Better Care Fund 2025-26
Narrative plan

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

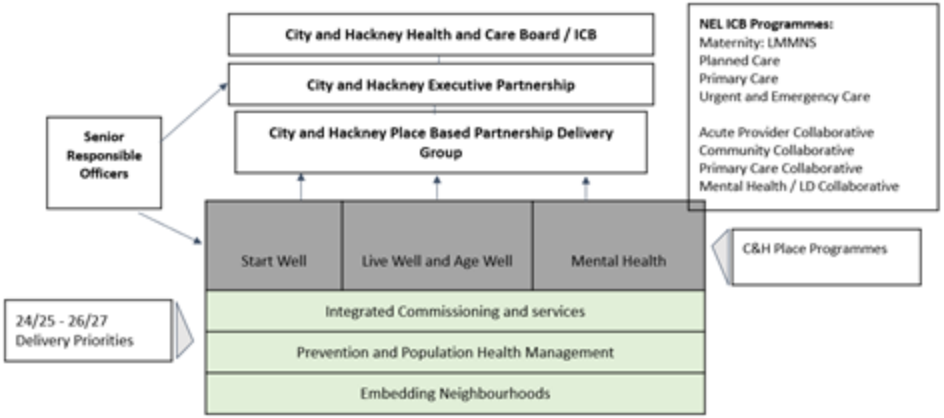
Contents

Overview

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

System Structures: BCF within a larger context

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



High Level Priorities for 2025-26

Area	Aim	Activities

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

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

High Level Priorities for 2025-26

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

Key changes since previous BCF plan

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

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

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

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

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

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

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

1. **Develop and embed virtual wards – exploring opportunity for increased capacity & capability through**
    - Introduction of technology and diagnostics
    - Collaboration with Community services, VSO and other neighbourhood assets
    - Integration with emerging SPOA to maximise utilisation
2. **Develop robust integrated urgent care pathway for C&H –**
    - Review current provision across 24/7
    - Collaborate with partners to identify opportunity for improvements – for patient and system
    - Align & respond to related work at NEL
    - 111 reprocurement
    - SDA – fuller
    - LiS review
3. **Agree local model / approach for delivering Single Point of Access**
    - Work with acute and community partners to consider scope and opportunity
    - Develop short / medium / long term options for making improvements & meeting requirements
    - Align / respond to NEL programme on this
4. **Development of the transfer of care hub as outlined earlier.**

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

- We are exploring development of a Multidisciplinary Meeting to include colleagues from Tower Hamlets Practices where City of London patients are registered. This allows us to have a full range view of all City of London residents and identify any complex cases that may require an integrated approach. This would include looking at discharge cases and the provision of intermediate care services.

- Short term care is provided through our rapid response service which is funded through BCF. This provides care for up to 72 hours to facilitate Discharge to Assess but also acts as an admission avoidance scheme.

- Where someone has an existing package of care, we can scale this up as required. We can also spot purchase a care home bed as required to provide intermediate care. We are currently monitoring the demand for intermediate care to identify if some block booking would be beneficial over the winter months in the future.

11

National Condition 2: Implementing the objectives of the BCF

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

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

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

- Core BCF schemes are monitored by commissioners to demonstrate value for money and are modified based on learning.
- Many health schemes take a secondary prevention approach.
- Review of local learning and best practice has lead to planned changes for the use of the Disabled Facilities Grant (further details in a following slide).
- Developments of the Transfer of Care hub is based on best practice, NEL ICS and placed-based learning. Through effective planning and linking to our community services, we should see a reduction in re-admissions supporting a shift to care at home.
- Our Neighbourhoods Programme has evolved annually through local learning and review of national best practice. It works closely with our statutory services, the voluntary sector and local residents to take a population health management approach. The programme will support a shift from sickness to prevention and hospital to home (more detail in slides below as it is a significant focus for change).

Neighbourhoods Programme: Integrated Neighbourhood Teams

NEL Vision for INTs

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

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

Our Vision

Based in and for local geographic communities

Coordinated and joined up

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

A culture of prevention in all interactions

Use the hyper local footprint to address local need

Targeting and seeking to reduce health inequalities

Our Approach

Use data to target our resources on those in most need

Build on existing integration work

Co-produce with communities

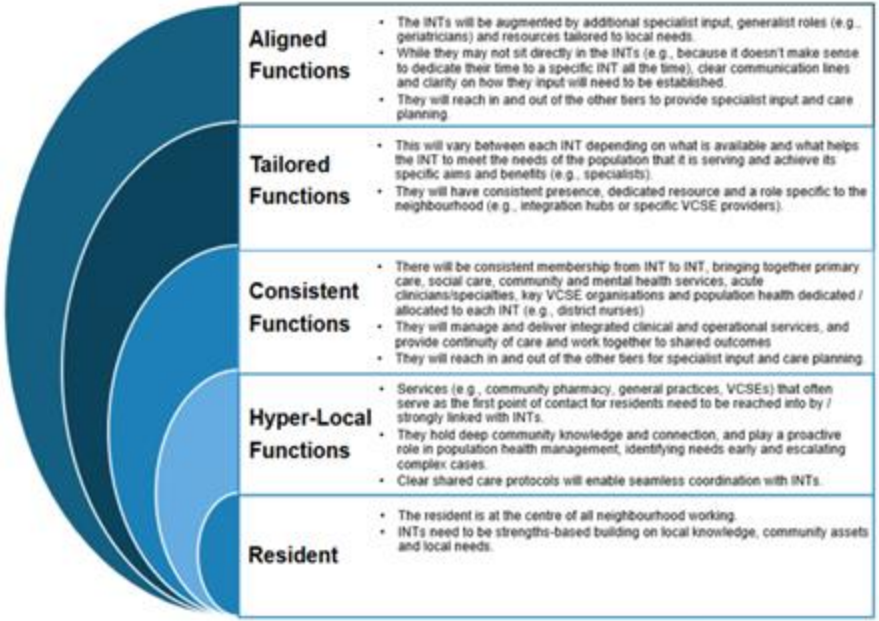
Recognise that this is a cultural change that will require new ways of working

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

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

Developing a core team

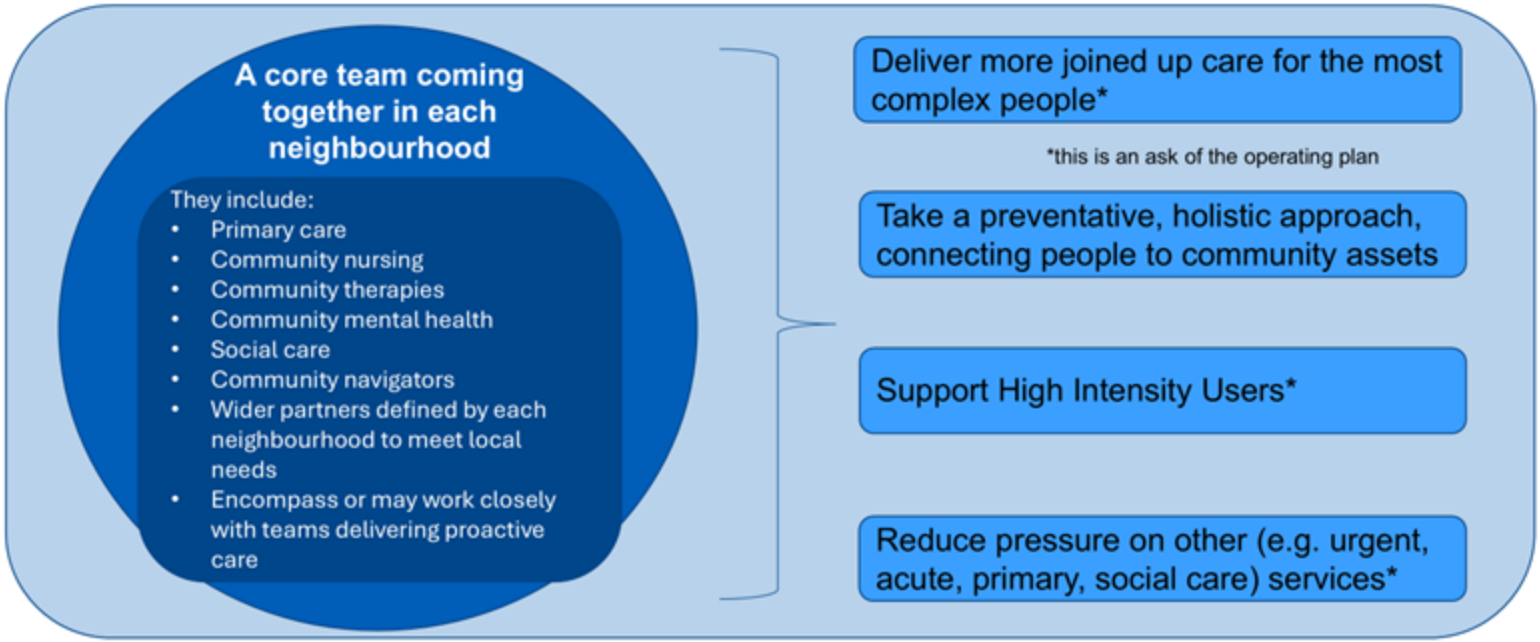
There will be a level of consistency across the core team, however, we will see variation in how the neighbourhoods connect to their communities and meet specific population health needs



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

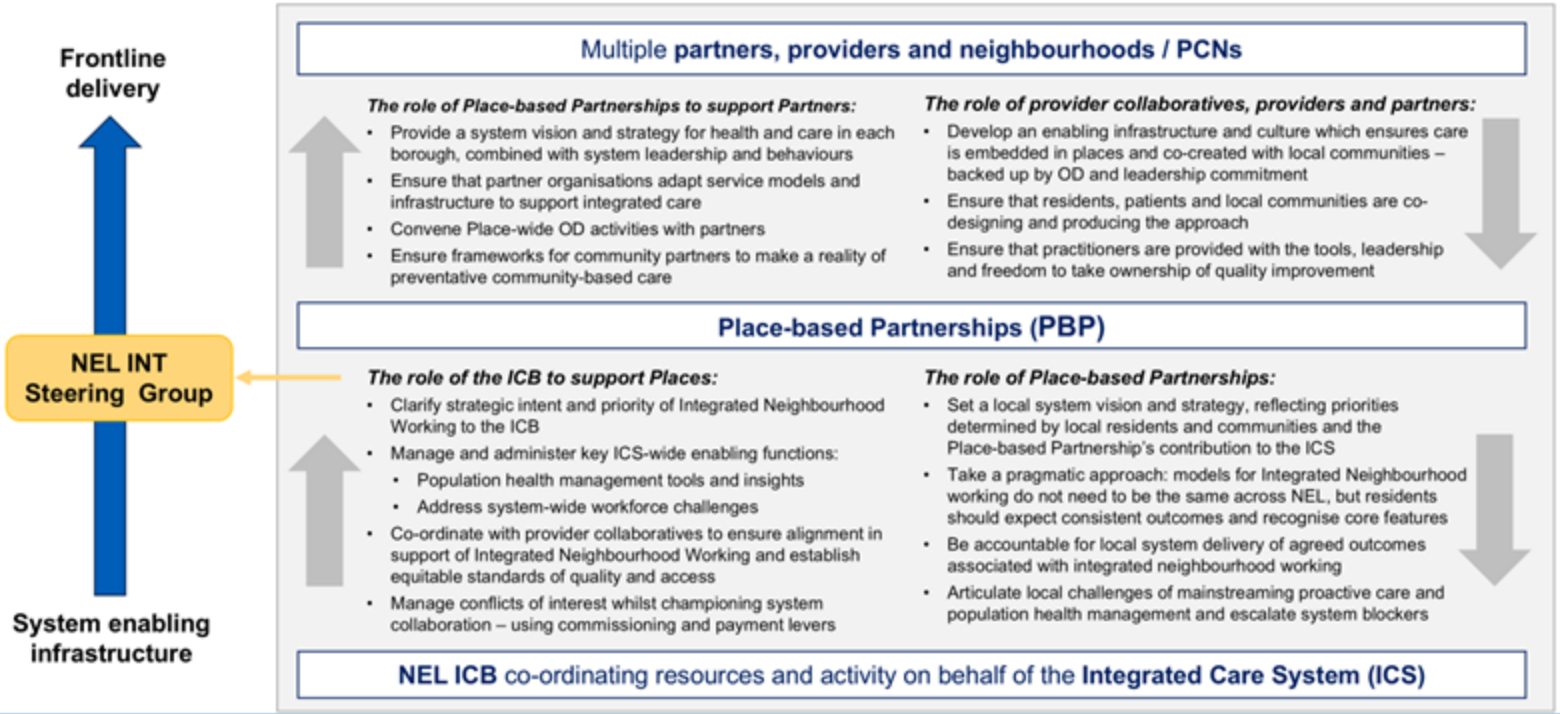
Developing a core team

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



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

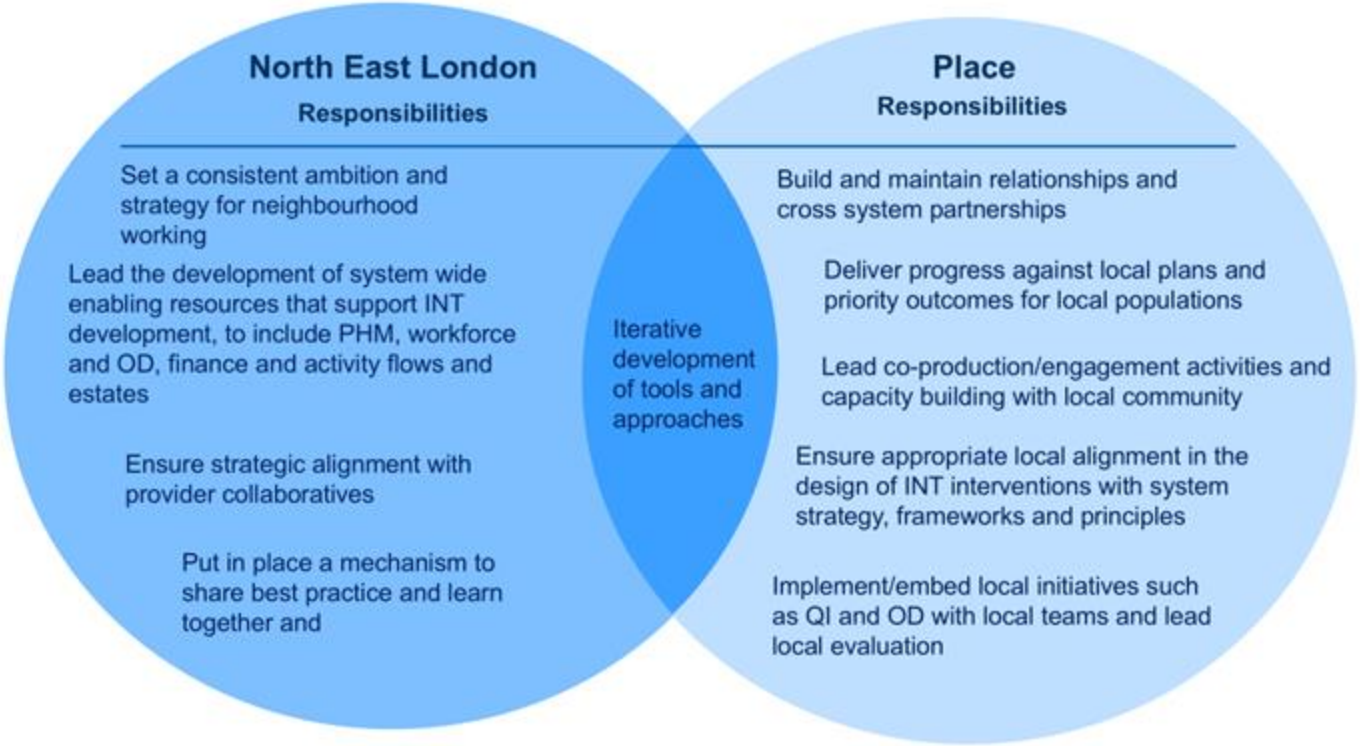
How do different elements of the system support each other to deliver integrated neighbourhood working?



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

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

Summary of NEL and Place responsibilities for enablers



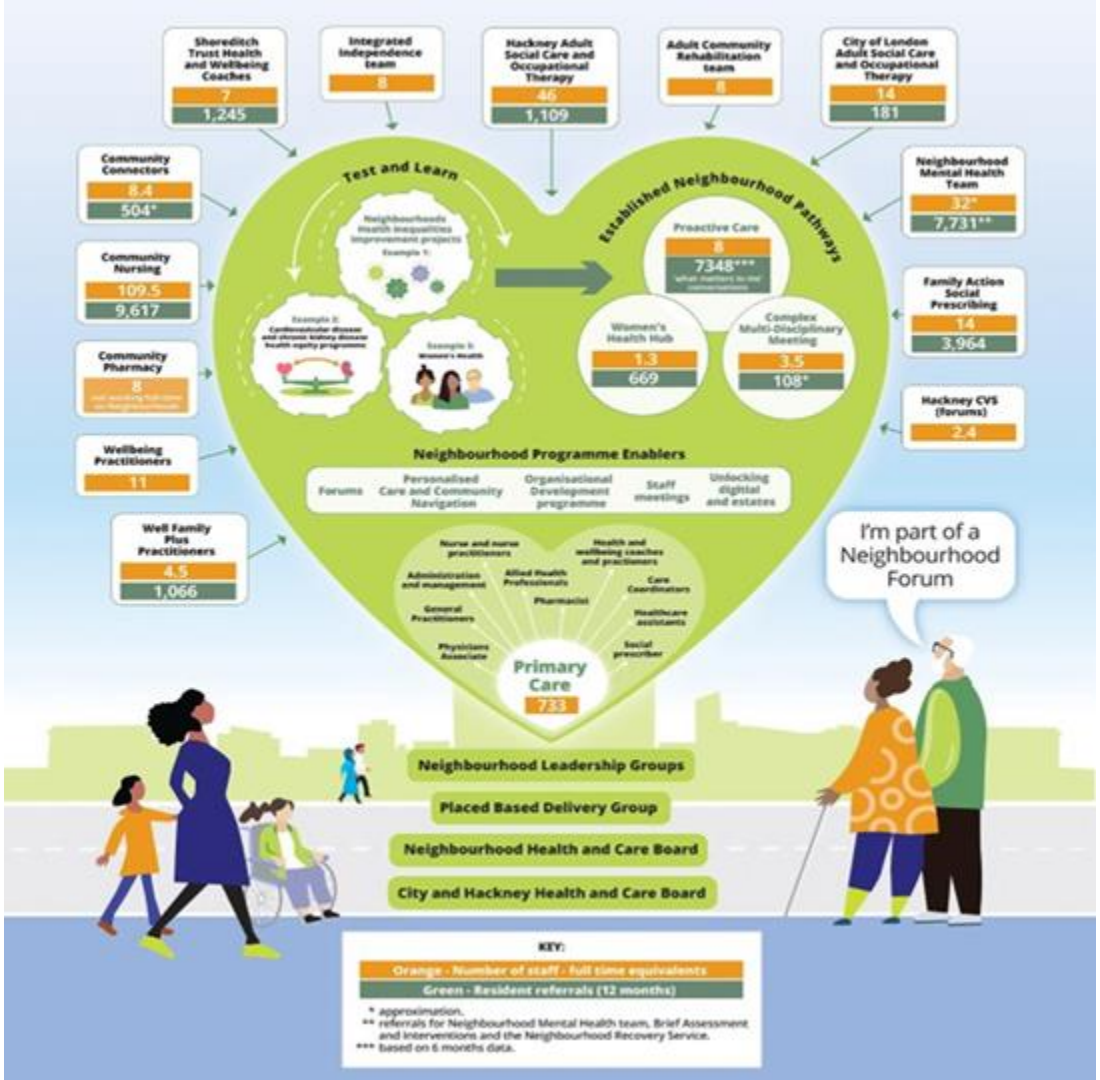
C&H Neighbourhoods - Where are we now?

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

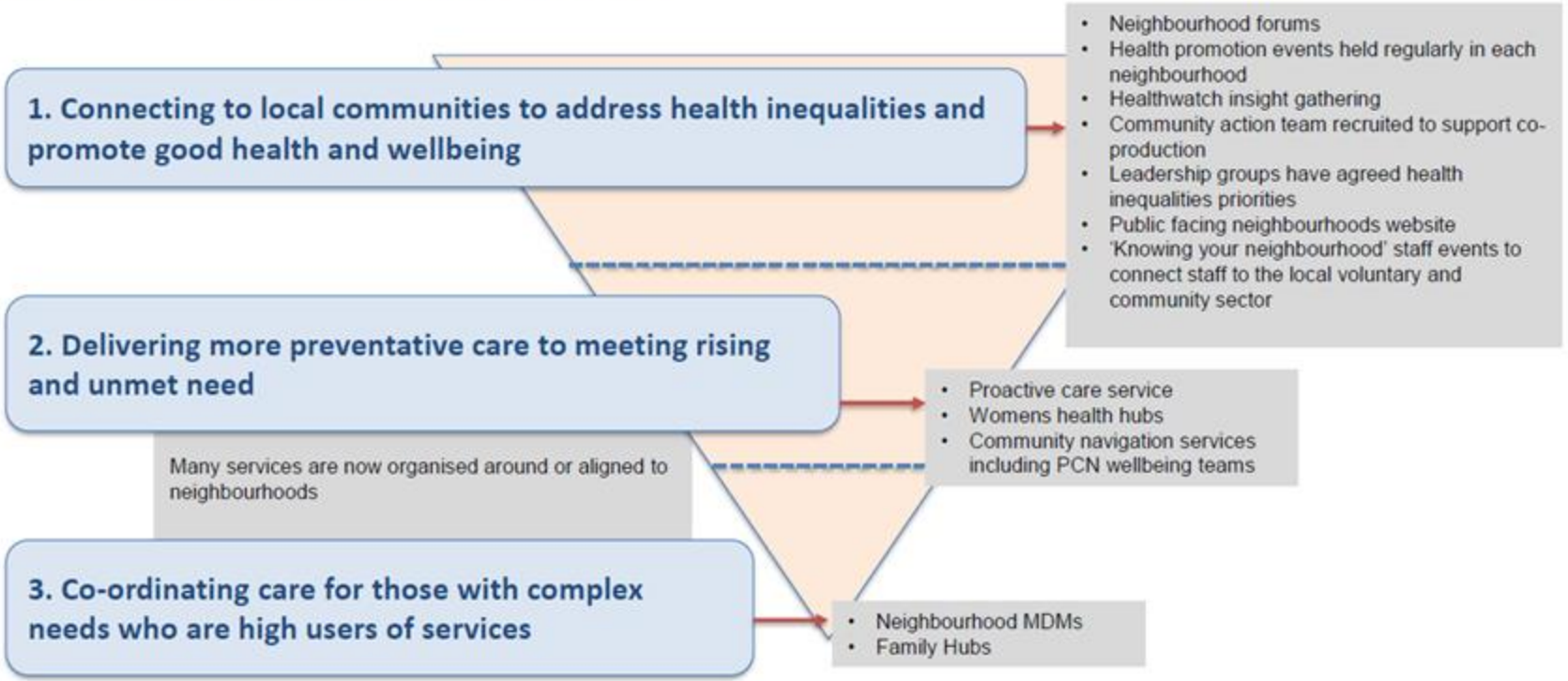
C&H Neighbourhoods

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

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



What are we doing against these aims?



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

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

Traditional services are not always meeting residents needs

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

Closer working in Neighbourhood team(s) could:

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

Metrics

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

Metrics

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

Metrics

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

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

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

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

Discharge Fund Consolidation

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

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

Capacity and Demand

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

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

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

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

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

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

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

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

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

Promoting Equality and Reducing Inequalities

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

To engage or consult with residents

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

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

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

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

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

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

Duty to Support and Involve Unpaid Carers

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

Disabled Facilities Grants

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