as Leading Sustainable Environment and Providing Excellent services, by improving climate resilience and protecting public health.

Financial implications

No additional revenue or spending required. Continuing actions largely involve coordination, engagement and monitoring.

Resource implications

Currently, resources for most actions are drawn from the Public Health Team and the Environmental Resilience Team, which operates under the umbrella of the Climate Action Strategy. However, many teams have indicated a need for specialist staffing (e.g. Environmental Health). Cross-team and inter-organisational collaboration will necessitate staff resources for crucial functions like planning, training, and exercises. It is anticipated that the effects of these climate-related risks and diseases would place a significant burden on existing resources, impacting areas from public health to habitat management.

Legal implications

Aligns with statutory duties under the Civil Contingencies Act 2004 by planning, exercising and updating Business Continuity plans.

Risk implications

Once an invasive species has become established, eradication is often extremely difficult, if not impossible. For this reason, robust surveillance and early detection are essential to mitigate this risk.

The City of London Corporation has a legislated role and responsibility in the prevention of, and response to, infectious diseases, including those linked to invasive

species. The risk of emerging infectious diseases is reflected in the London Risk Register, where it is scored as very high, and in the City of London Corporation Borough Risk Register and Animal Disease Register, where it is scored as a medium risk. Effective action has the potential to reduce both health and operational risks, while failure to act could result in cascading impacts, including reputational damage.

Equalities implications

Evidence shows that socioeconomic indicators do not consistently predict the risk of vector borne disease transmission from *Aedes* mosquito; human-vector contact patterns are highly heterogeneous and location-specific[9].

There will be lack of prior immunity to a newly introduced VBD, however, inequalities may emerge through differences in exposure, existing health conditions, socioeconomic status and adaptive capacity. Therefore not taking action to mitigate the impacts from climate and vectors is likely to exacerbate existing health inequalities.

Climate implications

The proposed recommendations directly support the resilience objectives outlined in the Climate Action Strategy.

Security implications

None.

Conclusion

30. Vectors and vector borne diseases pose a growing public health risk that is likely to be exacerbated by climate change. Robust surveillance, preparedness, and collaborative action are essential to prevent the establishment of invasive vectors and reduce the risk of disease transmission.

Background Papers

- 2023-11-24 - Climate & Health – Opportunities for Collaboration
- Appendix A - Update on the progress towards heat and water stress climate adaptation actions in relation to health and wellbeing

Authors

- **Tim Munday**

  Lead Environmental Resilience Officer

  E: tim.munday@cityoflondon.gov.uk

[9]Whiteman, A., Loaiza, J.R., Yee, D.A., Poh, K.C., Watkins, A.S., Lucas, K.J., Rapp, T.J., Kline, L., Ahmed, A., Chen, S., Delmelle, E. and Oguzie, J.U., 2020. *Do socioeconomic factors drive Aedes mosquito vectors and their arboviral diseases? A systematic review of dengue, chikungunya, yellow fever, and Zika virus.* One Health, 11, p.100188.

- **Ratidzo Chinyuku**
  Senior Public Health Specialist
  E: Ratidzo.chinyuku@cityandhackneyph.hackney.gov.uk

- **Sam Murphy**
  Environmental Resilience Officer
  E: sam.murphy@cityoflondon.gov.uk

Appendix A - Update on the progress towards heat and water stress climate adaptation actions in relation to health and wellbeing

Committee(s): Health & Wellbeing Board – For information	**Dated:** 04/02/2026
Subject: Update on the progress towards heat and water stress climate adaptation actions in relation to health and wellbeing	**Public report:** For Information
This proposal: Delivers Corporate Plan 2024-29 outcomes	● Leading Sustainable Environments ● Providing Excellent Services ● Diverse Engaged Communities
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 - Director of Public Health
Report author:	Ratidzo Chinyuku Senior Public Health Specialist, CCS Tim Munday Lead Environmental Resilience Officer, Environment Sam Murphy Environmental Resilience Officer, Environment

Summary

The Health and Wellbeing Board was presented with two climate-focused reports, specifically on overheating (November 2024) and water stress (July 2025). This paper provides a progress update on actions taken by the Corporation to address these climate-related risks in the City.

Progress has been made in improving resilience to heat and water stress, including expanding the Cool Spaces network from 3 to 16 locations, planting new street trees, completing an internal heatwave exercise, and maintaining 18 active public drinking water fountains. Further action is needed to strengthen health service preparedness, expand access to drinking water in high-footfall and greenspace areas, engage communities in resilience planning, and improve data sharing on health impacts during extreme weather events. Continued collaboration across system partners is essential to embed climate risks into public health planning and ensure the Square Mile remains resilient to future challenges.

Recommendation

Members are asked to:

- Note the progress update provided in this report.

Main Report

Background

1. At the November 2024 meeting of the Health and Wellbeing Board, a paper was presented outlining the impact to public health arising from overheating, and the potential opportunities and risk of acting. A related paper, focusing on water stress and drought as a health-related climate risk, was subsequently presented to the board in July 2025.

2. The Square Mile faces an increasing risk of overheating and water stress driven by climate change. Rising temperatures, compounded by the Urban Heat Island effect, are expected to have significant public health implications, including risks to the resilience and operational viability of healthcare and social care infrastructure. Wider determinants of health will also be affected, with impacts on education settings, housing quality, workplace productivity, and access to safe public spaces, disproportionately affecting vulnerable populations and exacerbating existing health inequalities.

3. Water stress, including the risks of regional drought and localised disruption from burst water mains, is an increasing challenge for London and the South-East of England. Existing pressures on water supply are expected to be exacerbated by climate change, population growth, and ageing infrastructure. Over time, these pressures are likely to intensify impacts on public health, including risks to hygiene and sanitation, healthcare delivery, heat-related illness, and the resilience of critical services, with disproportionate effects on vulnerable populations.

4. At previous Board meetings, members requested further detail on the actions being taken across the City Corporation to address overheating and other climate-related risks. This paper responds to that request and provides an update on additional actions implemented since. For clarity, actions are presented in two categories: **preparatory responses**, undertaken in advance of heatwaves and drought, and **incident responses**, implemented during periods of extreme heat or water supply disruption.

Current Position

Preparatory activity

5. The London Risk Register (2025) identifies extreme heat as a major and growing risk, with impacts on population health, critical infrastructure, and the power grid[10]. While the City Corporation's **Corporate Risk Register** recognises climate change and as a risk, overheating is not currently articulated as a distinct risk. Notwithstanding this, there continues to be a growing Corporate awareness of the impacts and opportunities associated with climate change, which is increasingly reflected through climate considerations embedded within relevant strategies, resilience planning, and preparatory activity across the organisation and partner-systems.
6. The **Climate Action Strategy** (CAS) has four core aims. One of these is to increase resilience to climate change in our buildings, public space and infrastructure. This includes resilience to overheating and extreme weather events including heatwaves and drought.

7. The **Resilient Buildings workstream** of the CAS is focused on strengthening the resilience of City Corporation–owned buildings. Detailed assessments of overheating risks across the estate have been completed, and pilot schemes for physical resilience interventions are now being progressed.

8. The **Mainstreaming Climate Resilience** workstream, part of the CAS, is responsible for enhancing preparedness across the City Corporation in key operational areas. Specifically, the Environmental Resilience Team collaborates with colleagues to determine how overheating and water stress affect their respective services and to develop mitigating actions. A core component of this workstream is the strengthening of our public health programme.

9. The **Cool Streets and Greening** workstream is focused on enhancing climate resilience within the public realm. Key initiatives include planting 100 new street trees for shade and improving both the quantity and quality of green spaces, which will help mitigate the urban heat island effect. Furthermore, an

[10] Greater London Authority. London Risk Register. 2025.

assessment of the impact on road surfaces was conducted, with the results being integrated into the climate materials catalogue.

10. Policy CR1 of the draft **City Plan 2040** aims to address the reduction of risks related to overheating and the urban heat island effect. To comply with this policy, developers must demonstrate how they will mitigate overheating both within their developments and in the surrounding areas. Furthermore, major developments must meet the BREEAM sustainability standard[11] for climate adaptation. Compliance is then reviewed by the Sustainability and Environmental Resilience Teams.

11. Since 15 June 2022, **Building Regulation Part O** has been in force, requiring new residential developments to limit unwanted solar gains during summer and to provide adequate means for removing excess heat from indoor living spaces. Where the City Corporation acts as the **building control body,** the district surveyor assesses compliance with these requirements. District surveyors also enforce **Building Regulation G2**, which aims to prevent the undue consumption of water.

12. The **Transport Strategy** sits alongside the City Corporation's City Plan 2040. The strategy aims to create a more climate-resilient street network and public realm through use of materials, and planting more trees and greenery across the schemes[12]. These opportunities and interventions also deliver co-benefits for reducing overheating risk and strengthening climate resilience.

13. The **Natural Environments** division leads the Nature Conservation and Resilience Strategy. The strategy aims to protect biodiversity and ecosystems while increasing their ability to withstand and recover from environmental stresses like climate change[13]. The strategy includes a core objective to strengthen climate resilience across the Corporation's open spaces, including reducing overheating risks through improved land management, greening, and shading. In addition, through the CAS Carbon Removals workstream, work is underway to strengthen wildfire prevention protocols, including convening a cross-departmental group of internal experts to share best practice, improve preparedness, and reduce the risk of heat-related incidents.

Incident responses

14. **City Operations and Preparedness:**
    a. Staff safety: City Corporation employees engaged in outdoor and/or physical labour are especially at risk during periods of extreme heat. To

[11] BREEAM (Building Research Establishment Environmental Assessment Method) provides a sustainability assessment method for the built environment.
[12] City of London Corporation. Transport Strategy. 2024.
[13] Natural Environment - City of London Corporation. Nature Conservation and Resilience Strategy. 2024.

mitigate the risk of adverse health due to overheating, guidance is issued by the Health and Safety executive. This includes

b. Water stress and drought: Measures to address water stress include the water fountain programme, the public refill scheme, and the introduction of drought-resilient planting across City gardens.

c. Cooling and access to drinking water: Access to public drinking water can support individual cooling during periods of extreme heat. There are a number of disused water fountains across the City, including one in the recently reopened Finsbury Circus Gardens. While GLA mapping currently shows two public drinking water fountains within the Square Mile, City of London mapping indicates that additional fountains are available across the City, with 18 locations identified.

d. Emergency planning:

- Emergency Planning Teams are intensifying their focus on climate risks, including heatwaves. Following the unprecedented 40°C temperatures recorded in London in the 2022 heatwaves, a pan-London exercise, *Exercise Helios*, was conducted in 2024 (which involved participation from the City Corporation) to assess preparedness and response to extreme heat.
- More recently, the City Corporation's Resilience, and Environmental Resilience teams led an internal heatwave exercise in May 2025. The exercise considered local risks associated with a prolonged period of extreme heat and included an assessment of public health preparedness and potential impacts.
- Planning is underway to deliver a water stress/drought exercise specific to the City for 2026.

15. **Port Health & Public Protection** is particularly susceptible to climate-related impacts, where service disruption could result in significant downstream consequences. Critical services, such as the Heathrow Animal Reception Centre, already include extreme heat scenarios in their annual business continuity plans, specifically addressing staff levels and operational delivery.

16. **Cool Spaces network**. Cool spaces are indoor spaces for Londoners to shelter from the sun, cool down, rest and take respite on hot days[14]. Cool spaces are suggested by boroughs, community groups, faith-based or cultural organisations and others, and validated based on specific criteria. Cool spaces are vital for critical areas like the Square Mile; in 2025, the number of cool spaces there grew from 3 to 16.

[14] Greater London Authority. Cool Spaces. 2025.

17. The **Planning for Sustainability Supplementary Planning Document (SPD)** was officially adopted in 2025. The SPD provides guidance on how developers should address environmental sustainability, including measures to tackle the Urban Heat Island effect and manage overheating risk, as part of the planning application process. Planning applications are required to demonstrate how these considerations have been integrated into design and delivery, supporting climate resilience and improved environmental outcomes across the City.

18. The SPD also sets planning policy requirements for residential developments to meet a water efficiency standard of 110 litres per person per day, alongside guidance on water use in commercial developments. Planning applications are required to demonstrate how these considerations have been integrated into design and delivery, supporting climate resilience and improved environmental outcomes across the City.

Current progress and further opportunities

19. Actions proposed to the Health and Wellbeing Board to address overheating included: strengthening place-based partnerships promoting cooling-focused roof design; undertaking or participating in overheating exercises; developing a network of cool spaces; and expanding the role of community champions to support residents most vulnerable to climate change impacts.

20. While several of the actions detailed above have been progressed, further opportunities remain to strengthen and embed this work (potentially as part of the pending refreshed Climate Action Strategy). These include:

21. There are further opportunities to improve adaptation to heat and water stress. For overheating these include the following.
    a. Improving understanding of heat risk within the Square Mile, including the recording, management, and adaptation of housing and other critical buildings such as community centres and libraries.
    b. Continued promotion of the Cool Spaces scheme, and ensuring existing sites continue to meet scheme requirements.
    c. Enhancing workforce safety through appropriate heat-related guidance.
    d. Improving data sharing, including healthcare utilisation during periods of extreme heat, to better understand impacts and inform future adaptation.
    e. Working with health system partners to understand readiness for extreme heat scenarios and identify priorities for preventative measures in buildings and service delivery work.

22. The Board was also presented with several actions to mitigate water stress including:
    a. Reviewing existing drought preparedness plans.
    b. Promoting the registration of vulnerable residents and communities with the (utilities) priority services registers.
    c. Organising a drought emergency exercise.
    d. Disseminating best practices for water efficiency measures.
    e. Ensuring clear public communication about drought impacts and opportunities for residents to take action.

23. For water stress, additional potential actions are detailed below:
    a. Incorporate water stress scenarios into Business Continuity Planning.
    b. Expand public drinking water fountains, focusing on City Gardens and other high footfall areas.
    c. Monitor and share data on health impacts and healthcare service utilisation during periods of water stress.
    d. Facilitate knowledge exchange and sharing of best practices on water efficiency and management strategies across all sites and services by bringing together asset and facilities managers.
    e. Raise awareness of water use, conservation, and safe drinking practices during droughts.

Proposals

24. Another climate and health related paper focusing on the impact of vector borne diseases is being presented to the board on 4 February 2026. Further climate-related topics will be brought as appropriate. It is proposed to continue to report ongoing activities related to this series of topics on an annual basis to the Health and Wellbeing Board.

Key Data

25. Impact of rising temperatures and heat:
    - London's heat-related mortality rates are projected to double by 2030 and quadruple by 2050 across all age groups.
    - In 2024, the global temperature surpassed 1.5°C for the first time. Current policies suggest a trajectory towards 2.6°C warming.
    - For the Square Mile, the Met Office forecasts that a 2°C warming scenario would lead to summer maximum temperatures approximately 3.6°C higher, coupled with a 9% reduction in summer rainfall.
    - Temperature increases will manifest as more frequent days above 35°C. Health consequences include heat-related illnesses, increased hospital admissions, or death. Wider sector impacts (e.g., transport disruptions, due to track buckling on railways and road melt).

- Tropical nights (above 20°C) will become more common, causing heat stress and putting vulnerable people at greater risk of hospitalisation or death.

26. Water stress and demand:
    - In 2024, London's water demand was 2,104 million litres per day (ML/d), with a deficit of 143 ML/d.
    - By 2024, demand is anticipated to rise to 2,246 ML/d (an increase of 104 ML/d). The projected deficit is expected to increase significantly to 362 ML/d, representing 16% of the total anticipated demand.
    - The Square Mile currently consumes 9.42 ML/d of water, with 8.17 ML/d supplied to commercial premises, and the remainder to residential users. Without intervention, this consumption is modelled to increase by 14% by 2050. However, high-ambition water saving measures, including retrofitting and new building development, could reduce consumption to 9.12 ML/d while still accommodating anticipated growth.
    - East London presently experiences 88 days of water stress annually (where water usage exceeds the system's intake). This is projected to increase to 234 days per year under a scenario of high population growth and high investment. Under a lower population growth (and thus limited investment) scenario, water stress is expected to rise to 363 days, virtually every day of the year.

Strategic implications

Aligns with Corporate Plan 2024-2029 outcomes such as Leading Sustainable Environment and Providing Excellent services, by improving climate resilience and protecting public health.

Financial implications

No additional revenue or spending required for this report. Continuing actions largely involve coordination and engagement.

Resource implications

Resources for most actions are covered by the public health team and the Environmental Resilience Team, working as part of the Climate Action Strategy. Collaboration across team and organisations will require staff resources for needs such as planning, training, and exercising.

Legal implications

Aligns with statutory duties under the Civil Contingencies Act 2004 by planning, exercising and updating Business Continuity plans.

Risk implications

Addresses ‘very high’ risk of heatwaves and drought as scored in the London Risk Register, and City of London Corporation Borough Risk Register. Actions potentially reduce health risks and operational risks. Failure to act could lead to cascading risks, including reputational.

Equalities implications

Positive impact: interventions protect vulnerable groups who are disproportionately affected by heat and water stress. Actions such as cool spaces specifically consider accessibility and inclusion in the criteria for spaces.

Climate implications

Directly addresses climate risks through climate adaptation actions. Supports resilience objectives under CAS and Corporate Plan.

Security implications

None.

Conclusion

27. Both extreme heat and water stress pose serious risks to the Square Mile and there are significant public health impacts that need to be addressed. Significant progress has been made to date, with key achievements including increasing the number of registered ‘cool spaces’ from 3 to 16, undertaking an internal heatwave exercise and planning for a drought exercise in 2026. Many other actions have been taken as described in this report, and there is support for further actions to continue.

28. Embedding climate risks into public health planning and policy is an integral part of improving the resilience of the Square Mile and the health of its residents, workers, and visitors. Continued actions are needed to: expand access to drinking fountains; strengthen health service preparedness; develop community engagement on these issues; and improve data sharing with health partners. Continued support from the Health and Wellbeing Board and endorsement of ongoing actions and future proposals is important to maintain momentum.

Appendices

None

Background Papers

2023-11-24 - Climate & Health – Opportunities for Collaboration

2024-11-15 - Health and Wellbeing Board - Overheating and Health

2025-07-11 - Health and Wellbeing Board - Health and Water Stress (1)

Authors

Tim Munday

Lead Environmental Resilience Officer

E: tim.munday@cityoflondon.gov.uk

Ratidzo Chinyuku

Senior Public Health Specialist

E: Ratidzo.chinyuku@cityandhackneyph.hackney.gov.uk

Sam Murphy

Environmental Resilience Officer

E: sam.murphy@cityoflondon.gov.uk

This page is intentionally left blank

Committee(s): Health and Wellbeing Board - for discussion	**Dated:** 24.11.2023
Subject: Climate & health - opportunities for collaboration	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	2, 3, 11, 12
Does this proposal require extra revenue and/or capital spending?	**N**
Report of: Dr Sandra Husbands, Director of Public Health	**For discussion**
Report authors: Jayne Taylor (Consultant in Public Health) Tim Munday (Lead Environmental Resilience Officer) Rebecca Waters (Deputy Programme Manager Net Zero & Anchor Organisations, North East London Health and Care Partnership)	

Summary

This report summarises a more detailed presentation (Appendix 1) which sets out:

- why climate change is an important public health issue, and the health co-benefits of mitigation and adaptation strategies
- an overview of the Corporation's Climate Action Strategy
- an overview of work being led under the North East London Health and Care Partnership Green Plan
- opportunities for (further) local collaboration to achieve shared aims.

Recommendation(s)

Members are asked to:

- note the report
- advise on areas for (further) collaboration to maximise the collective impact of local action on climate change to protect and improve population health (and reduce health inequalities) in the City of London.

Main Report

Background

1. Climate change has been described as the biggest public health crisis of our generation. We are already seeing evidence of this with unprecedented heatwaves, droughts, wildfires, floods and pollution of UK coastal waters from storm overflows. While it is difficult to reliably measure the specific health impacts of climate change, we do know that the effects are wide-ranging and (without positive remedial action) will have the greatest impact on already vulnerable residents and communities, and create additional pressure on health and care services.

2. Taking carefully planned action on climate change has many potential benefits for population health, over and above protecting people from harm.

Current Position

3. The presentation appended to this overview paper provides more detail on the impacts of climate change on population health - both the *direct* effects of weather events (such as flood damage and heat stress) and *indirect* effects mediated by natural systems (such as allergens and increased water/air pollution) and social systems (such as food supply, mental stress, health and care facilities).
4. These health impacts include harms to the respiratory, cardiovascular and respiratory systems; increases in skin cancer; adverse pregnancy outcomes; and wide-ranging implications for mental health. Those most at risk are the people and places that are less able to adapt, with the impacts most concentrated among economically and socially marginalised groups.
5. There is much we can do to reduce the negative health effects of climate change. Action is needed at international, national, regional and local level. Local action is being progressed through the City of London Corporation's Climate Action Strategy and the NHS North East London Integrated Care System (ICS) Green Plan.

Proposals

6. While the risks to population health of climate change are far-reaching, there are significant opportunities for climate action to benefit human health, via evidenced, coordinated and equitable strategies across multiple sectors/partners.
7. The Corporation's Climate Action Strategy sets out how the organisation will achieve 'net zero' and build climate resilience in its buildings, public spaces and infrastructure. At the same time, NHS North East London Integrated Care System (ICS) Green Plan seeks to create a greener NHS by reducing its carbon footprint by 80%. There are common objectives contained within these plans and both have potential to have a significant positive impact on protecting the public's health from the worst effects of climate change, and to create positive health co-benefits more generally.
8. Organisations represented on the Health and Wellbeing Board have significant power to protect and improve population health through their individual green/climate action plans. Through closer collaboration, there is an opportunity to maximise the collective impact of our local climate action to protect and improve population health (and reduce health inequalities) in the Square Mile. The Health and Wellbeing Board is in a unique position to influence partnership action to achieve this.

Corporate & Strategic Implications

Strategic implications

Climate action contributes to a number of the Corporations aims and priorities:

- contribute to a flourishing society - alleviate fuel poverty, protect health and wellbeing

- support a thriving economy - promote a world class financial centre, mitigate future costs, efficient job creation
- shape outstanding environments - improve air quality, conserve and enhance open spaces and biodiversity.

Financial implications

None

Resource implications

None

Legal implications

None

Risk implications

Risk to reputation if collaboration with the Integrated Care System is inhibited.

Risk to life if climate change is allowed to happen without system transformation, adaptation and mitigated.

Equalities implications

The presentation in Appendix I highlights the fact that the impacts of climate change are not experienced equally, with already disadvantaged and vulnerable communities (including those with protected characteristics) bearing the greatest impact, thus further exacerbating inequalities. In developing and implementing local climate action plans, the concept of 'climate justice' is key to ensure that everyone has the ability to prepare for, respond to and recover from the impacts of climate change.

Climate implications

The primary focus of this report is collaborative action to achieve health and climate co-benefits and achieve climate justice.

Security implications

Climate change brings with it a risk to energy security and increases food scarcity.

Conclusion

9. Climate change has far-reaching implications for the public's health and, without strong remedial action, will lead to a significant widening of pre-existing health inequalities.
10. There are untapped opportunities for local collaboration to protect the public's health from the worst effects of climate change, and for action on climate change to create positive health co-benefits for local people. Members of the Health and Wellbeing Board are well-placed to participate in and influence stronger partnership working to leverage these opportunities.

Appendices

• Appendix 1 – Climate action and health: opportunities for collaboration (presentation to the Health and Wellbeing Board)

Jayne Taylor, Consultant in Public Health

T: 020 8356 7885
E: jayne.taylor@hackney.gov.uk

Committee(s): Port Health and Environmental Services Committee – For Information Health and Wellbeing Board – For Information Licensing Committee – For Information	**Dated:** 25/11/2025 04/02/2026 05/02/2026
Subject: Tobacco and Vapes Bill	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	Providing Excellent Services
Does this proposal require extra revenue and/or capital spending?	**N**
If so, how much?	**£**
What is the source of Funding?	
Has this Funding Source been agreed with the Chamberlain's Department?	**N/A**
Report of: City Remembrancer	**For Information**
Report authors: James Edwards City Remembrancer's Office Rachel Pye Environment Department	

Summary

This report outlines the provisions of the Tobacco and Vapes Bill and any implications for the City of London Corporation.

Recommendation(s)

Members are asked to note the report.

Main Report

Background

1. The Tobacco and Vapes Bill was first introduced in the House of Commons in November 2024 and, at the time of writing, has passed all its stages in the first House and has begun its Committee Stage in the House of Lords.
2. The Bill would implement a commitment contained in Labour's General Election manifesto to ensure that the next generation can never legally buy cigarettes, and to ban vapes from being branded and advertised to appeal to children. This commitment was made as part of Labour's pledge to introduce preventative public health measures to support people to live longer, healthier lives.
3. The Bill follows on from a previous Tobacco and Vapes Bill introduced during Rishi Sunak's premiership, which sought to raise the legal smoking age each year, to ensure those born after 1 January 2009 could never legally purchase cigarettes.
4. The Bill has, to date, made relatively slow progress through Parliament, with six months elapsing between its Second Reading in the House of Lords and the tabling of its Committee Stage. Nonetheless, it has cross-party support within Parliament and is likely to reach Royal Assent towards the end of the year or in early 2026.

Current Position

5. The Bill aims to create the first "smoke-free generation" by ensuring children born in 2009 or later can never be legally sold tobacco. It also includes provisions to make vaping less attractive and accessible to children and young people, strengthen smoke-free restrictions, and strengthen enforcement around the sale of tobacco and vaping products.
6. In relation to tobacco products, the Bill would:
    I. make it an offence to sell tobacco products, herbal smoking products and cigarette papers to anyone born on or after 1 January 2009. This would replace the current age of sale restriction of 18 years for these products.
    II. provide regulation-making powers that would enable the government to extend smoke-free restrictions to a wider range of premises (such as outside schools and hospitals), and to designate smoke-free places as also being heated tobacco-free.
    III. provide the Secretary of State with powers to make regulations about tobacco products, such as establish requirements for product, substances and flavours.
7. In relation to vaping and nicotine products, the Bill would:

I. widen the scope of nicotine and vaping products that are subject to an age of sale restriction (18 years). For the first time, it would be an offence to sell non-nicotine vapes, e-liquids and refills to under 18s.

II. prohibit the sale of vaping and nicotine products from vending machines in the UK.

III. prohibit the free distribution, advertising, sponsorship and brandsharing of vaping and nicotine products to people of all ages.

IV. extend ‘smoke-free’ restrictions to vaping.

V. provide the Secretary of State with regulation-making powers to regulate vaping and nicotine products, including contents and flavour, packaging, and product requirements.

8. In relation to enforcement and retailer licensing, the Bill would:

    I. provide for regulation-making powers to create a retailer licensing scheme for the sale of tobacco products, herbal smoking products, cigarette papers, vaping and nicotine products.

    II. provide enforcement authorities with the power to issue fixed penalty notices for offences related to the underage sale, proxy sale and free distribution of tobacco and vaping products (£200) and offences in connection with licensing (£2,500).

9. In relation to advertising and sponsorship, the Bill would:

    I. introduce a UK-wide ban on the advertising, brandsharing and sponsorship of herbal smoking products, cigarette papers, vaping and nicotine products.

    II. extend provisions of the Communications Act 2003 about audiovisual and radio broadcasting to all herbal smoking products, cigarette papers, vaping and nicotine products.

    III. make a “relevant person” (such as a director or manager of a company or a partner in a firm) potentially liable for an advertising or sponsorship offence committed by a “body” (such as a body corporate, a partnership, or an unincorporated association).

    IV. impose a duty on relevant enforcement authorities to enforce the provisions in part 6 of the bill (relating to advertising and sponsorship) and regulations made under powers in part 6.

    V. empower the appropriate national authority to take over enforcement functions or proceedings instead of the relevant local enforcement authority.

10. Finally, the Bill would enable the UK Government and devolved administrations to expand the extent of provisions in existing legislation and within the Bill itself that

regulate the sale and distribution of tobacco products, including to include products not currently in scope.

Implications for the City of London Corporation

11. The City of London Corporation will be in scope of the Bill both as a local weights and measures (Trading Standards) authority and as a licensing authority.
12. The implications with respect to the City of London as licensing authority relate to the proposed retail licensing regime for the sale of tobacco, vapes and nicotine products. The government has indicated a two-tier approach separating a personal licence for individuals from a premises licence for retail locations, aimed at ensuring that only responsible retailers and staff can sell these products.
13. Licensing authorities would administer applications, renewals, suspensions and revocations and could attach conditions to licences. The practical design of the retail licensing scheme is still to be determined including the licence fee, whether it will be nationally or locally set, subject to annual review or if it will fully cover the costs of administration and enforcement.
14. Trading Standards and licensing will enforce elements of the new penalties for unlicensed selling or breaches of licence conditions which could include fixed penalties and higher fines through the courts for offences such as underage sales, packaging and advertising. The licensing model is intended to deter rogue traders, support legitimate businesses that comply with rules, and provide a clearer enforcement route for local authorities.
15. All of these responsibilities introduce additional finance, skills and resource burden implications for the licensing and trading standards authorities in establishing and discharging these new additional functions.
16. A further potential implication is that the new licensing scheme could encourage further the illegal market, with the consequence that the controls create an opportunity for criminals to exploit demand for unregulated and cheaper products, particularly if flavoured vapes are restricted.
17. The market in illicit products is controlled by organised crime, and the products represent a significant funding avenue for organised crime groups' other illegal schemes, such as human trafficking, money laundering and modern slavery.
18. The sale of illegal tobacco and vapes makes it easier for children and young people to start smoking and establish addictions. Some illegal cigarettes are not fire safe, they do not extinguish themselves if left unattended, presenting an increased fire risk.

Corporate & Strategic Implications

Strategic implications – Providing Excellent Services: Protecting and promoting public health.

Financial implications – None at this stage

Resource implications – None at this stage

Legal implications – As outlined in the body of the report.

Risk implications – None at this stage

Equalities implications – Tobacco use continues to be the leading preventable cause of death, disease, and disability in our communities. Smoking rates show strong positive correlation with deprivation and reducing smoking rates among disadvantaged groups is the most effective way to tackle health inequalities.

Smoking rates are disproportionately higher amongst vulnerable populations such as the homeless, those with serious mental illness, and those with substance misuse issues. As the harms of tobacco use are not experienced equally across the population, reducing overall smoking rates in the City will contribute to mitigating the disparity in health and wellbeing burdens experienced across different population groups.

Climate implications – Every stage of the tobacco supply chain poses serious environmental challenges, including deforestation, the use of fossil fuels and the dumping or leaking of waste products into the natural environment. Reducing tobacco product use will lead to positive environmental outcomes.

Security implications – None

Appendices

- None

Background Papers

- Tobacco and Vapes Bill – https://publications.parliament.uk/pa/bills/cbill/59-01/0121/240121v2.pdf

James Edwards

Remembrancer's Office

T: 020 7332 1202

E: james.edwards@cityoflondon.gov.uk

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank