Care City Year in Review

2022/23

Care City

Supporting people across North East London
to live healthier, happier lives.

www.carecity.org

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Welcome

...we recognise that all of our projects and all the hard work of our staff only really matters when we work with other organisations that give us their time, effort and resources to partner with.

A message from our Chair

Given our aim is to improve the services and lives of patients and the public it's always important to recognise that Care City rarely makes any impact except through our partners. This means that we recognise that all of our projects and all the hard work of our staff only really matters when we work with other organisations that give us their time, effort and resources to partner with.

This has been the case in our last year as much as it will be the case in our next. This means that when our partners are having a tough time, so are we. And the last year has been particularly tough. So, thanks very much to all the major organisations who have worked with us over the past year.

For the NHS, the Winter of 2022/23 with long waits both before and in A&E was tough. Over the year we have been working with Local Authorities to help with the development of social care staffs use of new technology to help keep the frail and elderly out of A&E and the emergency beds inside hospital. Whilst we all recognise it is much better to treat people in their own homes, too many spend too long in hospital beds at risk of losing their independence.

The theme of maintaining independence runs through most of our work including working alongside very clever partners whose successful development of AI and AR technology helps map community spaces to enable those living with dementia to still enjoy their community and maintain their independence for longer. Technology can appear very abstract, but the way in which it enhances the possibilities of keeping independence for a few more years is very heartening.

During this year we have been very pleased to welcome Matthew Skinner as our new CEO and James Sinclair as our COO. Fresh insights and drive have been very important in keeping us on the move.

This year I have had my own health problems with a prolonged period of healthcare delivered by the good people of Guys and Tommys. I would not have been able to contribute to Care City without the real hard work and support of the other Board members and all of the staff. Thank you.

Professor Paul Corrigan, Chair

Reflections from Matt Skinner

How time flies. It's been six months since I joined Care City as Chief Executive. Joining the organisation, I was acutely aware of the changes that the team had been through. A new leadership team, several new team members and an expanded Community Board – all in the last year. I'm hugely grateful for how welcoming and supportive the Care City team and Board have been and how dedicated they are to making a huge impact through our work. I've met with partners across local government and health in North East London, and I've found vast amounts of enthusiasm, passion and support for our work locally.

At the same time as we have been going through change, our partners across health and social care are also facing unparalleled pressures. Growing demand for public and health services, coupled with austerity and re-organisation, all of this on top of a cost-of-living crisis that is exacerbating inequalities and threatening the social fabric in our communities.

> **This context has meant that Care City has had to continue to adapt to help our partners with these challenges and to meet the needs of our local communities in the last year.**

One of the areas we've been focused on this year has been addressing the workforce challenges across health and social care. We've continued to work on expanding the Apprentice Nursing Associate Programme so that care homes can benefit from new skills as well as providing a route to progression and new career ladders for care staff. We have also just started some work with local partners BHR Academy to consider how we can improve the work experience offer for local young people into health and care opportunities.

We were delighted to receive grant funding from the Cadent Foundation this year. This has seen us working with local residents and taking a co-design approach to understand what opportunities there are to help local residents at risk of fuel poverty. As this has been such a critical challenge for our local communities, we also launched a Fuel Up campaign with partners BDCollective and BDGiving this winter to encourage donations for fuel vouchers to help those families struggling with soaring energy bills.

Care City has continued to develop its relationships with local authorities across North East London and with the NEL ICB. We've been supporting several councils to think about how they can make use of care technology. Care City has a wealth of experience at implementing and scaling technology innovations with communities, through projects like our enhanced homecare work and we will continue to share this insight for the benefit of our local partners.

Looking ahead to next year, I will be working with the team, our Board and Community Board to refresh our Mission. I want to make sure that our work is closely aligned with the needs of our communities and partners and that we bring the creativity and innovation to help them tackle the challenges ahead. We will also work hard to scale successful innovations so that they have a greater impact, including exploring opportunities to share our learning and to learn from implementing them in other places.

I joined Care City because I think this amazing organisation can be at the forefront of reimaging health and care from the ground up and play a role in bringing this about. In the next year we'll be doing more work with our communities and partners to show how new ways of working, new models of delivery and relationships supported by innovation and technology can bring about much needed change.

Matt Skinner, Chief Executive

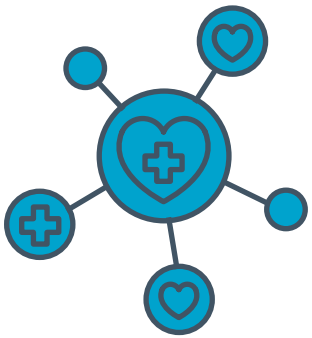
At a glance

Building a local health and social care workforce for the future

Now totalling approximately **200**, continued to build a network of health and social care career ambassadors.

Engaged with over **10,000** 14-18 year olds across a host of school and college events in NEL including Skills London.

Receive **500** unique monthly users on the NEL Careers website, all interested in learning more about local opportunities in health and social care.



Promoting our work and encouraging new investment to North East London

Welcomed **5** new staff members with backgrounds in public health, voluntary and community services and local government.

Recruited **6** new Community Board members helping ensure our work is led by the people of North East London we serve.

Collaborated with over **80** organisations across the region including the 5 NHS Trusts, community sector organisations including BD Giving, technology providers including Feebris and education providers including Newham College.

Launched **1** new website to better showcase the work we do and the insights we develop, to encourage continued investment into improving health and social care for our NEL communities.

Working together to help make a difference to health and care

Engaged over **500** service users with our work to understand local challenges being faced and hear their stories to help us shape improvements.

Published **5** reports sharing insights to improvements people would like to see across post hospital discharge processes and reablement, living with dementia, cardiac rehabilitation and supporting care leavers into local employment.

Raised **£3,974** through our collaboration with BD Giving and BD Collective to support those living in fuel poverty in Barking and Dagenham.

Our achievements

Creating better patient, staff and sector outcomes

Improving uptake of cardiac rehabilitation services

Our report identifies barriers to cardiac rehab uptake and suggests ways to overcome these.

Our work with North East London Health and Care Partnership's (NEL HCP), supporting its health equity audit on the uptake of cardiac rehabilitation (CR) in North East London (NEL) aimed to identify the barriers to CR participation and to provide recommendations on how to drive CR uptake.

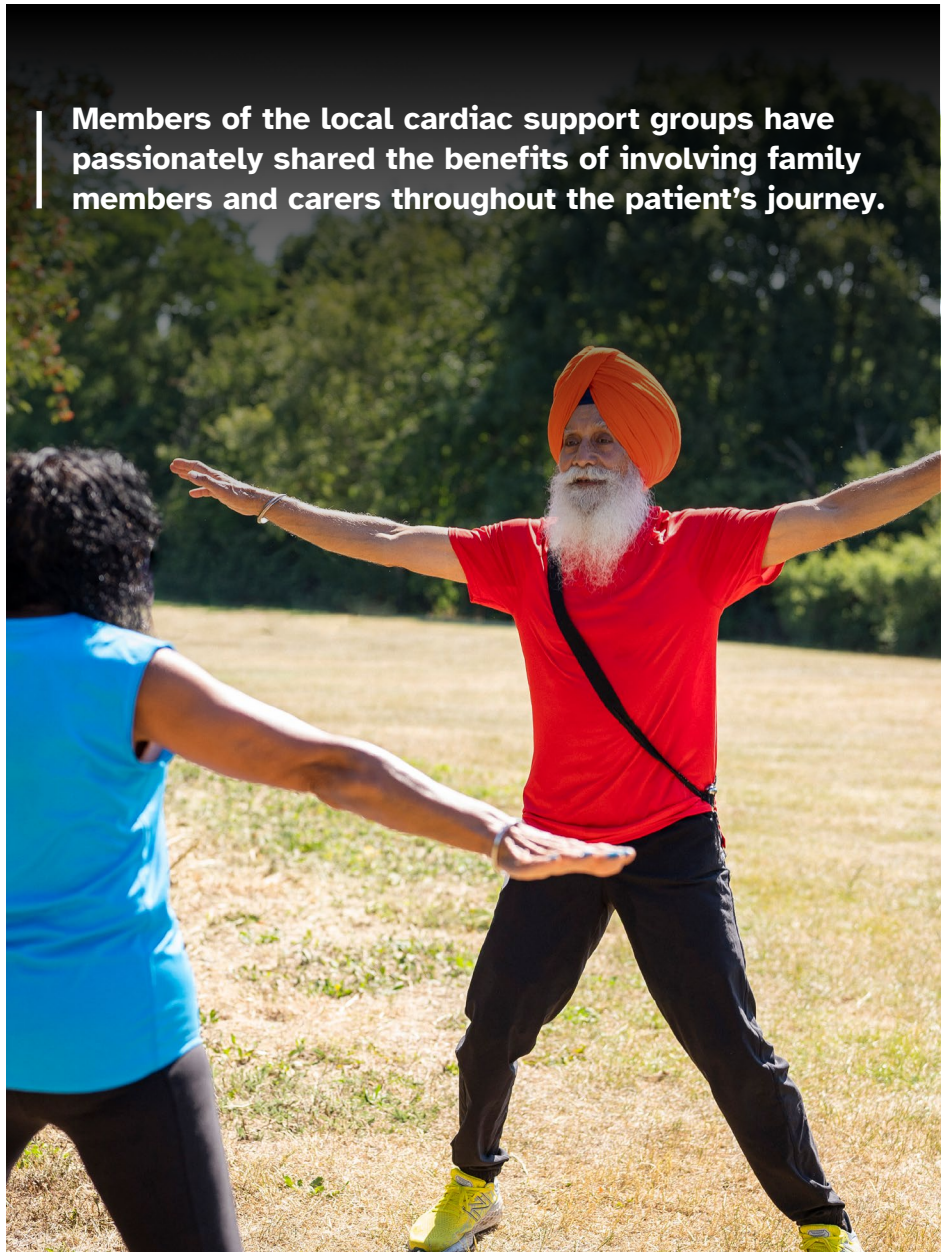
In addition to literature reviews we spoke with 26 patients and carers, and 7 healthcare professionals receiving and/or delivering cardiac rehabilitation services in the London Boroughs of Barking and Dagenham, Havering and Redbridge (BHR) who told us:

1. Strong and supportive clinical endorsement, early engagement following discharge and working with local cardiac support groups to reach out to patients that may have initially refused to participate, can help drive CR uptake.

> *When you leave the hospital, you're obviously then thrusted into the world on your own. Having had a major event and you've been looked after for days, you know, if anything went wrong or anything happened, help would be there within seconds... and then all of a sudden you're on your own.*

2. Involve family members and carers early on. Members of the local cardiac support groups have passionately shared the benefits of involving family members and carers throughout the patient's journey.

> *A small number of people don't have a next of kin and they're the ones who are less likely to respond to our invitation. If they've got a next of kin, a relative, a wife, a child, they would encourage that person to take up the service.*



3. Provide high quality information in a timely manner. Poor understanding of cardiac rehabilitation contributes to low uptake.
4. Identify and engage with local community champions. They can provide long-term social and psychological support for patients following their CR programme completion.
5. Offer a mixture of CR formats such as telehealth, online or community or home based delivery and if offering digital-based CR programmes ensure that patients are empowered to use the technology by equipping them with the skills they would need to confidently use the tool.

We are now working with Barts Health and North London Cardiac Operational Delivery network to understand how we can best support Cardiac Rehab services to achieve green status from the National Certification Programme for Cardiac Rehab.

blog

Together with patients and NHS Staff, Care City is at the heart

Author: Paul Corrigan

Access to Arrhythmia Nurse Specialists (ANS) and Heart Failure Specialist Nurses (HFSN) improve patient outcomes and deliver cost savings to the NHS. However, across North East London there is inequality of access to these specialists, and where there is access to these specialists the staffing levels per population don't meet national recommendations.

There is therefore a requirement for more specialist nurses across North East London. We are developing local business cases to provide justification to the Trusts and Integrated Care Boards to fund these posts.

*Read more **here**.*

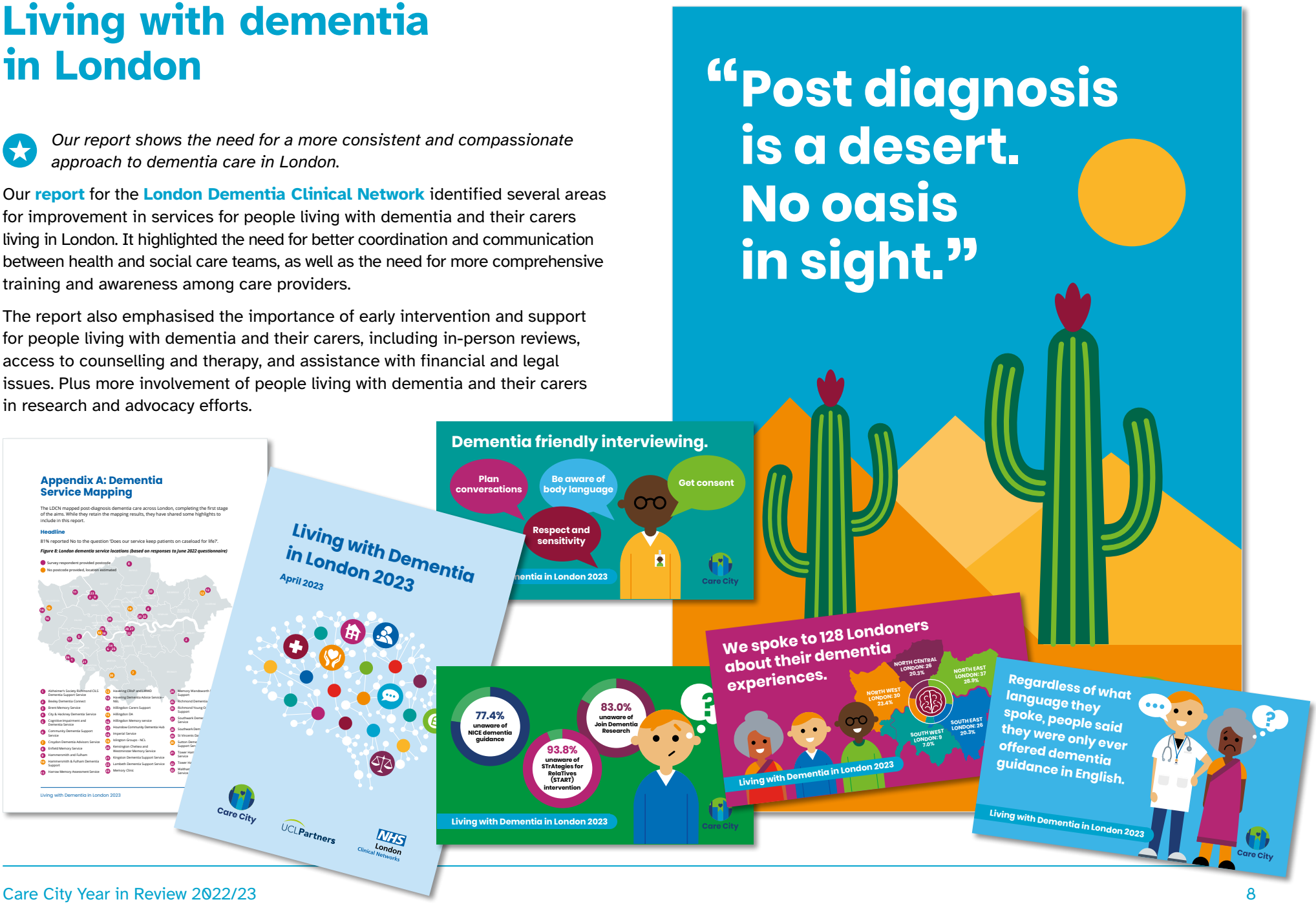
Thanks to our partners: Barts Health NHS NHS Trust · North East London Health & Care Partnership CAREERS

Living with dementia in London

Our report shows the need for a more consistent and compassionate approach to dementia care in London.

Our **report** for the **London Dementia Clinical Network** identified several areas for improvement in services for people living with dementia and their carers living in London. It highlighted the need for better coordination and communication between health and social care teams, as well as the need for more comprehensive training and awareness among care providers.

The report also emphasised the importance of early intervention and support for people living with dementia and their carers, including in-person reviews, access to counselling and therapy, and assistance with financial and legal issues. Plus more involvement of people living with dementia and their carers in research and advocacy efforts.



The Headlines

- Londoners feel abandoned after they get a diagnosis for dementia, something that is for many extremely traumatic
- Londoners living with dementia and their carers are facing a fragmented and hard to navigate healthcare system. What is available in one borough is not available in the next
- Carers don't know who to turn to for advice and are burnt out. Information is only ever provided in English and there is little respite
- People want to have the same offer as people with other long term health issues, such as those with cancer or learning disabilities. People want a six month review of their support needs, followed by annual reviews. People want a dedicated dementia practical advice line staffed by dementia experts who they can contact whenever they face issues
- Professionals feel they are held back by the digital tools and technology they use, in particular, communications and booking systems. They don't feel they are given a chance to do a good job

> *[NELFT have] been using Care City's 2023 report, which consulted with people with Dementia and family, carers and other representatives across London to get the service user views of desired improvements...which include having a key point of contact having some sort of continuity of care, being in contact with services over or similar individuals over a period of time, rather than, for example, just for assessment and then not followed up beyond then.*
>
> *And other things that were emphasised in the Care City report include making sure that we address diversity, particularly diversity around language, and we found that within our own memory services enough that the service was designed in a way that perhaps doesn't fit the broad range of communities that are using that service now.*
>
> Dr Georgina Charlesworth, Associate Professor Clinical, Education & Health Psychology, University College London

Based on this report the London Clinical Dementia Network is piloting a framework to introduce annual health checks and reviews for those living with dementia in London.

Our focus on dementia and improving dementia services and support will continue, as we begin to shape our own Health Ageing Programme. We're very excited about our upcoming work with Dorothy and TPXImpact supporting the development of a virtual 'yellow brick road', wayfinding technology that will enable people living with dementia to physically navigate through their community without further support, keeping them independent for longer.

We're also committed to continuing our work with UCLPartners, on their dementia programme, supporting Commissioners, Service Providers and Service Users, helping prepare them for the new medication becoming available for people living with mild Alzheimer's disease and mild cognitive impairment due to Alzheimer's disease.

blog

Focussed on the challenges of living with dementia TODAY!

Author: Ben Williams, Senior Project Lead, Care City

In the past year, two new dementia treatments have been discovered, treatments that can slow some people's symptoms. It offers hope that people can spend more time being themselves with their loved ones and having their independence. But, some of the almost one million people with dementia in the UK will not have the type of dementia that these drugs treat, and some that do may consider the serious risks and side effects as too much for them. Even if the drugs were approved in the UK tomorrow, the health service is not prepared to administer them immediately. You need to find locations to treat people and train staff in how to use it.

So we need to act now to better support the current generation of people living with dementia. They are already a group living without hope. "Post-diagnosis is a desert," said one carer for his wife with dementia to me while interviewing people for a recent **report** *into living with dementia in London.*

Read more ***here****.*

Thanks to our partners: UCLPartners NHS London Clinical Networks

Understanding carers' experiences of the hospital discharge process

Interviewing carers to understand their experiences of discharge, and how they may be improved. Read more ***here****.*

There is a well-evidenced, well-intentioned view that patients should 'leave hospital as soon as they are medically optimised for discharge'. This is based on the need for system recovery after COVID-19 and discharge evidence and practice. On average, this is clearly beneficial for patients. However, for some carers, whose home situation is more complex, it does seem to raise some challenges, placing an even greater premium on the quality of support they receive.

On behalf of Barts Health, we talked to a number of Carers about issues that can create risks for a successful discharge from hospital including family networks, housing and finance, paid social care and exploitation and made recommendations as to the support that might make a difference.

Communication

Carers need to be kept closely informed about patients' condition, location and the timeline for their discharge. They need to be part of planning for discharge and to be helped to prepare for discharge, practically and psychologically.

Education

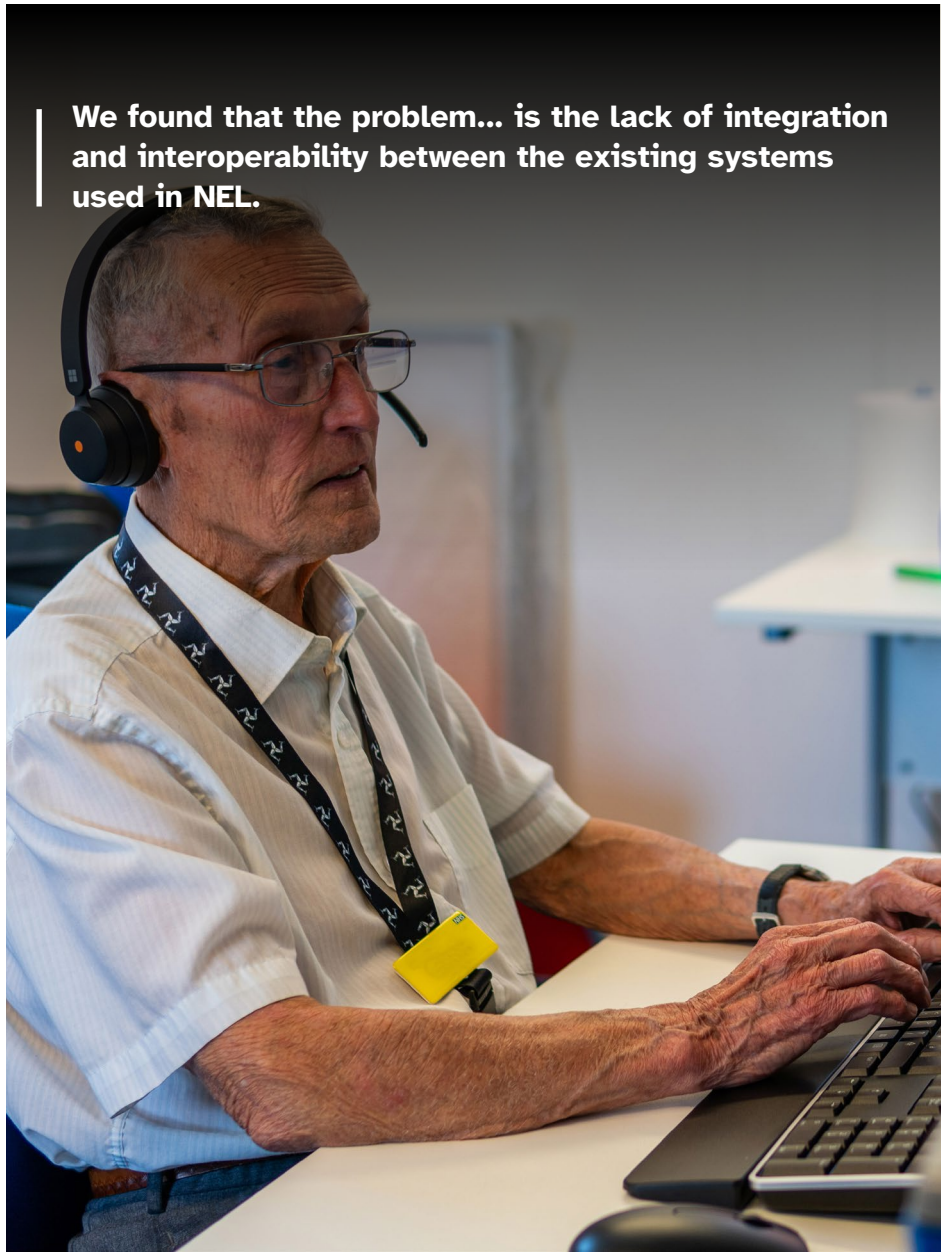
There are skills and pieces of information that carers want to learn to support the patient, and there are clearly opportunities to do more to identify these resources where they exist, fill any gaps and provide them in a user-friendly way to carers.

Support

For some, this is about connecting to wider communities and support groups. However, it can also start with a good, honest conversation with a clinician. When these conversations are at their best, they are about listening to carers' wishes and feelings but also actively coaching and negotiating with carers about what is best for the patient.

A big focus throughout all of our work is prevention and how we can stop people from ending up in the hospital in the first place. We've been using this insight to support partners across health and care with preparing for winter challenges. We also continue to explore opportunities to rethink roles and use new technology in care to help prevent people from deteriorating health, such as our work with remote monitoring and telehealth technology providers Feebris and Whzan.

Thanks to our partner: Barts Health NHS Trust



Digital roadmapping in community health services

*Enhancing the digital provision for Community Health Services in order to provide a comprehensive digitally enabled service. Read more **here**.*

The Digital Community Health Services Programme (NHS England) recognises the critical importance of community health services (CHS) and the current lack of comprehensive digitally enabled services.

Our work on behalf of the North East London Health and Care Partnership (NEL HCP) aimed to inform the development of the CHS provider element of the NEL digital roadmap through reviewing the systems that the community providers use and how they connect (if they do) with primary, secondary and tertiary health and care providers, the digital infrastructure challenges faced by CHS providers and potential solutions to these challenges.

We found that the problem isn't the absence of a universal CHS patient management system – it is the lack of integration and interoperability between the existing systems used in NEL.

> *There is no joint working across systems, even in contracts where they have great working relationships with partners and trusts. There needs to be a system wide approach to ensuring genuine interoperability across systems and providers.*

CHS providers welcome the flexibility to be able to select a system that caters to their individual needs. However, whilst there was an overwhelming consensus that it would be beneficial if the existing systems can talk to each other, there is a clear need to support providers in clearly articulating what an "integrated and interoperable data system" looks like across the sector.

In order to enable this, our conversations highlighted:

A robust change management process is required to support providers with any system changes

CHS providers are open to changing their existing systems to an alternative system deemed by the ICS to be integrated and interoperable. This would require a robust change management process that is co-designed with providers covering clear rationale for the change, funding, workforce training and support and support managing clinical risk.

Improved access to the North East London Patient Record needed

Providing CHS providers with edit access will enhance the shared patient records. By doing so, patients receive more holistic care as healthcare professionals are able to see patient information from different parts of the sector and can spend more clinical time with patients instead of spending too much time pulling information from different sources.

> *I think there's an assumption that [providers] have access to all [information] from the patients, from the hospital. In reality, they have access to none of it. It's quite frustrating because there's not the understanding of what's out there really.*

The need for an improved patient pathway

Incomplete referral forms lead to increased admin burden which ultimately impacts service delivery and in some cases, poses safeguarding risks. The lack of a feedback loop to patients affects how they perceive the quality of care they are, or are yet to, receive, especially when they are left waiting to receive the service due to long waiting times. Additionally, staff have reported that there is a sense of mistrust in patients when it comes to how their data is handled.

> *I think particularly for young people, there's a real sense of mistrust of the system. So it's about making clear where the information is going and who's going to get access to it.*

However there is enthusiasm within the sector to improve this process through:

- Harnessing existing systems – such as the ELPR – to increase automation when filling in referral forms.

> *I think manual waste is my priority because whether you are a referrer or at the receiver, you spend hours self-writing and making those referrals, which should be quite automated. Rather than doing your job, you're making that referral. For example, a therapist who is making a wheelchair referral should be doing therapy, not writing a wheelchair referral.*

- Moving away from relying on manual data entry to using systems that are interoperable with each other
- Increasing transparency and visibility of the capacity of other service providers so that patients are able to be signposted to the right service as soon as possible
- Having a dedicated patient-facing system that allows patients to access and view their medical records will build trust in patients
- Providing or signposting patients to relevant information regarding their situation whilst they are waiting to receive their care, by utilising digital options that are already widely available

As the North East London Integrated Care Board (ICB) uses some of these insights to inform their future approaches, we will continue to collaborate with the ICB as they develop their digital strategy in 2023. We'll also be working with the Social Care Health Record programme team across London to understand how the shared record could be implemented in domiciliary care providers. We'll be sharing the insight we've learned from working with smaller organisations to help them engage with and implement the shared care record programme successfully.

Thanks to our partner: North East London Health & Care Partnership CAREERS

Using research to understand the role of healthcare services as a route into social care

New research we've led alongside **UCLPartners** and **The Health Foundation** and published in the **British Medical Journal** has demonstrated that the length of time someone is admitted to hospital is directly linked to their chances of needing further care at home when discharged.

By using the **Care City Cohort** dataset, the team was able to clearly show that across all age ranges, hospital admissions were strongly associated with a need for new home care packages. And that new home care needs were most common among patients who were older, had more comorbidities, were admitted in an emergency, and had longer hospital stays.

...new home care needs were most common among patients who were older, had more comorbidities, were admitted in an emergency, and had longer hospital stays.

The Care City Cohort remains one of very few linked datasets that connects council data with health and social care service use across hospital, primary, community, mental health and community care settings. This is a powerful tool in understanding the relationships between health and social care and should help health and local authority planners and commissioners anticipate and plan for future home care need.

The research shows that hospitals are a major referral route into domiciliary care. While previous studies have examined the overlap between health and social care use[1] no studies have yet looked at the role of healthcare services as the route into social care.

> *"The Care City Cohort is a unique resource that allows us to get a better idea of service use across settings of care. For this research into home care service use we have been able to show how someone's point of entry into the care system can help us predict what future care support they might need. It will be great to see the Care City Cohort being used by other research projects to further inform care planning, and demonstrate the benefits of a system wide, integrated approach."*
>
> Dr Jenny Shand, Chief Strategy Officer, UCLPartners

To use the Care City Cohort linked dataset to inform your research, email **carecitycohort@carecity.org**

[1] Bardsley M, Georghiou T, Chassin L, et al. Overlap of hospital use and social care in older people in England. *J Heal Serv Res Policy*. 2012;17(3):133–9. doi:10.1258/jhsrp.2011.010171

Thanks to our partners: UCLPartners The Health Foundation

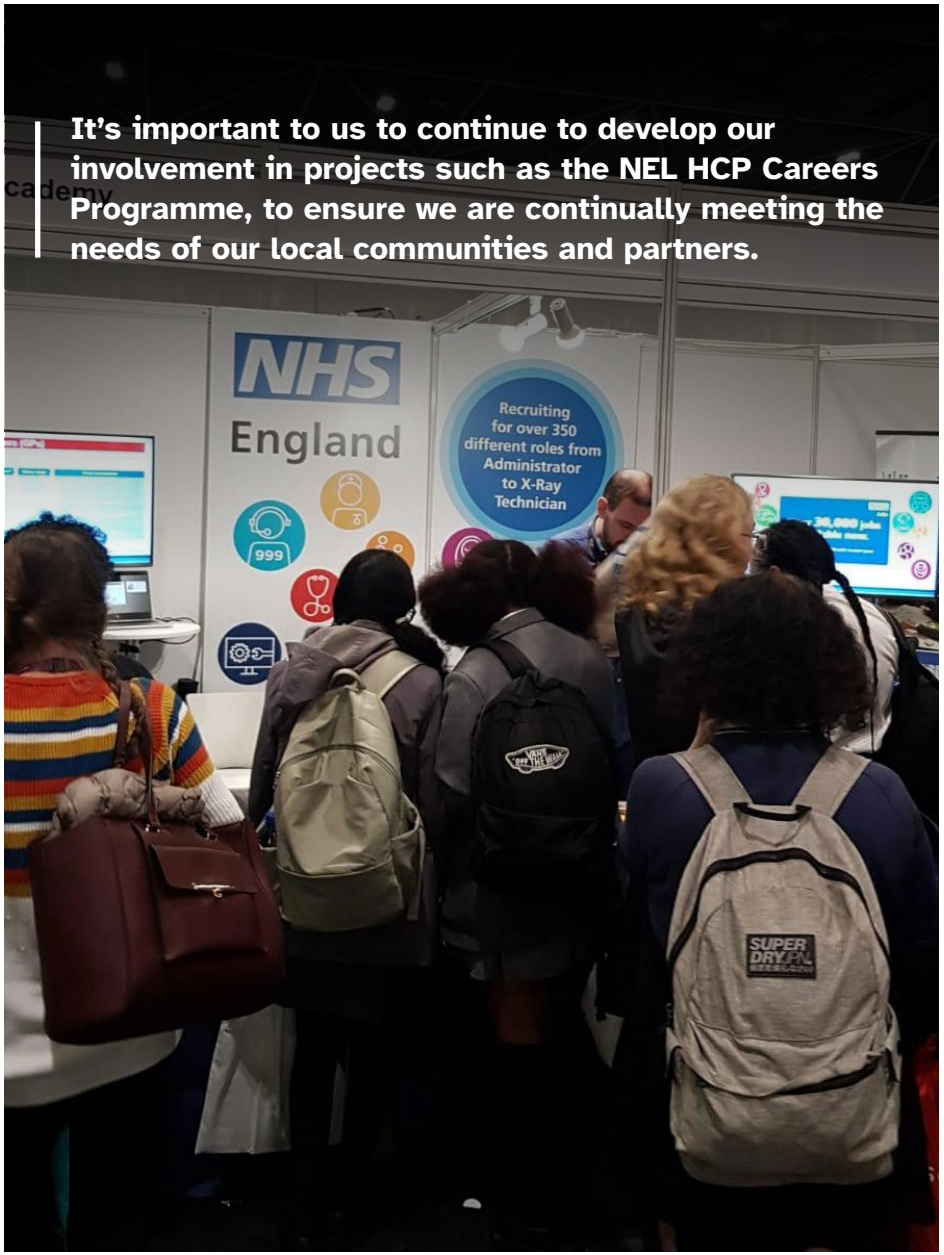
Creating good jobs and training opportunities for local people

Encouraging young people and job seekers to consider careers in health and social care.

Since 2019 we have acted as the engagement partner for North East London Health and Care Partnership's (NEL HCP) careers programme. With a reduction in numbers of students accessing health and social care careers, challenges accessing harder to reach groups i.e. those not in full time education and a higher than average number of school leavers going straight into employment, the need is there for us to promote health and care careers to local residents. Ensuring all residents are aware and have equal access to the broad range of career opportunities, training and work experience schemes available to them in NEL.

Our network of Health and Social Care Careers Ambassadors continues to grow and includes administrators, carers, nurses, doctors, allied health professionals and IT and finance staff from across Primary, Secondary and Social Care, Mental Health and Community Trusts, Local Authorities, Commissioning, HEE and NHSX. They have been invaluable in supporting us to engage over 10,000 14-18 year olds across a host of school and college engagement events in NEL.

> *Through our involvement as a Career Ambassador with Care City and the NEL HCP Careers Programme, we were able to meet with 40 students at a careers workshop, hosted by Barking and Dagenham College and help them understand the local careers opportunities available to them in the health and social care sector. As a result, we have been able to forge connections with the college and recruit four students to take up carer work placements.*
>
> Pooja Barot, Owner, Shreeji Training



> *Learners were motivated and gained important info to help make informed choices about careers in health and social care. Colleges should take advantage of @NELHCP Ambassador network to help their students make career choices.*
>
> Jeanette Griffin, Employer and Skills Lead, Barking College

It's important to us to continue to develop our involvement in projects such as the NEL HCP Careers Programme, to ensure we are continually meeting the needs of our local communities and partners. We carried out a mapping exercise to capture the careers activity taking place across North East London to see how we can support the NEL HCP Careers Programme to be more effective, such as avoiding duplication of work, identifying where we can share learning and best practice and better understanding the career support needs of the system.

Interviews were conducted with 11 key partners including NHS Trusts, Barts, Homerton, BHRUT and NELFT, Enterprise coordinators from North East London and Central London Careers Hubs, Social Care Partners CPV and Skills for Care, as well as HEE.

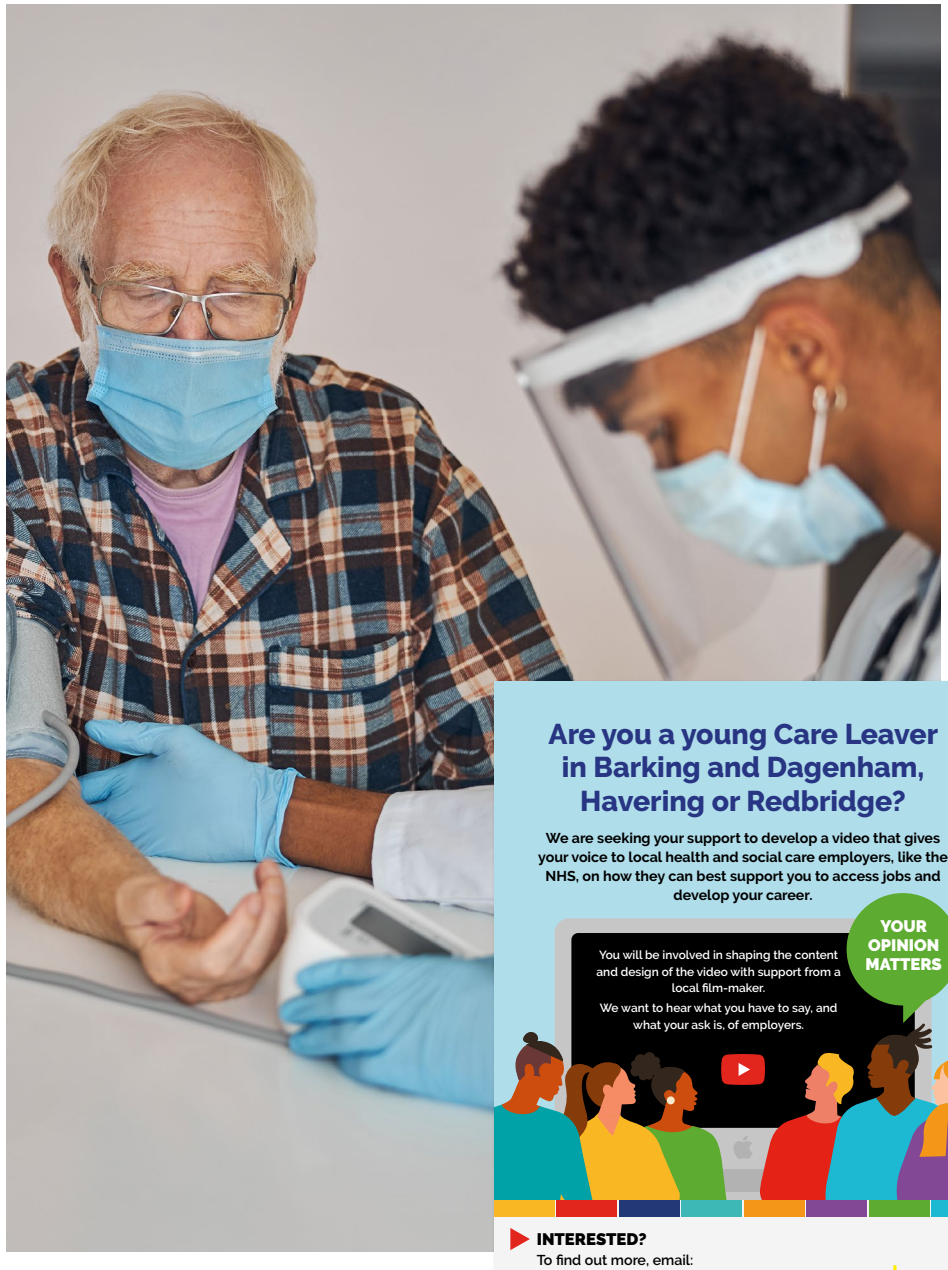
We found 11% of our partners rely on the Careers Project for school/college engagement, 55% manage ambassador programmes, but of these 33% said they were happy for the NEL HCP Careers Project to manage ambassador recruitment, engagement, induction and co-ordination.

Interestingly 44% of NEL HCP partners offer online/in person work experience, an area that at Care City we are keen to work on in the next year, particularly for audiences at risk of not being in education or employment or training (NEET), such as Care Leavers.

We continue to think about the need for new roles across care to support people to stay healthier and to age well. We will be looking to do more work around Allied Health Professionals (AHPs) and to support our partners to make use of new career pathways into health and social care such as T-Levels.

Thanks to our partner:

North East London Health & Care Partnership
CAREERS



Supporting Care Leavers into the sector

Care leavers are young people who have been looked after by the state, some for all of their childhood, and have subsequently left the care system or are in the process of doing so. In England and Wales, the leaving care age is 18. Care leavers are legally entitled to ongoing support after they leave care, up to the age of 25.

Care leavers are more than three times as likely to be not in education, training or employment (NEET) than other young people.

We partnered with BHR CEPN to look at how we can better support Care Leavers into roles in health and social care. Care leavers bring fresh ideas and through their lived experience, a broader range of perspectives. Because of their experiences, many have a strong sense of resilience and independence, and maturity beyond many of their peers.

But care leavers often face serious disadvantages growing up and challenges in their lives which impact on their long-term life chances. We wanted to understand as employers what we could do better such as providing opportunities, offering sensitive and effective support, breaking down barriers to and in employment.

> *"By understanding our perspectives, employers can support us to develop the skills, experience and confidence we may need to gain, stay and progress in work – and support us to achieve our huge potential."*
>
> Care Leaver

We spoke with a number of Care Leavers, who gave us some incredibly valuable feedback as to what more employers need to do, to recruit and support them through their careers and the huge value they can add to an organisation through their lived experience.

Understand their needs throughout the recruitment process

From interpersonal skills, to practical skills (complete applications, write a CV, timekeeping) to practical needs (financial help with clothing, travel). Although many care leavers may lack the skills, confidence and qualifications, they may also be reluctant to declare their experiences of care; unsure how employers will react to this information.

Understand how we can prepare them for the world of work

Finding work experience opportunities often depends on connections through family, extended family and friends which care leavers are less likely to have. We know that there are insufficient work experience opportunities for school students in general, but these opportunities help prepare care leavers to develop new skills and build confidence, experience a workplace environment, have experience to include in their job applications, understanding of different careers and make informed choices about their future career.

When recruiting, focus on their strengths and what they can offer employers

Only 14% of young people in care gained five GCSEs at grade A – C (including English and maths) in 2016, compared to 53% of all other young people*

Care leavers are less likely to participate in higher and further education, compared to those with no care experience. But they are more likely to use some NHS services compared to other young people, so are therefore experts by experience. Use value based recruitment approaches, recognising that values are intrinsic to a person, skills can be taught.

Understand their lived experience and how this may impact their decisions at work

Housing and related financial security is a key barrier faced by care leavers in employment. They may lack family safety nets and finding somewhere to live may be a greater priority than a career. Care leavers have a range of different attitudes and needs regarding work. Some may have had disrupted school experience. This may be their first experience of employment. They may not have learned key skills like timekeeping and may need extra support to understand their role and the expectations of them in the workplace.

It's important not to "just assume the worst" but be appropriately challenging about any negative or disruptive behaviours, find out if there are any underlying issues and ask the care leaver what support they need to address them.

Understand how to support them to thrive at work

Looked After Children and Care Leavers are one of the most vulnerable groups in terms of their emotional wellbeing and mental health; 46% of Children in Care will have a diagnosable mental health disorder.

Many care leavers appear to experience social exclusion, which can limit networks on who they can ask for support. Work-based relationships can offer informal support systems and opportunities to build trust with line managers with whom they can discuss (work and personal) issues, seek guidance and be supported to make informed decisions. Feeling valued and listened to and being part of a wider team can positively impact on a care leavers' confidence and self esteem.

Having an awareness of the challenges and barriers that care leavers often face, while not making stereotypical assumptions, will help us to offer opportunities and support that are both appropriate, effective and make a difference in enabling care leavers to take the first steps in building successful careers.

1. Be inclusive and supportive
2. Challenge negative stereotypes and be a role model
3. Find out how you can offer work experience/shadowing/mentoring opportunities to care leavers
4. Find out where to get support within your organisation – both as a care leaver and as a line manager
5. Link with organisations that provide support

Care Experience and Employment, IRISS, 3rd August 2021

Building successful careers: Employers guide to supporting care leavers in the workplace, Learning and Work Institute, 2017

'Ready or not': care leavers' views of preparing to leave care, Ofsted, 19th January 2022

Looked After Children and Care Leavers Outcome Report – Survey of Mental Health Services for Looked After Children and Care Leavers 2019-20, Healthy London Partnership, June 2020

Thanks to our partner: BHR CEPN YOUR TRANSFORMATION AND TRAINING HUB

Community and preventative health

Tackling fuel poverty in Barking and Dagenham

We joined forces with **BDGiving**, **BD_Collective** and **ELBA** to launch the 'Fuel Up' campaign, enabling Barking and Dagenham community members that can, to help other community members in need, by donating some or all of their monthly £67 government energy rebate that was sent to every household.

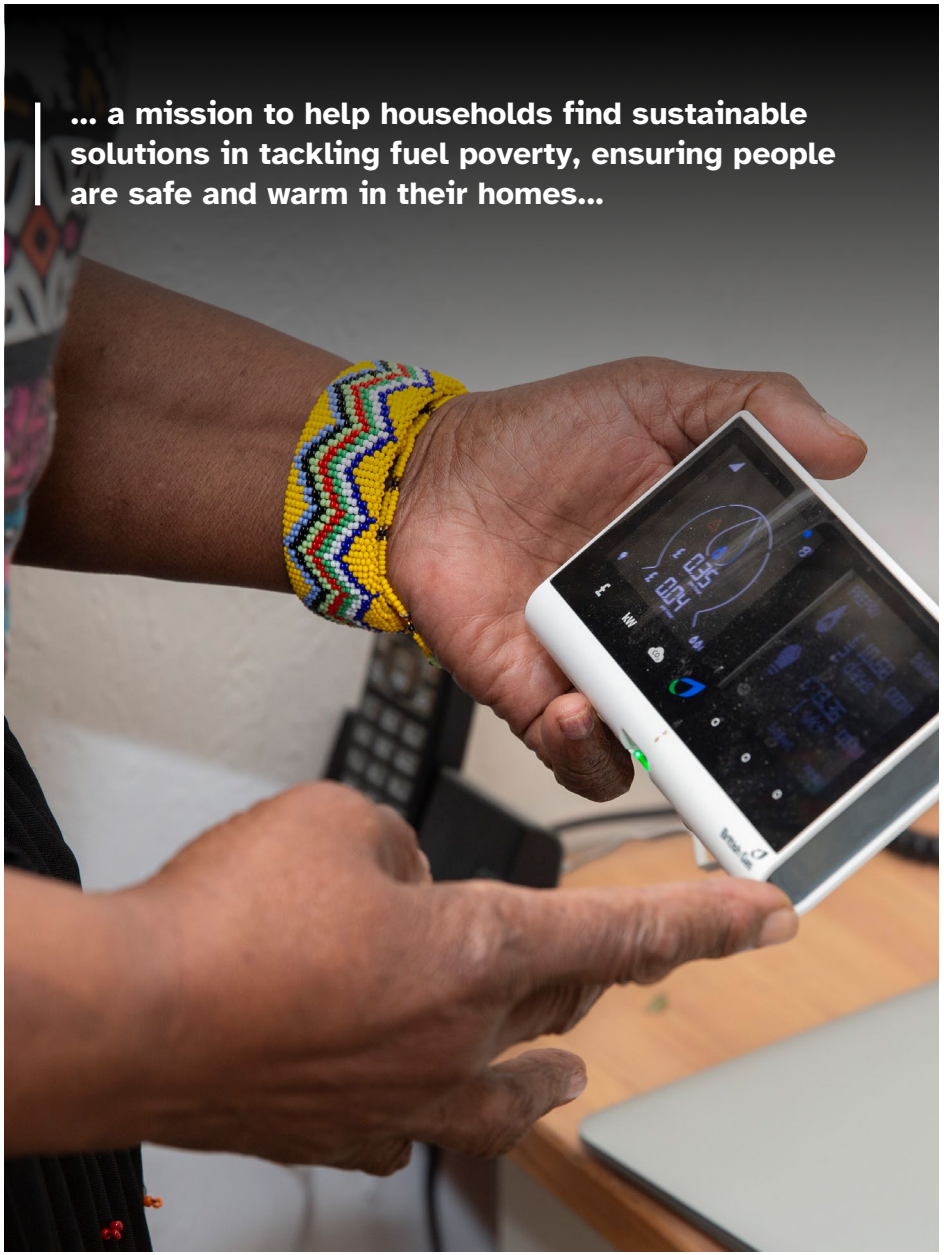
£3,974 was donated by generous B&D residents and organisations and was used to provide vouchers to those in need, through the BD Collective's Food Network, a network that supports 20 local organisations that provide essential food and other necessities to vulnerable residents.

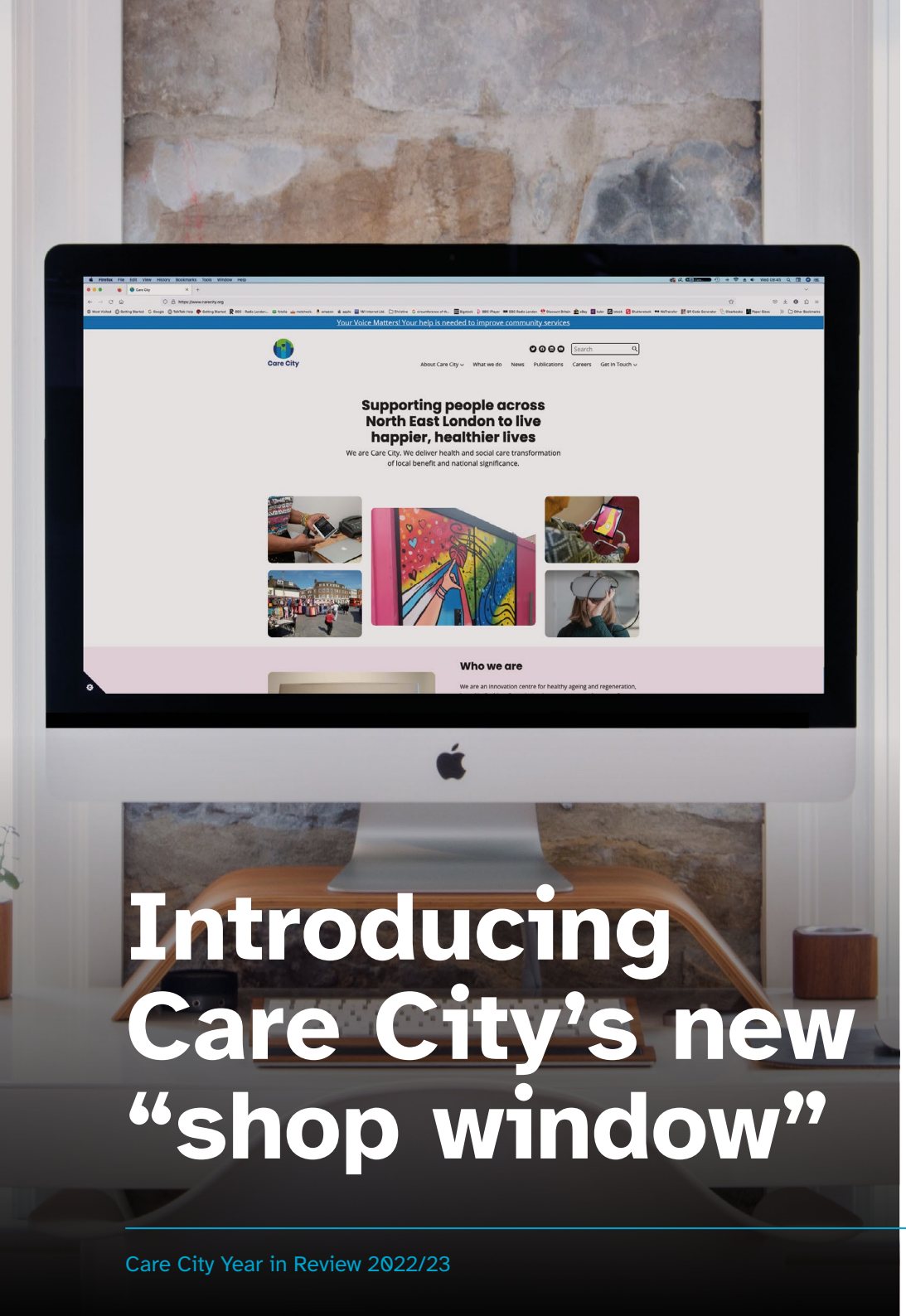
> *We were thrilled to collaborate with BD_Collective, Care City, and ELBA on the Fuel Up campaign. With the increasing needs of families and individuals in our community, it is reassuring to know that our community has a long history of generosity.*
>
> Geraud de Ville de Goyet, CEO, BD Giving

This video shares insights from two Foodbank volunteers as to how donations can make a difference.

We have since secured a £102,714 grant from the **Cadent Foundation** to pilot important new initiatives to continue to help tackle fuel poverty within the Barking and Dagenham community. With a mission to help households find sustainable solutions in tackling fuel poverty, ensuring people are safe and warm in their homes, the Cadent Foundation funding will support us in creating an innovative new model to identify where fuel poverty invention needs to take place, specifically targeting vulnerable communities with health issues.

Thanks to our partners: BD COLLECTIVE · Barking & Dagenham Giving · Cadent Foundation





Introducing Care City's new "shop window"

Time for a change...

Our website

Websites should be constantly evolving "shop windows", reflecting an organisation's work and adapting to its audience needs. The Care City website was initially developed in 2016 but with a change of management, ongoing success delivering projects and improved brand recall, we realised it was time for a change. We worked with DXW, experts in digital strategy for public and third sector to design and build a website that we feel better reflects the spirit of our organisation, showcases our business, enables access to a library of resources and publications and speaks to the quality of how we support North East London.

Logo

Next up, was our logo. Focussing on the blue of health and green of care, we reduced the number of colours on the Care City logo and hope we've brought a slightly more "grown up" feel to our brand, just as we feel we have grown and developed since becoming a CIC in 2019.

We're not stopping there...

2024 will see us continue our rebrand in order to make new connections, develop our relevance to a more diverse audience and reinforce our values.

Expanding and diversifying the Care City team

Five new faces joined Care City in 2022

2022 saw us welcome Matt Skinner, James Sinclair, Rahela Begum, Pia Barna and Christine Sanger to our Care City team. They've come to us from a variety of different backgrounds including NELFT, local Government, Voluntary sector, Finance and Tourism and brought with them some creative new ways of working.

Matt Skinner

Matt, our new CEO, introduced us to Personal User Guides, or PUGs as they have now affectionately become known (probably as the majority of the team is crazy about dogs!). PUGs are User Manuals that enable team mates to explicitly communicate to others how they work. We've been sharing our PUGs with each other, to better understand our individual backgrounds, values, and communication styles.

James Sinclair

James, our COO's background in clinical research has seen him very helpfully deliver 'Research in the NHS' training to the team. And to support the diversification of the audiences we want to target to ensure they are included in our work, his LGBTQ+ and Health Inequalities training was very insightful. He also loves a spreadsheet and is happy to give his top tips to achieving spreadsheet brilliance to anyone who will listen!

Pia Barna

Pia, our Project Lead quickly established a new Buddy System, based on her experiences of being “the new girl” at Care City. Every new person that joins us is paired up with a dedicated person in the team that they can go to with ALL of their questions. The buddy will explain any new systems, purpose of various team meetings and generally be there to make the first few weeks as informative, efficient and fun as possible.

Rahela Begum

Rahela, our Project Lead’s background in co-design and collaboration across Barking and Dagenham has helped foster new introductions and relationships with local community groups, improving our local connections and amplifying Care City’s messages.

Christine Sanger

Christine, our Project Support Officer, like James, loves a spreadsheet, but adds more colour to hers, which the majority of us applaud! Her background in user acceptance testing was invaluable during the launch of the new website and we simply don’t know how we managed before without her!

We continue to think about what makes us a great organisation to work for (and with) and focus on improvements to our working environment and practices that could encourage fresh talent to the team. The team has supported the development of a new internal progression framework and we’re testing this over the coming year. We’re also focussed on reviewing our Health and Wellbeing practices, ensuring that we provide an environment where people can succeed and flourish.

The team at Care City:
Back row from left: Rahela Begum, Christine Sanger, Mez Jardiel, Pia Barna, Julie Atkins
Middle row: Lindsey Carter, James Sinclair, Matt Skinner, Ben Williams
Front row: Rachel Fuller, Nicola Kelly

blog

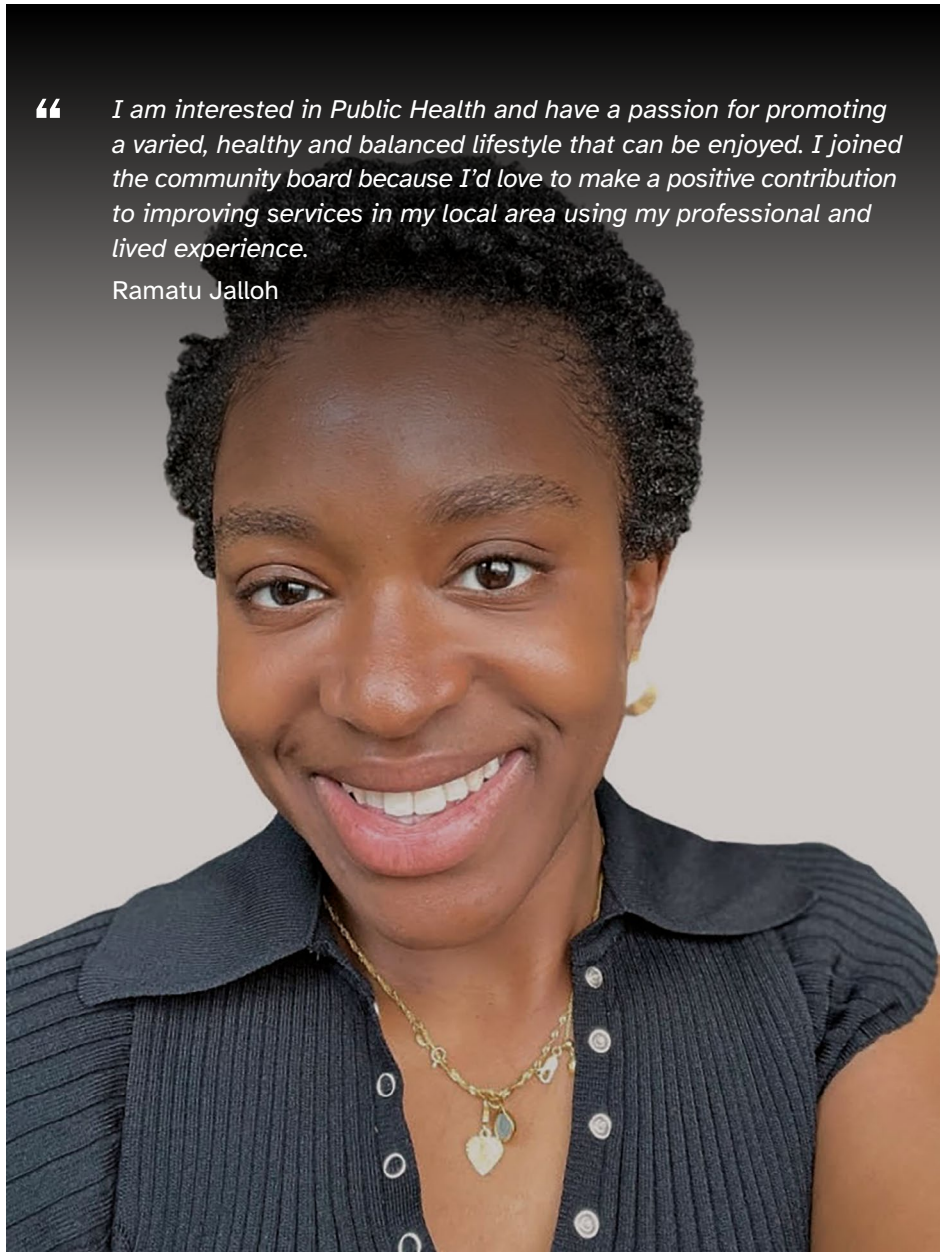
From uncertain beginnings to impactful leaps

Author: Pia Barna, Project Lead, Care City

A while ago, my colleagues and I wrote about our – very different – career paths and how we were all brought together by Care City’s mission to support people living happier and healthier lives.

When I wrote my application for this position, I felt pretty strongly about wanting to find a role which would allow me to put my skill set to good use and to make a meaningful impact. With neither experience of having worked in the non-profit sector or the health and care sector before, I wasn’t all too confident in my chances of being considered for the job but I believe that honesty, my genuine interest to learn and a little bit of luck played a role… and here I am!

*Read more **here**.*



Developing our Community Board

The focus of our Community Board is to involve patients, carers and representatives of our North East London community within our decision-making processes to ensure our work is led by the people we serve. It includes local residents, patients, carers, and staff from the voluntary sector, care and health agencies – people who have professional and/or lived experience and can bring that expertise to the Board. And last year we recruited seven new members.

Sef Allali

Project Management Consultant with experience of working with youth groups

Angela Ankhomar

Pre-Analysis BHRUT, Volunteer and Co-Director of Wellness

Dionne Corrodus-Weekes

HR Manager and Volunteer Community Builder

Caroline Edser

Peer Support Volunteer at LBBD and NELFT Patient Experience Programme (PEP) participant

Susan Harper

Family Worker Leanne Mason

Leanne Mason

Social Isolation and Loneliness Support Worker, LBBD and NELFT Involvement Representative

Ramatu Jalloh

Registered Nutritionist for local catering organisation

> *I hope the Community Board can work cohesively with families, individuals and service providers in North East London to ensure 'Every Person Matters' and an Inclusive Practice is administered within the implementation of social care/well-being interventions.*
>
> Susan Harper

Since then they've supported our discussions around dementia, and unmet needs in our community, fed back on marketing materials and comms requirements for new projects and sat on interview panels supporting Care City recruitment.

As we move forward, we're investing time in looking at how we can best train and integrate the Care City team and the Community Board. For our team it's about ensuring the right internal processes, culture and capability is in place to support the ongoing involvement of Community Board members in our projects.

For the Community Board we're focussed on working with them to further develop their involvement in agenda setting, bids, research design, data collection and analysis and dissemination and communication.

> *I have experience of working in and using health services and feel that both physical and mental health should be integrated to provide optimum healthcare. I enjoy undertaking research into mental health which addresses new therapies and ideas and have worked as a volunteer mentor to individuals experiencing mental ill health. I like to work holistically to support a recovery ethos that inspires hope. I am really excited about my work with the Care City Community Board.*
>
> Caroline Edser

blog

26 years of volunteering and still going strong

Author: Val Shaw

Meet Val. She joined us as one of our first Care City Community Board members and is an avid volunteer within her community of Barking... 26 years volunteering and still going strong!

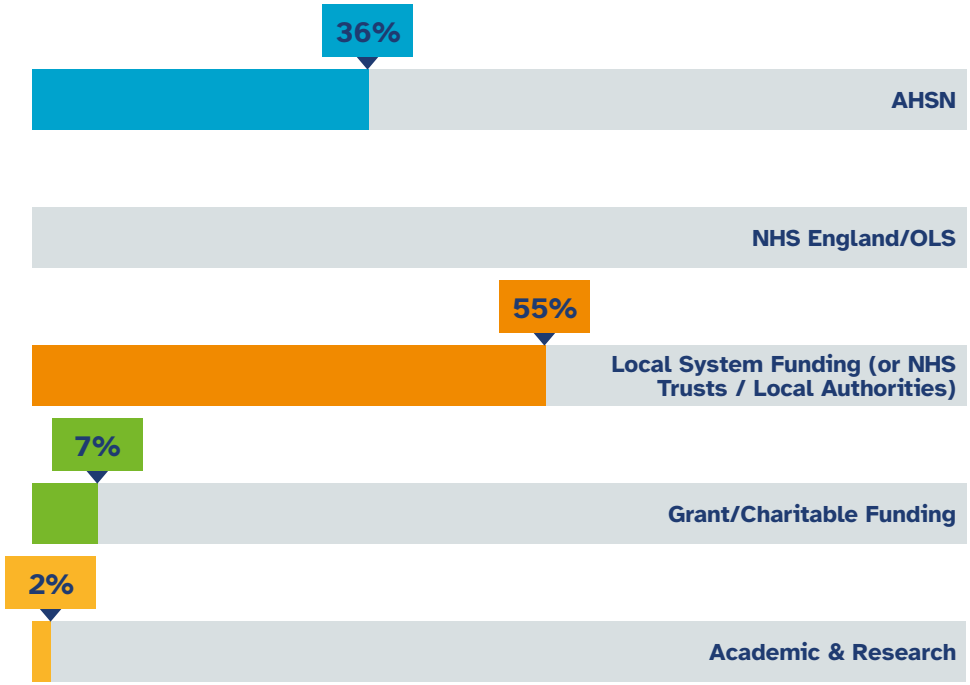
Since 1997, Val has volunteered for many organisations and in many diverse roles. She became a Befriender for **Age Concern**, volunteering for them full time at one stage, supported Gateway To The Games, when the Olympics came to London in 2012 and was a member of the Barking vaccination team during the pandemic.

I was lucky enough not to have been around during WW1 or 2, but my ancestors were and they did their part to keep our country safe. Therefore I wanted to do my bit to protect our communities during the pandemic, so volunteering to help deliver the vaccination programme was an easy choice.

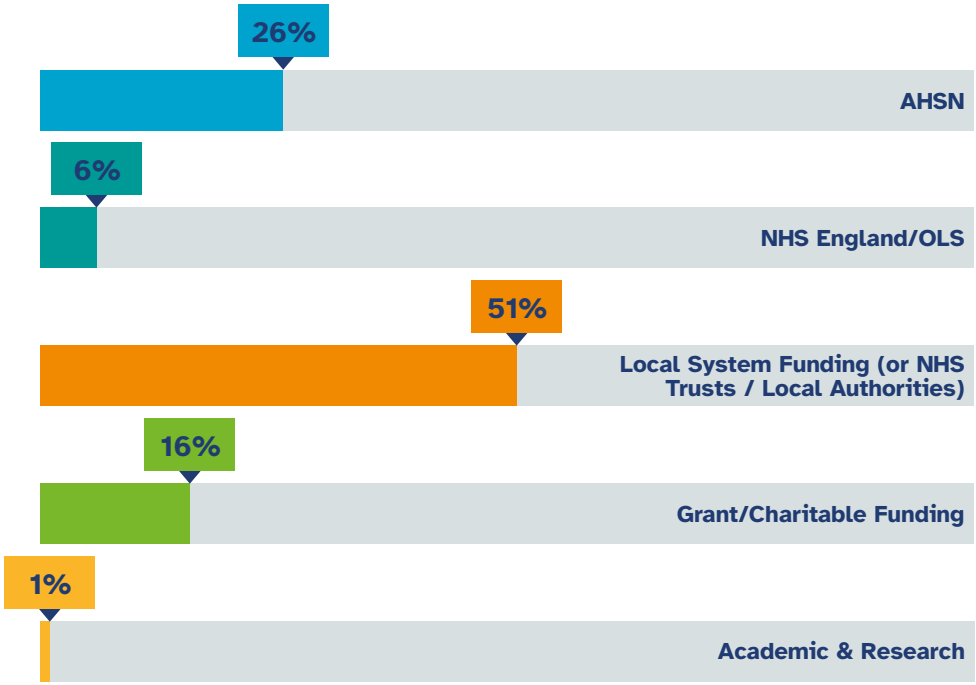
*Read more **here**.*

Our finances

Summary of our income in 2022/2023

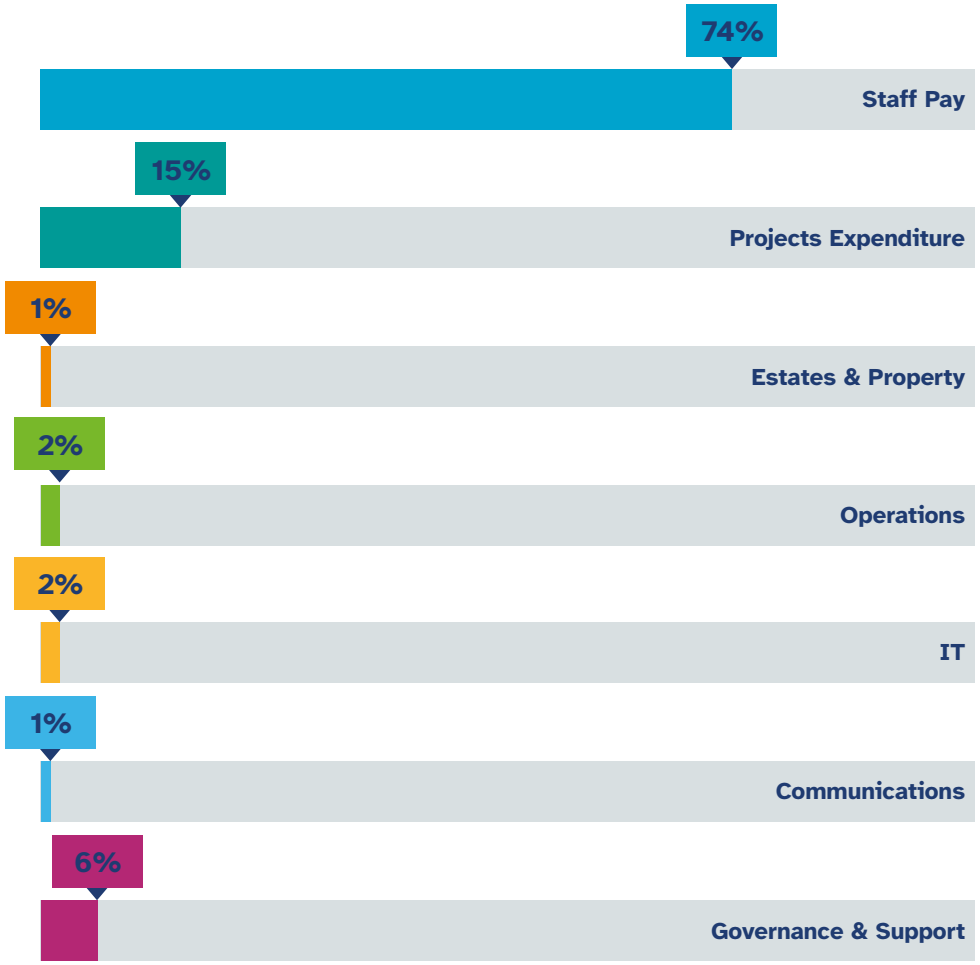


Summary of our income in 2021/2022



Summary of our spending in 2022/2023

Summary of our spending in 2021/2022



Looking to the future

Evolving our Mission

To date, Care City's Mission has been described as **'to create a happier, healthier, older age for North East Londoners'**.

Over the last six months, we've had several discussions with clients, our team and the community board to understand some of the perceptions about Care City and our work. It is clear from all of these conversations that Care City has a huge amount of trust among these stakeholders and has delivered significant value. We are seen as an innovation partner to the local health system, and we are now members of several place-based partnerships locally. However, there remains confusion about what the scope of our Mission includes and how we know we are delivering it.

Through discussions with the team, it is evident that we want to be delivering work that **impacts our community at a significantly greater level**. This means innovations impact a bigger percentage of our local population. We've talked about 'not just wanting to deliver research that lives in a desk drawer' – we want to see the outputs of our work being used and to be able to measure the outcomes we are helping our partners to achieve.

We are also acutely aware that **our partners need us to help them with problems in the short term as well as in the longer term**. This is particularly true of innovations that can help solve problems in the immediate term, that are proven to save money and improve efficiency and the experience for service users and communities.

Therefore we plan to make some changes to our mission and how we are delivering it, starting with our mission statement.

'Supporting people across North East London to live healthier, happier lives'. We deliver health and social care transformation of local benefit and national significance.

This is a subtle change, one that may not be noticed. But we used to reference a healthier, happier, **older age**". Dropping 'older age' better reflects our geographic community being the **whole of North East London** and allows us greater flexibility to talk about work that we already do that cuts across different age groups.

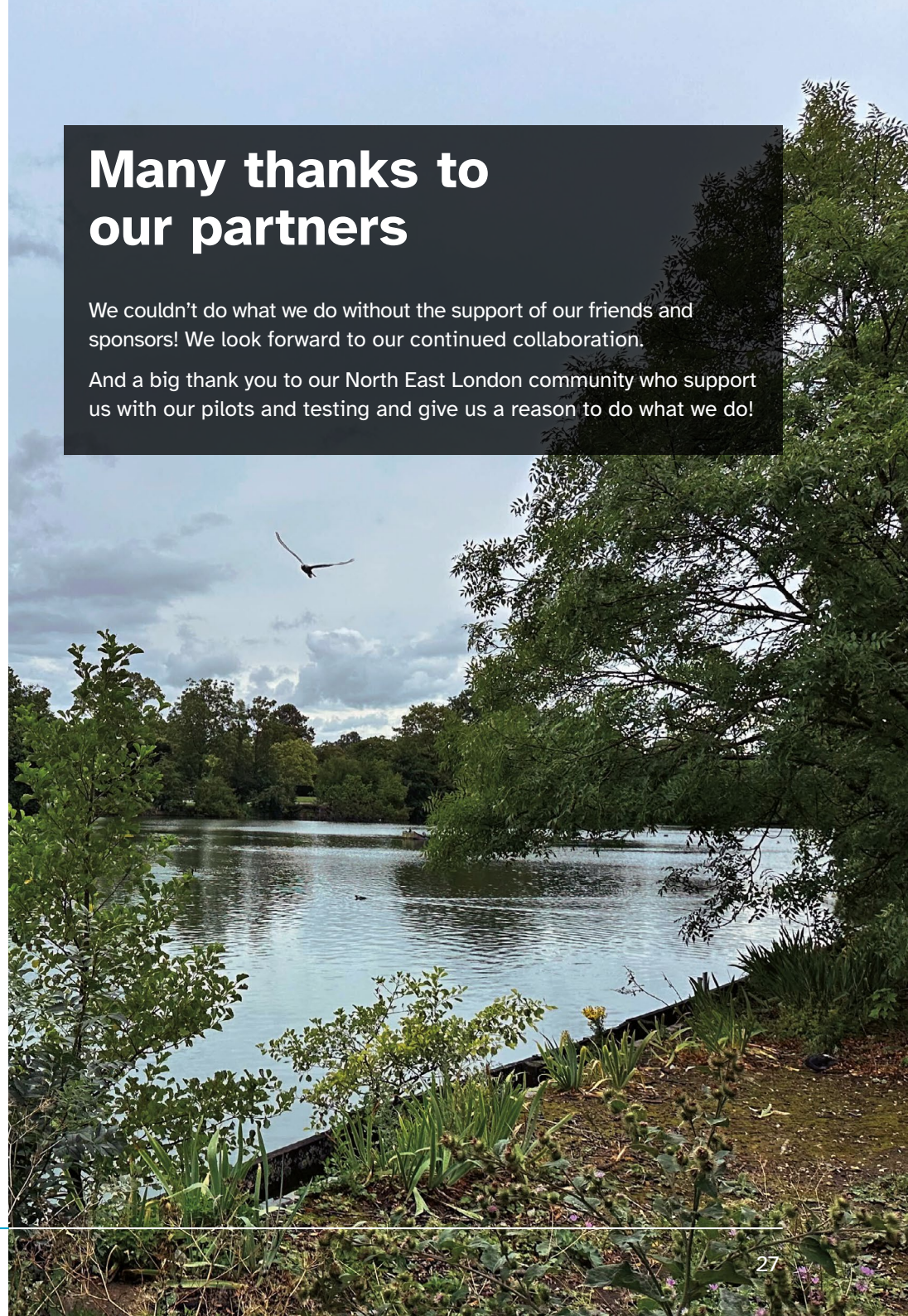
We will continue to **talk about our organisation as an innovation partner in the health and social care sector**, with a firmer recognition of the USP that we have for integrated working.

We will **spread innovations that work at scale**. If innovations only impacted 1% of the population, then we will never get ourselves out of the crisis in the NHS and social care.

We will use technology and data better, **work more closely with our communities and implement new approaches and ways of working that focus on prevention**. We will challenge our partners to think differently about their workforce and how they work together and with the local community to **bring about radically different models of care and health**.

Increasingly we will do more work outside of NEL that allows us to test, learn and bring this back to the NEL system and community.

We're excited about the future of Care City. New team members, new partnerships and an improved understanding of the work that we need to do to establish North East London as a great place to live, work and play.



Many thanks to our partners

We couldn't do what we do without the support of our friends and sponsors! We look forward to our continued collaboration.

And a big thank you to our North East London community who support us with our pilots and testing and give us a reason to do what we do!

Care City Innovation C.I.C.

E theteam@carecity.org

@CareCityUK • facebook.com/carecity.london

linkedin.com/company/carecity.london/

www.carecity.org

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Registered Address: Care City Innovation C.I.C, 1st Floor, Barking Enterprise Centres C.I.C., 50 Cambridge Road, Barking IG11 8FG