Appendix 1

City & Hackney Partnership

Better Care Fund
Narrative Plan
2021-22

Contents Page

Stakeholder input into preparing the plan

- Discussions with senior officers at the Council, CCG and Homerton Hospital
- Discussions at Discharge Steering Group (includes service user reps, Healthwatch and Age UK East London)
- System operational command group (SOCG)
- Local and North East London (NEL) wide Homelessness meetings
- Hackney HWB sign-off will be on 27/01/22
- City HWB sign-off will be on 26/11/21

Background

Background

Like all partnerships, 2021-22 has been an extremely difficult and testing time. As winter approaches we are again planning for unprecedented pressure on the Health and Social Care System.

This year saw the continued implementation of the NHS Discharge Policy which has had a significant impact on all areas but particularly adult social care. Our partnership has been tremendously successful in reducing and maintaining low length of stays, with Homerton Hospital consistently being the Trust with the lowest length of stay within NEL and London generally.

Last year also saw Hackney Council subject to a major cyber attack in October 2020, with the effects still impacting adult social care systems, including our payment and performance management abilities. Work is ongoing to develop new modern systems to meet our future needs. This has meant that as well as managing the pandemic, staff have also had to deal with manual recording systems and have had to develop work arounds, which has also affected our ability to produce performance reports.

Governance

ICP Governance Arrangements

The following outlines how we have structured ourselves and our work:

- Historically, the commissioning and planning of services with partners was arranged under **care workstreams** structured around major areas of commissioning investment in health and care improvement.
- The pandemic has emphasised the importance of working in partnership on an operational basis to coordinate delivery of improvement work.
- Our future approach to system-level planning is organised around a single view of **population health outcomes** and improvement areas, broken down into broad thematic categories, rather than four or five separate plans reflecting the way that services are structurally organised.
- We have arrived at **five areas of focus for our improvement and transformation planning**, three which reflect broad thematic areas: “Children, Young People, Maternity and Families”, “Communities and Staying Well”, and ”Rehabilitation and Independence”; and two which represent areas which have distinct national and regional funding and oversight regimes: “Primary Care” and “Mental Health”.
- We have also mobilised a time-limited City and Hackney vaccination programme, given the importance of this agenda in 2021.

BCF Governance

As the following slides show, BCF schemes and priorities are integrated into the overall system governance, planning and priorities.

There is huge amount of joined up working and cooperation happening at the local level and BCF is part of these discussions.

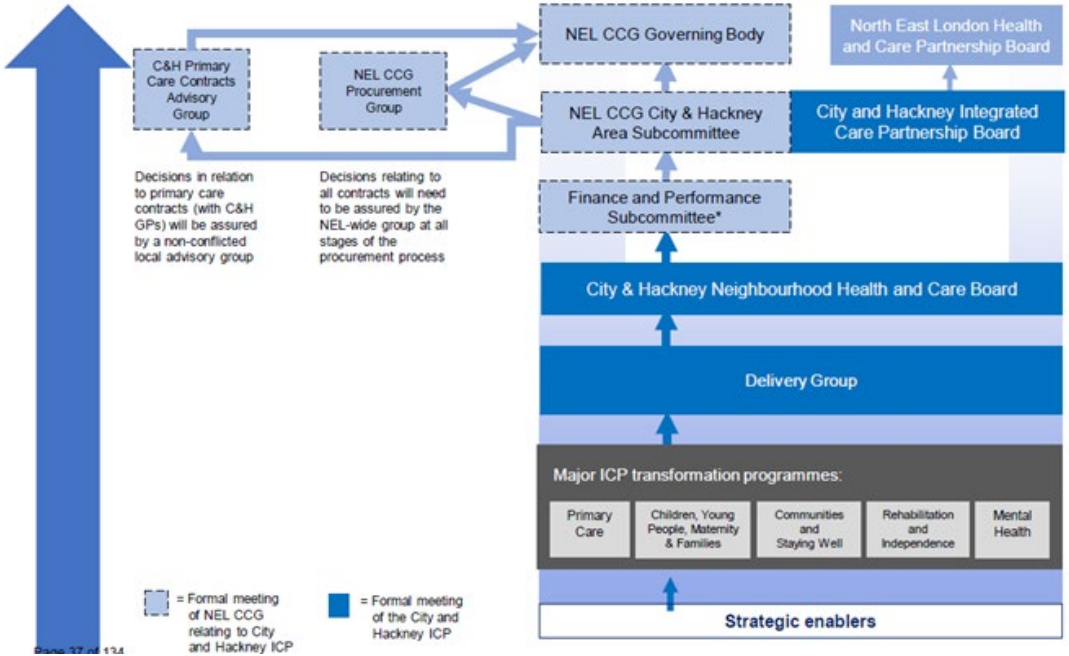
At a local level, LBH ASC Director, Finance and BCF Lead meet quarterly with two CCG Workstream Directors, Finance and BCF lead to monitor BCF schemes, performance and sign off returns. City of London Corporation staff also meet with CCG leads for monitoring and sign-off.

There is a also a monthly Hospital Discharge Group which is comprised of system partners, including service users, Healthwatch and Age UK. This group plans, challenges and reviews progress against the NHS Discharge Policy and related BCF Metrics.

Governance, Management and Reporting

Governance route for financial decisions between ICP and NEL CCG

This diagram shows the indicative route by which decisions would be assured in relation to major proposals, however the use of SFIs and the Scheme of Reservation and Delegation mean that many decisions will not require this full governance route.



Governance:

- The governance process to follow will be in-line with the NEL CCG Governing Body approved City & Hackney ICP structure (in addition to the approval by HWBs).

Management:

- Once the BCF budget is agreed between partners, it must be presented to the City & Hackney Finance and Performance Sub-Committee for approval prior to presenting to the Health & Wellbeing Boards.

Reporting:

- The existing reporting structure will continue in terms of financial data shared by LBH and CoL for invoicing purposes.

- Variance analysis and emerging risks will be highlighted to the FPSC to make recommendations to take action by the BCF commissioning leads.

City & Hackney ICP
Overall Approach to Integration

The 21/22 City and Hackney Integrated Care Partnership Priorities

The next slide sets out our key priorities for health and care partners in 2021/22, as established through the System Operational Command Group. This work will continue through the ICP Delivery Group. Two key themes run throughout the plan:

- **Addressing inequalities:** this has grown in significance, and we are taking a more systematic approach across all areas of our work. This should become core business, supported by a new Population Health enabler.
- **Covid recovery:** is a key focus for all parts of the system, including through the delivery of a vaccine programme, re-starting services, developing or adapting services to support people who are experiencing the ongoing impact from Covid-19 and being prepared to respond to future outbreaks / campaigns and resulting pressures on the health and care system.

Our local priorities also include delivery of the key 'must dos' for the health and care system defined in the NHS Operating Plan for 21/22.

Given the context of the ongoing pandemic the plan is predominantly focused on health care services, however, it does include a number of priorities that are focused on integration with social care, wider local authority and other partners.

Work is currently underway to develop the City and Hackney ICP that will bring together health and local authority partners to take joint responsibility for the health outcomes of the City and Hackney population. As this partnership is formed there will be a wider strategy development process, which will align to the development of the Health and Wellbeing Board(s) strategies over the next year.

The following plan presents the key deliverables for this year whilst we develop our longer term multi-year strategy.

City and Hackney Borough-based Partnership priorities 2021/22

High level one-page summary

Children, Young People, Families and Maternity

1. Mental health and wellbeing:

- Childhood Adversity, Trauma and Resilience support for system professionals working with families
- Prioritise earlier prevention and wellbeing through new Integrated Emotional Health and Wellbeing Action plan
- New pathways in place for CAMHS discharge and a T3.5 service with strengthened community approach to S&LT

2. Addressing inequalities in most vulnerable groups:

- Continue to Increase uptake of immunisations and vaccinations in childhood and pregnancy
- Continue to prioritise health and wellbeing needs of Looked After Children (LAC) and Unaccompanied Asylum Seeking Children (UASC) by tailoring services to specifically meet their needs.
- Continue multi agency early help for families who have complex medical needs, SEN and identified vulnerabilities.

3. Improving quality and integrating services:

- Continue to deliver maternity transformation in safety, address inequities and improve perinatal mental health
- Test approaches to social prescribing at PCN level for children and families, alongside NEL partners

Communities and Staying Well

1. **Integrated Urgent Care –** support people away from hospital and develop effective pathways from 111
2. **Discharge Pathways –** implement a sustainable single point of access, embed Home First and better involve patients in decisions about their discharge
3. **Neighbourhoods:**
   - Take a more proactive and joined up approach to support residents with rising needs
   - Continue to redesign services that will make up Neighbourhood blended teams and provide OD support to them
   - Increase resident involvement and integration of VCSE services in a Neighbourhoods
   - Arrangements to improve our knowledge of and act on health outcomes and inequalities
   - A Neighbourhoods approach to population health

Mental Health

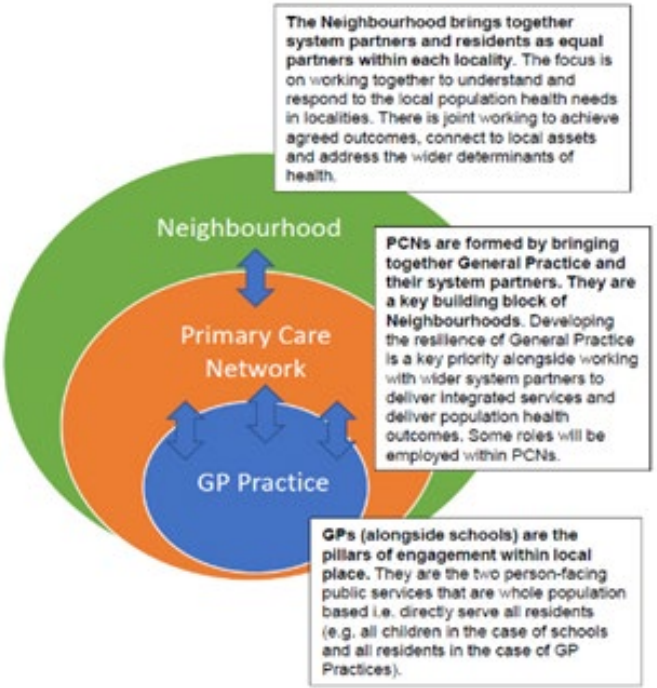
1. **Severe Mental Illness Digital Platform**
2. **Personal Health Budgets (PHBs)**
3. **Expand services that address Common Mental Health Problems** (Anxiety and Depression)
4. **Develop Staff wellbeing recovery plans**
5. **Dementia Service**

Rehabilitation and Independence

1. **Restoring Elective and Cancer Services –** working with NEL Cancer Alliance, wider partners and support services
2. **More integrated care for residents with ongoing health and care needs:**
   - Improve access to neighbourhood provision and integrating specialist skills in areas like: Diagnostics, First Contact Practitioner, LTCs (diabetes, heart and respiratory disease), Gynaecology; services for LD & autistic people
   - Develop new pathways and services for residents with long term rehabilitation needs after COVID-19
   - Improve specialist advice from consultants to GPs and patients and developing the model of advice and guidance
   - Better integrating the health and care offer to residents in care homes and residential settings
3. **Specific actions to address health inequalities**
   - Monitor and address the additional needs of particularly vulnerable people, and implement learning from the review of premature deaths of people with LD
   - Ensure that the 'in for good' approach taken to support homeless people and rough sleepers is built upon
   - Ensure that we improve end-of-life care within our health care system

Neighbourhoods approach to Integration: strengths-based & person-centred care

- Neighbourhoods is our major transformation programme for the redesign of community services locally. The programme is provider led.
- Neighbourhoods are critical to the delivery of integrated care and provide the geography around which we are aligning many of our health and care services. They are crucial in working together as system partners to address health inequalities.
- We are already bringing together these services, supporting multi-agency working and adopting a more strengths-based approach that focuses on what matters to residents.
- As a local system we want ‘place’ rather than ‘organisation’ and ‘conversation’ rather than ‘referral’ to be the currency of integrated service provision locally. We want to ensure that residents receive care and support that is closer to home, based on what matters to them and in a way which means they do not have to tell their story multiple times.



Key Changes Since Last BCF Plan

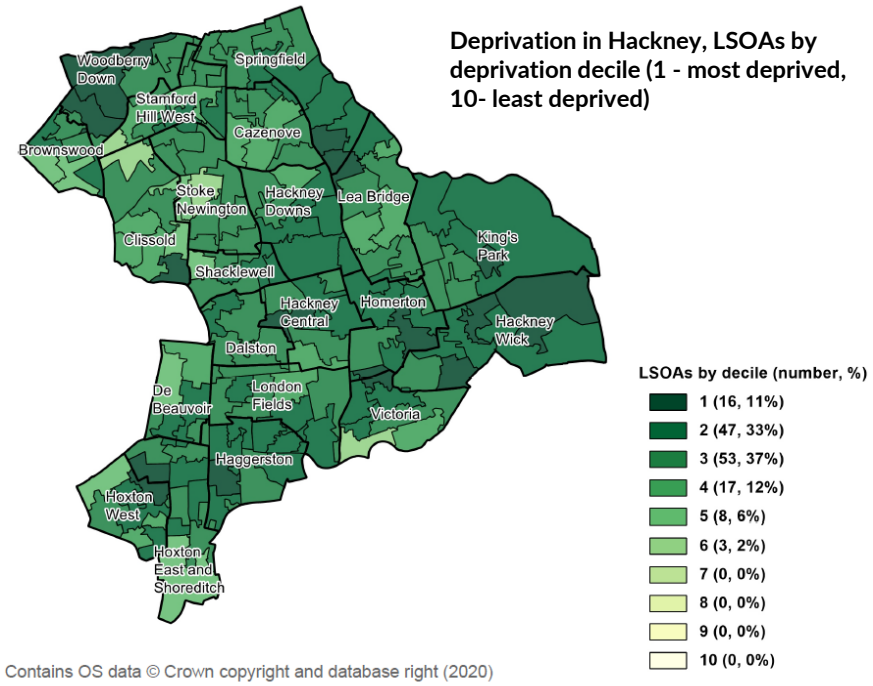
Funding remains in place for implementation of care act duties, carers services and reablement in addition to other core community services. The partnership has reviewed the schemes that formed the previous years return and it has been agreed that this year's plan should better reflect the partnership spend to reflect the investments which support the BCF metrics.

Schemes added this year:

- Pathway Homeless Hospital Discharge Team
- DES Supplementary Care Homes Service

The BCF plan also aligns with transformation and integration initiatives such as Ageing Well.

Hackney's Population



Sources: ONS, Population estimates. Ministry of Housing, Communities & Local Government, English indices of deprivation 2019.

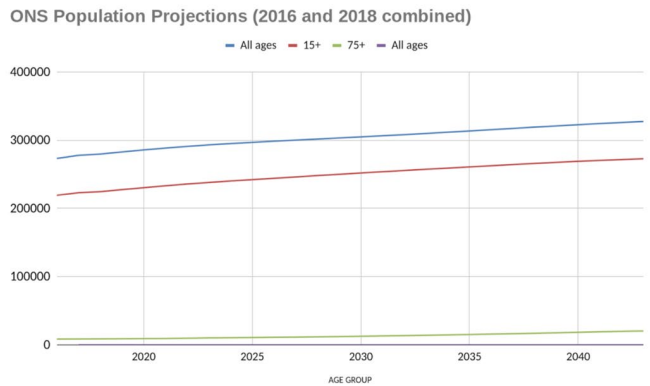
- Hackney has a population of just over 280,000 residents
- More than 20% are under 19 and under, 68% are aged 20-64 and c.10% are over 65 (gla figures)
- It is predicted that Hackney's population will grow to around 300,000 in 2030 and **the largest proportionate increase (around 33%) is predicted among residents aged 65+** (
- **Hackney is an ethnically and culturally diverse area** with around 40% of residents coming from a non-White background; the borough is home to large 'Other White', Black and Turkish/Kurdish communities, as well as a large and growing Charedi Jewish population
- **The borough is relatively deprived** although becoming less so on average; within-borough social inequalities are widening

Impact of COVID on Discharges in Hackney

Impact of Covid & Discharge Policy on Adult Social Care

- The number of hospital discharge clients has increased from 148 clients in 18/19 to **527** clients discharged in 20/21. Based on current trends there will be an estimated **670+** clients discharged in 21/22.
- The post covid homecare spend suggests an additional worst case scenario estimated pressure of **£6.8m** in 21/22
- The growth in all age population between 2016 and 2020 was on average 1.13% but the growth in the number of people receiving care was on average 6.14% in the same period.

ONS Populations figures



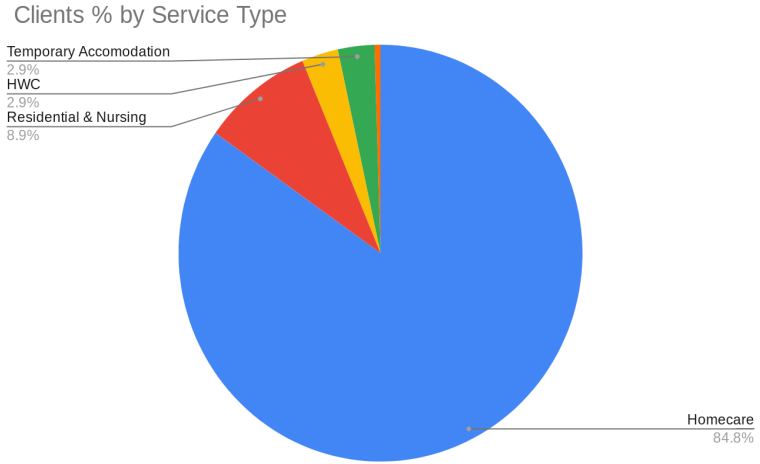
The predicted average annual growth in the Hackney population is 0.59%.

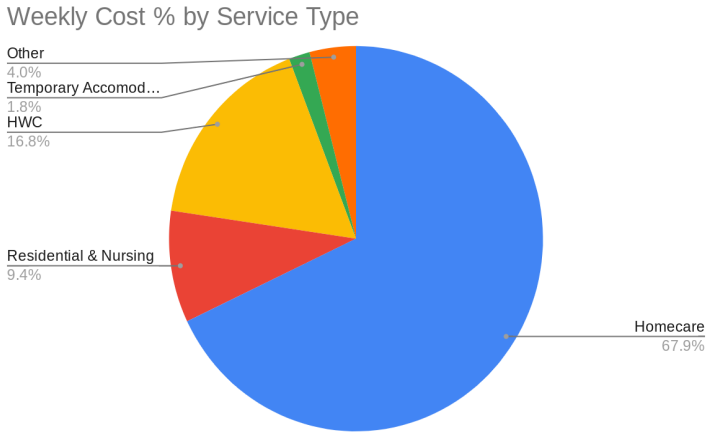
The predicted average annual growth of the population aged 75 or over is 3.42%.

The average annual growth in adult residents either accessing personal care or placed in a care home was on average 6.14% between 2016 and 2020.

The average annual growth in double handed care packages was 32% between 2017 and 2019.

Hospital Discharge - Client & Weekly Spend by Service Type

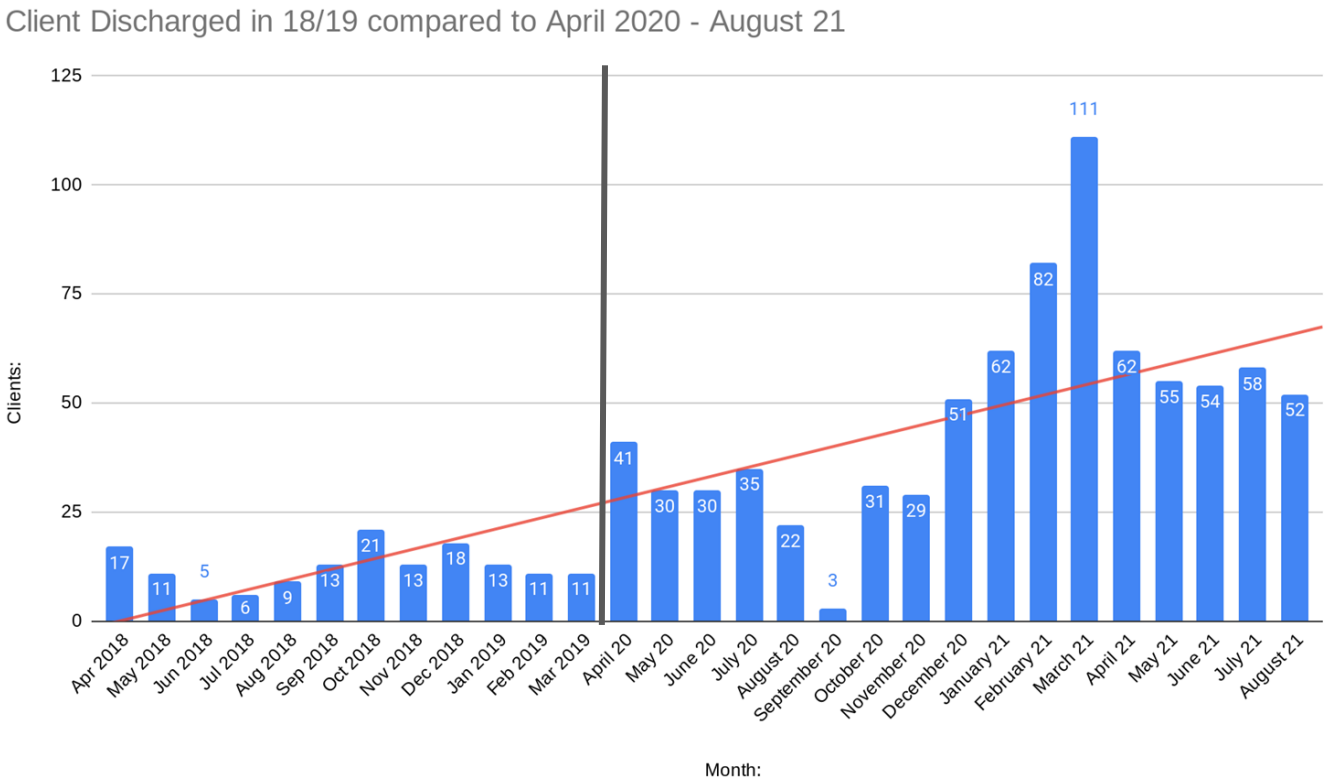




- In total there have been **808** clients discharged from April 20 to August 21
- **85%** of clients are discharged are into a homecare placement which equates to **687** clients
- **9%** of clients are discharged into a care home placement which equates to **73** clients

- **68%** of the costs of discharge directly relate to Homecare with an average Homecare package costing **£331** a week
- **9%** of the costs of discharge directly relate to Care Homes with an average Residential/Nursing package costing **£1,205** a week

Hospital Discharge - Clients Discharged between April 18 to August 21



18/19:

- There were a total of **148** clients discharged in 18/19

20/21:

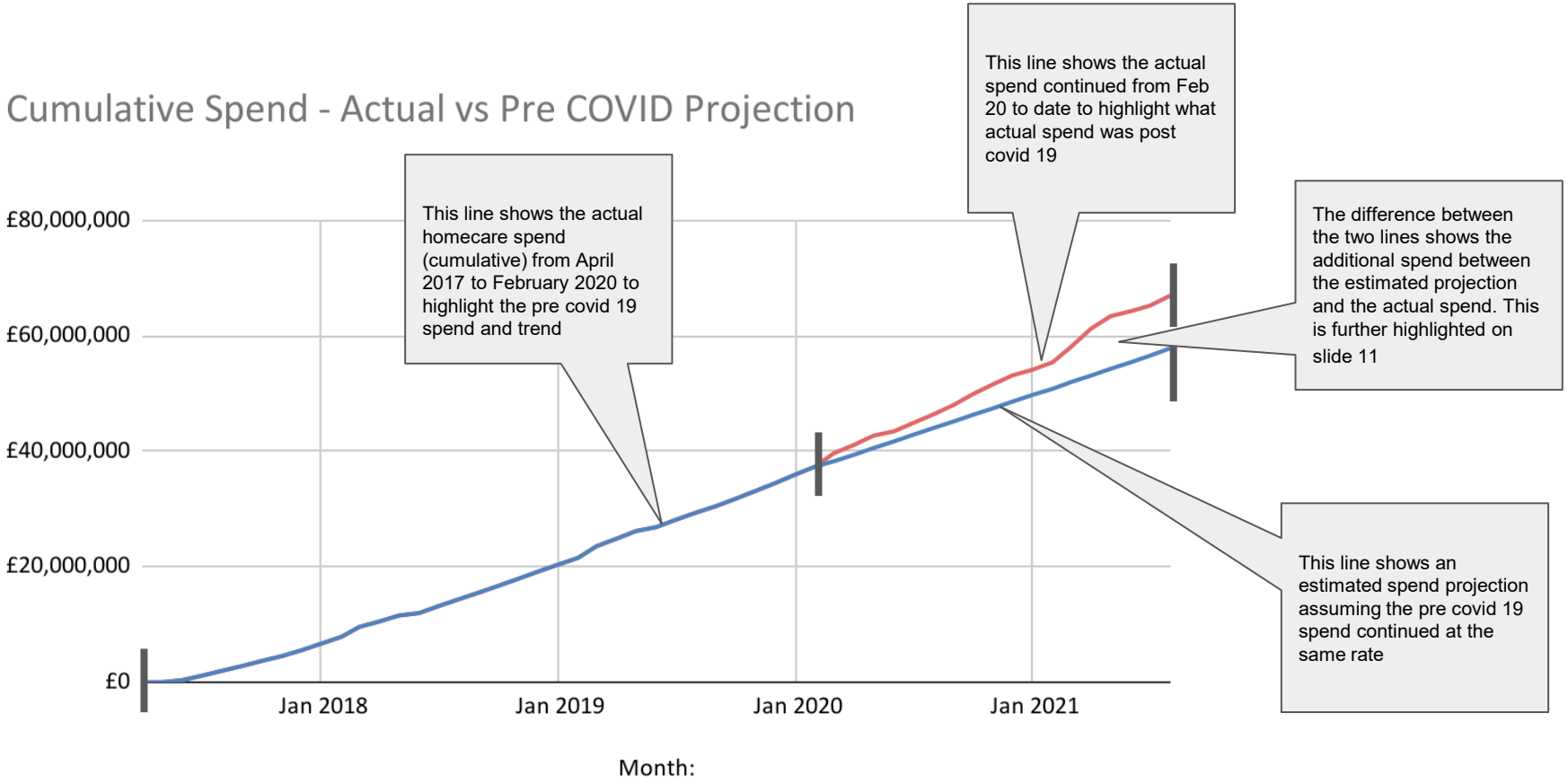
- In 20/21 there was **256%** increase in clients discharged compared to 18/19 (**527** clients discharged for 20/21)

21/22:

- There have been a total of **281** client discharged from April 21 to August 21
- Based on current 21/22 trends there is an estimated **670+**
- This would reflect an increase in clients of **353%** compared to 18/19 and **27%** compared to 20/21

**September 20 data skewed due to the Cyber Attack*
**Full data for 19/20 currently not available*

Monthly Cumulative Spend - Homecare April 17 to August 21



**** Data used is based on the actual monthly homecare cost (cumulative from April 2017)***

Additional Cumulative Homecare Spend Projections

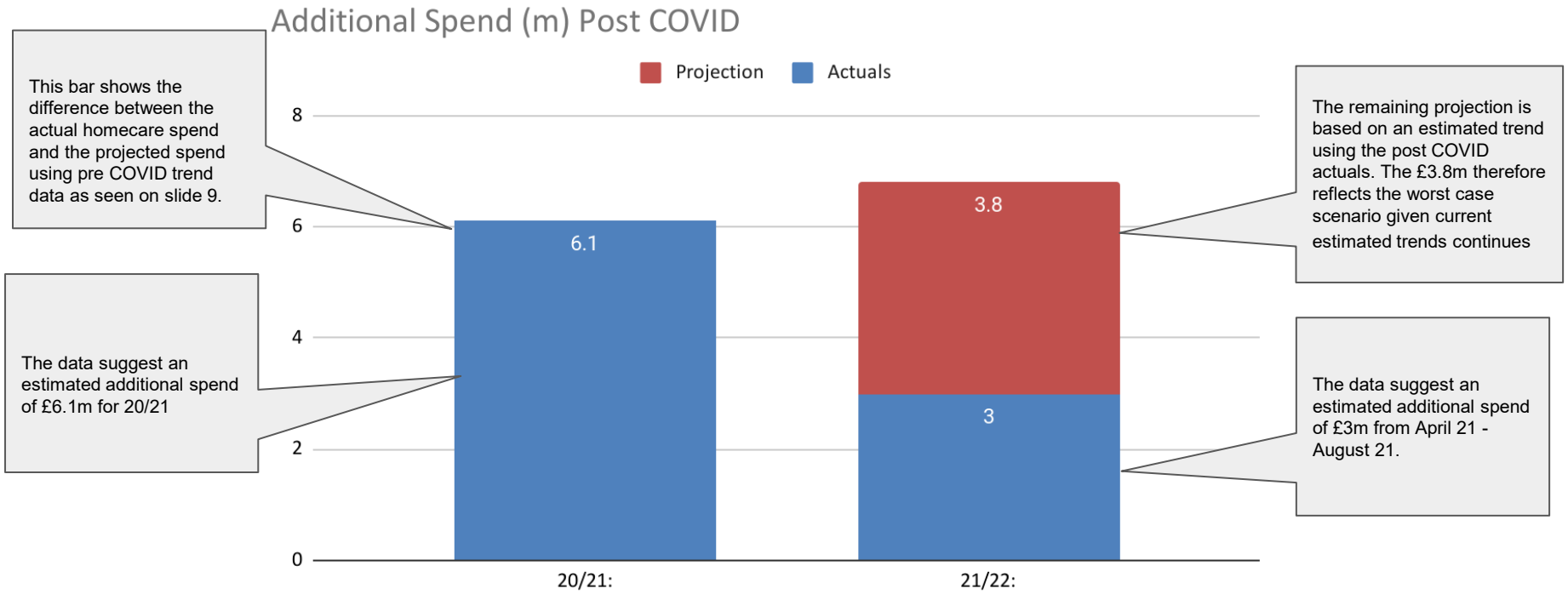


Table summary of Discharge pathways

Period	Numbers in Residential Homes	Numbers in Nursing Homes	Number in Homecare
2018-19	21	26	101
2019 - 20	n/a	n/a	n/a
2020 - 21	24	36	442
2021-22 (To date August)	13	16	244
2021-22 (Estimate)	30	36	563

Supporting Discharge (national condition four)

Supporting Discharge (national condition four)

To further improve outcomes for people being discharged from we have developed the following strands of work in 2021/22 - as described in the next four slides:

- New activities supporting the NHS Discharge Policy
- New Discharge support pathways
- Development work with the LGA and Social Marketing insights

Activities supporting the NHS Discharge Policy

Supporting Discharge	Action
Weekend working	Brokers extended hours (10 - 2 p.m.) Social Work (SW) discharge team increased capacity Weekend DSPA call re-established in Nov
Extend Bridging service for home care (Winter Plan Scheme)	Purchased block homecare hours to increase capacity to support same day discharge.
Out of Area	Discharge SW to continue to attend out of area calls where needed and Hackney clients OOA continue to be discussed at daily DSPA calls
Escalation plan	In place
Local weekly discharge meeting	Existing partnership meeting weekly to include updates on vacancies of discharge pathway facilities
NEL weekly discharge meeting	To escalate issues and offer mutual aid across three ICPs within NEL

Discharge Support - Interim Placements

Newly Commissioned Discharge settings	Facilities
Acorn Lodge	Block contract for 3 nursing hospital discharge beds
Goodmayes	2 accessible flats 4 rooms in shared house 1 Covid positive flat
LBH Assessment flats	6 flats plus 2 COVID
Housing with Care Flats	Housing with Care
Mary Seacole	7 Designated COVID+ Care Home beds
Manor Farm	Spot purchase beds
Homeless & no recourse to public funds	B&B Goodmayes (above) or Homeless hostel 6 Peabody step-down beds (aim January)
Charedi Community COVID-19 Post Discharge and Hospital Admission Avoidance Facility	Can be up to 9 beds
Homecare	Existing Framework
Mutual aid will be provided at other sites across NEL where available.	

Development Work with the LGA

The table below outlines work we are undertaking to review and improve our discharge work.

LGA Offer	Detail input
Review of joint working arrangements between social workers and therapists	Using the ethical Framework to reflect on practice and to identify the specific changes for social workers and therapists implementing the discharge policy and operating model. ● 1 session with social workers - 24 Nov ● 1 session with therapists - 24 Nov ● 1 joint session - 2 Dec
Review of the reablement Pathway	A Peer Consultant appointed by LGA will initiate a desktop review initially. ● Understanding of how other systems have maximized reablement offer ● Review of model and cost benefits analysis
Session to discuss how to manage out of area patients with other local authorities	● Lead a London-wide discussion - one off session
Data Support	● Initially share dashboard they have helped develop with another system

Social Marketing - Patient Information

Funded via a local BCF grant, we employed Claremont, a local Hackney-based social marketing company to use social marketing techniques to gain insight into the target population. These insights can be used to help design marketing messages and tools to reduce delays relating to patient and family choice, and better manage patient expectations around hospital stay and planned discharge home or to a residential placement.

To include: communicating the right message at the right time to ensure patients and their families are aware at admission to hospital of the home first approach and options available post discharge.

Phase 3 Feedback - Headline findings from public testing

Consistent and strong dislike of the term discharge – clear preference for 'leaving hospital'

When asked to rank the importance of different messages, the priority is around reassurance:
We won't send you home before you are ready

The second most important message was about being spoken to about what was happening:
Your team in the hospital will talk to you about getting you home again

The third most important message is regarding assessment:
Your specific needs for any ongoing support and care at home will be assessed and discussed with you, and the right package will be put together

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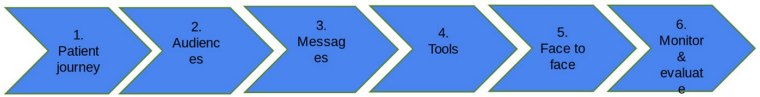
Claremont
Communications for Behaviour Change

Phase 3 Feedback - Six key thematic areas for our report back



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Claremont
Communications for Behaviour Change

The Disabled Facilities Grant

Disabled Facilities Grant (DFG) and wider services

- DFG is funded by the Department of Health and Social Care. Since 2014 the DFG has been part of the Better Care Fund with priorities summarised as:
  - Care home costs saving
  - Prevention/Early intervention
  - Support timely hospital discharge
- Both Authorities engage with Housing Teams to use the fund to support disabled people to live more independently in their own home.
- Local policy was reviewed between Hackney's Housing and Adult Social Care in Feb 2021 to ensure a more focused approach to DRF to support the BCF priorities. Summary of recommendations and changes on next slides.

Summary of Recommendations - Hackney

1) **Dementia Grants (DG) -** improving lighting, sound proofing, changing the flooring, tonal contrasting tiling and sensors within St Peters, a housing with care accommodation.

2) **Hospital Discharge Grants (HDG) -** examples of works include: moving necessary furniture from upstairs to downstairs, clearing a room to make it safe, deep cleans or any other work needed to facilitate the discharge that cannot be provided by other means.

3) **Contribute to the cost of the council's occupational therapy team** - 3 OT posts to support timely assessments for adaptations- to prevent falls, admission, and reduce micro living environments.

4) **Partial waiver of up to £10,000 contribution for means testing**

5) **Smart Homes Kit** - A part of every DFG application. The Kit to incorporate voice activated technology to help with environmental controls and medication reminders. Building on the technology planned for the Hospital Assessments Flats.

6) **Discretionary Grant** - when the situation cannot be resolved with the mandatory costs of £30,000 (inclusive of fees), additional costs of maximum £10,000 can be available when this will support better care arrangements to enable the person to remain in their home for longer. A charge will be placed on the property.

Disabled Facilities Grant (DFG) Spend - Hackney

	Discretionary RRO (Regulatory Reform Order- Housing Assistance)	Estimate of numbers x costs	Total
1	**Dementia Grants (DG)**	10 x 2500	**£25,000**
2	**Hospital Discharge Grants (HDG) - Maximum is £2000**	60 x 400 = 2400 30 x 1000 = 30,000 5 x 2000 = 10,000	**£42,400**
3	**Contribute to the cost of the council's occupational therapy team**	DFG OTs @ £32 an hour umbrella rate + oncosts £1,336.97 x 46 = £61,501	**£184,503**
4	**Partial waiver of up to £5,000 contribution following means testing for first £7000**	6000 (approx contribution 2019-2020)	**£6,000**
5	**Smart Homes Kit**	10 x 3000	**£30,000**
			£287,903

City of London

City of London Context

- Latest estimate of population in City of London is 10,938 with predicted significant growth in the over 65 population in next decade. There is high life expectancy in the City of London - better than the rest of London for both males and females.These factors create potential for increased demand for health and social care services in the future.
- There has been improvement in the City's deprivation ranking in recent years but significant gaps remain between the areas of Portsoken in the east of the City and the Barbican.
- The City of London borders seven London boroughs and residents often have to access services that are delivered outside the square mile. The City of London has complex care pathways. 75 percent of City of London residents are registered with the one GP practice in the City, which is part of City and Hackney partnership. 16 percent of residents, on the east side of the City of London, are registered with GPs which are part of Tower Hamlets partnership.

City of London Context

- For acute admissions, most City of London residents are taken to the Royal London Hospital (RLH) or University College Hospital (UCH). The main commissioned acute hospital for the local partnership is Homerton University Hospital Foundation Trust (HUHFT). Community Health Services are also provided by HUHFT.
- There is no residential care or supported living provision within the City of London boundaries and given the levels of demand for these services, they are spot purchased rather than block purchased. There is a single home care provider commissioned by the City of London Corporation in 2017. A number of service users use their direct payments to purchase other home care providers of their choice. Our homecare provision is currently being recommissioned and is set in the wider context of hospital discharge and reablement requirements.
- The City of London also commissions a number of preventative and support services from the voluntary sector. These include a Memory café, carers support, a wellbeing service and a universal advice service.

Changes to Services Commissioned

Area : City of London	Full Year Forecast
Mental Health Reablement Service (Decommissioned)	£0
Combined Hospital Discharge Scheme	£230,555

Area : CCG	Full Year Forecast
DES supplementary care homes services	£5,475
Pathway Homeless Discharge Team (5 months)	£4,913

Since the original BCF spending agreements, the steer from BCF became stronger in terms of hospital flow, delayed transfers of care and length of stay targets so partners have developed new services to support hospital discharges. Over the last few years, partners have also worked together to understand the issues homeless people face in accessing health services. We are building capacity into both discharge and community services to improve outcomes for this vulnerable population.

These services support implementation of the NHS Discharge Policy.

Impact of Covid on City of London Hospital Discharges

- There has been a more than 100% increase in the number of hospital discharges within City of London residents since April ‘20, with the medical stability of residents requiring more intensive packages of care.
- Compared with home care and reablement costs, Discharge to Assess hourly costs are 44% higher for single handed care and 54% higher for double handed care, as the service includes a premium to reflect the urgent nature and response required.
- With ‘home first’ a preferred pathway, we are seeing an increase in care requirements where perhaps a step down placement would be more appropriate. Once a resident is discharged home, a placement is often difficult to facilitate if a person wishes to remain in their own home. The cost of discharge to assess homecare support for complex cases are much higher than placement costs in some cases. 24hr sleep in costs £425 per day; 24 hr waking nights £695 per day. Double handed care packages are £58 per hour within this service.

Impact of Covid on City of London Hospital Discharges

- Our Rapid Response Service has increased in cost by 380% against budget allocation.
- A change in hospital discharge behaviour is not expected, meaning we will need to continue to support an assessment period until clients are more stable for ongoing care pathways.
- Hospital Prevention care and support is put in place via this service; both at home to avoid hospital admittance in the first instance, and to avoid hospital admittance due to medical stability fluctuation upon discharge.
- The City of London Corporation do not have a Hospital Discharge Team within a hospital setting. All discharges are ‘out of borough’ so 7-day working is in place within the current Adult Social Care Team. To ensure we are resilient in meeting winter and seasonal discharge activity, we will maintain weekend cover to support safe discharge and enhance our ability to maintain and support safe hospital discharge.
- With seasonal pressures from seasonal flu, covid fluctuations and winter impacts (poverty) a significant increase in demand and activity in discharge and discharge prevention is anticipated.

Supporting Discharge (national condition four)

New Consolidated Hospital Discharge Scheme

- Through the Better Care Fund, the City of London Corporation has funded a Rapid Response Service.
- During the pandemic, as hospital discharges increased, and policy changed, the Rapid Response Service became part of a wider approach to facilitating and supporting hospital discharges.
- Given that the mental health reablement service was decommissioned, this funding, in agreement with the local health partners, was shifted into hospital discharge work.

New Consolidated Hospital Discharge Scheme

The new consolidated service has three strands:

- The ***Hospital Admission Avoidance Service,*** providing home-based support for up to 72-hours for those most at risk of acute admission to hospital. It includes intensive home care support (e.g. live in or double up support) with an assessment of ongoing care needs.
- ***Supported Hospital Discharge Service (***Discharge to Assess), providing intensive home care support to accompany a person home from hospital, a care assessment in the home and installations of minor aids and adaptations. The Discharge to Assess model has varying timescales of delivery. It is expected that a period of up to 72-hours will provide sufficient assessment of need and care support, however, there is an increase in discharge of residents who require a higher package of care and support, who pre-pandemic, would have remained in hospital longer. The assessment of need during this time can vary due to a residents medical stability. In such cases, the discharge to assess care service will remain in place.
- ***7-day Hospital Discharge*** (post 30th September 2021) will continue to provide additional resource to the City of London Corporation Hospital Discharge Service in support of 7 day working. We preempt that the hospital discharge activity will not change in the immediate future, with complexity of cases and assessment still requiring 2-hour response times.

Equality & Health Inequalities

Equality and health inequalities at a System Level

- The direct health impacts of COVID-19 have disproportionately affected some minority ethnic groups, older people, men, people with underlying health conditions (esp multi-morbidity), care home residents and staff, those working in other public facing occupations, as well as individuals and families living in socially deprived circumstances.
- Whilst the pandemic has exposed inequalities in service access, our response has also provided opportunities to adapt and improve service delivery.
- The City and Hackney borough-based partnership priorities outlines a plan to tackle health inequalities through a population health framework.
- These actions and initiatives will enable better understanding of how equitable our BCF schemes are.

Tackling Health Inequalities through Population Health Framework

- Establish Population Health Hub as a system wide resource to support with the embedding of a population health approach
- Draft Health and Wellbeing Strategies, using the Kings Fund Population Health approach
- Improve routine collection and analysis of equalities data and insight, and its use to inform planning and action
- Develop and embed tools and resources to support routine consideration of health equity in decision making and planning
- Adopt a partnership position and action plan to tackle structural racism and wider discrimination with local institutions
- Build trust and adopt flexible models of engagement to work in partnership with residents
- Align with NEL work on anchor institutions
- Collectively develop plans for Prevention and Investment Standard
- Embed strengths-based, preventative based approaches (including MECC)
- Build on Covid19 risk assessments to provide ongoing support for wider staff wellbeing needs.

10 Cross-Cutting Areas for Action to Reduce Health Inequalities

1. **Equalities data & insights**: Routine collection and analysis of service equalities data & insight to inform actions
2. **Tools & resources**: Develop, and enable system-wide adoption of, tools to embed routine consideration of health equity in decision-making
3. **Tackling structural racism & systemic discrimination**: adopt a partnership position and action plan to tackle racism and wider discrimination with local institutions
4. **Community engagement, involvement and empowerment**: build trust and adopt flexible models of engagement to work in partnership with residents to improve population health
5. **Health in all policies**: ensure wider policies and strategies explicitly consider and address health inequalities
6. **Anchor networks**: local anchor institutions collectively use their local economic power to lead action on reducing social inequalities
7. **Strengths-based, preventative approach to service provision**: 'no wrong door' access to support for residents to address wider health and wellbeing needs
8. **Staff health and wellbeing**: build on Covid-19 risk assessments to provide ongoing support for wider staff wellbeing needs
9. **Digital inclusion**: pool system resources to x3 dimensions of exclusion: skills, connectivity, accessibility
10. **Tailored, accessible information about services and wider wellbeing support**: produce information in community languages that is culturally appropriate and responsive to local diverse needs

Source: City & Hackney Health Inequalities Steering Group (April 2021)

Equality and health inequalities at a BCF Level

Specific BCF projects which help to address health inequalities:

- Mobilise the Pathway Homeless Hospital Discharge team and step-down accommodation to support homeless people through their hospital stay, to support a safe discharge and ensure referral into the right onward services (new scheme)
- Development of patient information leaflets for hospital discharge that are accessible (new scheme)
- Implementation of the DES Supplementary Care Homes Service for older adults care homes (new scheme)
- Develop a neighbourhood approach to population health that addresses the variation seen between populations at the 30-50,000 level
- Integrating the Voluntary, Community, and Social Enterprises (VCSE) into neighbourhoods, to help reach wider communities and to address the wider determinants of health
- Ensure that we improve end-of-life care within our healthcare system working with all partners, including St Joseph's Hospice.

Summary

- The system is working well and the pandemic has helped bring us together but also brought new challenges which we are gearing up to meet.
- We've seen increased exposure of inequalities which has renewed system focus on this across all services. Through BCF schemes in particular we are supporting vulnerable people at home, care home residents and homeless populations.
- In working together to expedite hospital discharge we have increased demand in homecare, especially evident with the high level of need at discharge and increase in double handed care packages.
- While a home first approach is appropriate, we need to be aware of and acknowledge people's concerns and anxieties about returning home to safe settings and not being discharged too quickly or in a way that is not safe.
- Our independent sector providers (e.g. care homes, homecare, hostels, B&B's) are critical partners.
- The role of digital solutions (e.g. virtual assessments, remote monitoring, Assistive, Technology) enable a more flexible, patient-centred approach to health and care interventions.
- Prevention remains important and the development of the Population Health Hub as a system wide resource will support with the embedding of a population health approach.