BCF Narrative Plan 23-25

City and Hackney

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The City and Hackney Place-based Partnership and Health and Wellbeing Boards

The City and Hackney Partnership brings together health and social care organisations who have committed to work together to support improved outcomes and reduce inequalities for our local population. It is one of seven Place Based Partnerships within the North East London Integrated Care System.

The partnership is overseen by the City and Hackney Health and Care Board. The board has agreed a set of strategic focus areas and partners have developed an Integrated Delivery Plan that describes how we will deliver this strategy. The Integrated delivery Plan does not describe the totality of the work underway within each of our organisations. We have taken an outcomes led approach, meaning that we have developed actions that will address population health challenges.

The City of London is overseen by the City Health and Wellbeing Board.

Hackney is overseen by the Hackney Health and Wellbeing Board.

Signing off the BCF Plan

The Hackney BCF plan is jointly written and goes through the following integrated sign off process:

1. BCF Partnership Group - (ICB & LBH Senior Partners)
2. ICB Leadership Team
3. LBH DAS and Head of Finance
4. Hackney Health and wellbeing Board

The City Corporation BCF plan is jointly written and goes through the following sign-off:

1. Internal Integration Programme Board including Senior Leadership from the Department of Community and Children's Services and Finance
2. ICB Leadership Team
3. City of London Health and Wellbeing Board

Stakeholder input into preparing the Plan

- Senior officers at the Councils, NHS NEL and Homerton Hospital
- Hackney Discharge Group
- LBH Housing Needs & Benefits Team
- North East London (NEL) and place-based Homelessness and Health meetings
- City and Hackney Neighbourhoods Health and Care Board
- City and Hackney Health and Care Board

National Condition 1:
Plans to be jointly agreed.

BCF Governance

- 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.
- LBH Director's within ASC, Finance and BCF Lead meets quarterly with two NHS NEL Directors, Finance and BCF lead to monitor BCF schemes performance and sign-off returns. City of London Corporation staff also meet with NHS NEL leads for monitoring and sign-off.
- There is a bi-monthly Hackney Hospital Discharge Group which is comprised of system partners, including service users, Healthwatch and Age UK, in addition to statutory partners, which includes Head of Benefits and Housing needs. This group monitors any challenges within discharge pathways, and reviews progress against the NHS Discharge Policy and related BCF Metrics. The City of London Corporation has an internal hospital discharge group due to its more complex discharge pathways and its small numbers.
- Hackney DFG Governance includes a weekly adaptations panel to approve all major adaptations and collate soft spend, and a monthly contract meeting with representation from commissioning, housing team (Private Sector Housing) and Home Improvement Agency (HIA). In the City of London, the Assistant Director of People approves all DFG grants and spend is monitored in conjunction with the Capital Finance Team.

Local governance - Hackney

BCF Partnership Board
Chair:Jenny Murphy (AS Commissioning LBH)
Oversees S75 for BCF; BCF Planning and Finances

Senior Finance leads ICB & LBH
BCF Officers ICB & LBH
LBH Commissioning AD and Operations Director
Section 75 Lead officer ICB

Hackney Discharge Group
Joint Chair: Jenny Murphy (AD Commissioning LBH & Anna Hansbury Programme Manager Unplanned Care Workstream ICB)
Oversees Local discharge service design; performance and monitoring

Homerton Senior Officers
LBH Commissioning
ICB Commissioning
Experts by experience
Age UK

Weekly Stand Up (Discharge)
Joint Chair: Jonathan Carter LBH Discharge Team & Mark Watson LBH Commissioning

Discharge Lead for Homerton
IDS Senior officer
Age UK Senior staff
Commissioning
Equipment commissioning lead

Delivery plan big ticket items: preventing and improving outcomes for people with long-term health and care needs

Area	Outcomes	Activities
Enhanced Community Response - 2 hour	• Ensuring that people with long term health needs are better supported in their own home through a more personalised and proactive approach. • An improved health-related quality of life for people with long term conditions • A reduction in the inappropriate use of the urgent -and emergency care system – •Reduced mortality / morbidity from emergency presentations • An improvement in patient experience of urgent care services • Resident knowledge of urgent and community care services and confidence in using them	• Maintain and improve UCR to maximise benefits • ICB and Hackney Council to work in partnership to develop plans for Telecare Response Service that is integrated with urgent and emergency care services with pathways between services • Procurement of End of Life Rapid Response service
Homelessness and vulnerably housed	•A reduction in the number of residents in vulnerable housing •An improvement in the population •vaccination rates •An increased engagement with health, social care and wider services	• Continued delivery of and development of a business case for recurrent funding of Pathway Discharge team, Lowri House step down beds and Routes to Roots Housing Workers.
Discharge	•An improvement in health-related quality of life for people with long term conditions •Making sure more people are able to live independently for longer	•Hackney implementation of improvement plan / recommendations from Discharge Review
Long-term conditions	•A reduction in premature mortality from cardiovascular and respiratory illness •Improved blood pressure control in particular within black population •Improved diabetes outcomes (Blood glucose, blood pressure and cholesterol) •Accurate diagnosis of diseases to enable correct management and treatment in community – (avoid unnecessary hospital admissions)	•Implementation of Blood Pressure Monitoring (BPM) @ Home – Hypertension Specialist Nurse with ACERs •Implementation of 1 year pilot spirometry service to be delivered by ACERs in primary Care

Priority schemes - enabling people to stay well, safe and independent at home

Hackney policy objective 1:

1. **Implement the review of the discharge pathway**

Why: We commissioned PPL to review the current discharge pathway and results will be available at the end of June 2023.

Outcome: further development of an integrated discharge service (and transfer of care hub). Increased capacity of reablement and home care.

1. **Use discharge funding to recruit more permanent staff in the adult social care discharge team**

Why: Many of the Social Work staff and move on team have been funded by short term funding, meaning we have only been able to recruit agency staff.

Outcome: Increased stability within the workforce.

1. **Commission/Recontract discharge services**

Why: Similar to the staffing, short term funding while welcome, has only allowed us to issue short term contracts.

Outcome: Increased stability within the market.This 2 year funding will allow for extended contracts via new procurements. This includes bridging services; accomodation services and other discharge related schemes.

City of London policy objective 1:

1. **Hospital prevention and discharge scheme (scheme number 4 in planning template, includes reablement)**

Why: need is still there, shifting focus to early intervention and prevention. Strengthen social worker and OT within discharge and community.

Outcome: prevent hospital admissions where possible and continue to support Home First approach.

1. **Commissioning Brokerage pilot (scheme number 3 in planning template)**

Why: area identified for development. Strengthen our ability to deliver hospital avoidance support and/or facilitate hospital discharges more rapidly in order to maximise independence.

Outcome: stronger, co-produced and integrated services supporting the individual to maintain their levels of independence within their home environment.

Areas for development - City of London

- DFG - we are developing a Housing Assistance Policy to allow more flexible use of DFG funding for self-funders to access more support with adaptations processes. This is because many people who may need adaptations are self-funders but would benefit from support. The policy will also consider whether a handy person scheme would be appropriate.
- The commissioning brokerage pilot will run for one year and be evaluated

Carers - LB Hackney 23-25 Plans

(Funded scheme number: 01)

It's estimated there are over 19,300 people in Hackney providing care for a relative or friend. The BCF supports a carers budget that funds 3 elements, based on strength-based model

1. Prevention, Early Intervention and Outreach service - Provided by Carers FIRST
2. Long Term Targeted Support Service and Carers Assessments - Adult Social Care
3. Long Term Targeted Support Service - Mental Health - East London Foundation Trust (ELFT)

The key features of the service are as follows:

- Carers assessment
- Early intervention and prevention; signposting and advice
- Carers events and training
- Ongoing peer support and carers groups
- Maintaining a carers register
- Carers reviews
- Support planning
- Assigned practitioners for carers; however, this shall change to Lead Worker for LBH ASC and ELFT teams when the Care Act assessment is fully implemented.
- Contingency planning

23-24 Plans for Carers

- LBH will continue to provide support to informal carers
- The current contract is about to enter into its final year. Due to this LBH are reviewing the current model of delivery, with a view to take actions and make improvements where necessary to ensure that the support provided for informal carers continues to meets their needs.
- During the Covid 19 Pandemic, like many other services the delivery model was adapted to meet the needs of the carers. Feedback from carers to date has identified they may wish to have some of these changes extended but this will be considered as part of the service review.

Carers – City of London

Supported under scheme 2

There were 496 City of London residents who self-identified themselves as unpaid carers in the 2021 census. Adult Social Care currently support 37 carers, with universal services supporting over 100 (with some cross-over). All assessments, support plans and reviews are carried out by social workers. The proportion supported by ASC is higher than neighbouring local authorities.

General carers wellbeing support is currently provided through City Connections, by Age UK and BCF funding contributes to this support. During 2022/23 a pilot for more intensive carer support was provided which was successful in identifying an additional 45 carers and providing more carer specific advice and support. This service will now be continued.

Joint commissioning - Hackney

Examples of how LBH and the ICB work together to join up commissioning:

- Published our Market Position Statement (MPS) in 2023: London Borough of Hackney Market Sustainability Plan
- As part of Hackney's Market Sustainability and Improvement Fund work, our BCF Lead officer from the ICB was part of the working group. This was very useful in understanding the intentions of the ICB with their framework agreements in costs for Homecare and Care homes, as well as a shared understanding of both the market feedback and future direction.
- Commissioning across the discharge pathway will be planned together during the year, including any bridging service extension, temp accommodation and other services
- The Homeless pathway was jointly commissioned and will continue to be jointly supported.
- All our BCF hospital discharge services are jointly commissioned, or while led by one agency jointly agreed. (Scheme number 6;8;9;18;19 & 29-58)

Joint commissioning - City of London

- Published our Market Position Statement (MPS) in 2023: City of London Market Sustainability Plan
- Aims of the MPS workstream include supporting choice and quality for those on Direct Payments as well as self funders within the City of London to ensure that they have access to, and can help shape, quality care provision within the City.

- We also commission a range of co-produced services to support unpaid carers as part of the BCF funding.
- We develop collaborative working with NEL partner authorities from a commissioning and finance perspective.

National Condition 2:
Enabling people to stay well, safe and independent at home for longer.

Priority schemes - City of London

BCF policy objective 2 - providing the right care, at the right place, at the right time.

- Care Navigator Service (scheme number 1 in planning template)
  - Why - build on existing service to reduce delayed discharge and provide links with reablement team.
  - Outcomes - supports safe hospital discharge for City of London residents and reducing potential delayed transfers of care.

- Carers' support (scheme number 2 in planning template)
  - Why - provide more specific extended support service for carers.
  - Outcomes - better, targeted support for carers. Better links to City Connections or ASC Voluntary sector service that links with acute hospitals and GP surgeries.

- Commissioning Brokerage pilot (scheme number 3 in planning template)
  - Why - area identified for development. Strengthen our ability to spot purchase planned and hospital discharge placements and find appropriate services quicker.
  - Outcomes - stronger, co-produced and integrated services and improved partnerships resulting in appropriate services being received quicker and supporting hospital discharge timeframes.
- Neighbourhood Programme (Scheme 18)
  - Why - development of community pharmacy support at a neighbourhood level
  - Outcomes - enhanced pharmacy access
- ParaDoc (Scheme Number 11)
  - Why - Continued implementation and development of our 2 hour community response is a system priority
  - Outcomes - Ensuring that people with long term health needs are better supported in their own home through a more personalised and proactive approach. A reduction in the inappropriate use of the urgent and emergency care system
- GP Care Home Scheme (Scheme 16)
  - Why - Enhanced access to health in care homes continues to be a national and local priority.
  - Outcomes - Providing care to care home residents in their own home environment. A reduction in the use of the UEC system

National Condition 2: Enabling people to stay well, safe and independent at home for longer.

Our local BCF planning template sets out spending on prevention and support for people to remain at home.Those that support e ntirely this objective include:

- Neighbourhood Programme (Scheme 10)
- Bryning Unit/Falls Prevention Scheme (Scheme 12)
- ParaDoc (Scheme Number 15)
- Integrated Independence Team (Scheme 9, and together with ParaDoc provide a joint falls service)
- GP Care Home visit Scheme (Scheme 23)
- Fit 4 Health (Scheme 24)

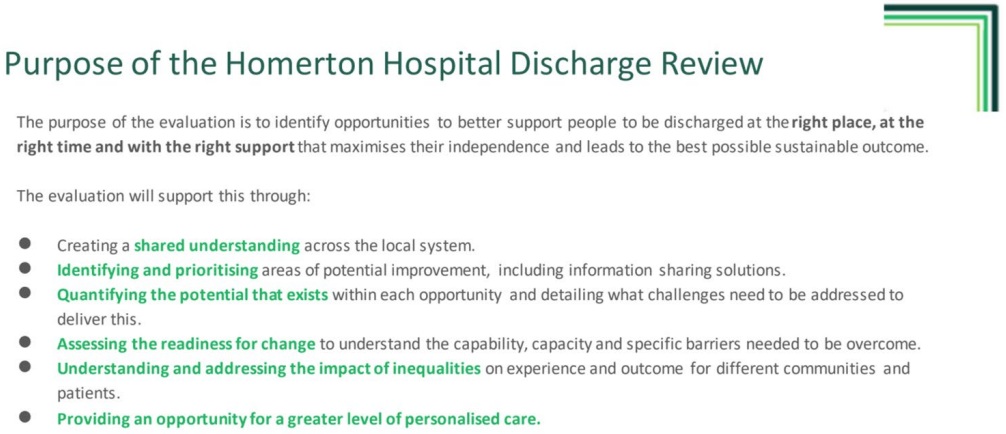
Those that contribute partially to this objective include:

- Support to carers (Scheme 1)
- Funding of equipment services to enable people to stay at home (Scheme 2 &5)
- DFG funding to enable people to stay in their own homes for longer.

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

Hospital discharge - Hackney

Hackney partnership has employed PPL, a local consultancy firm to help review and carry out a diagnostic and review of our current hospital discharge pathway with a view of helping the Discharge Group and commissioners use the discharge money where it will have the most impact locally on meeting the national guidelines for safe discharge.



Purpose of the Homerton Hospital Discharge Review

The purpose of the evaluation is to identify opportunities to better support people to be discharged at the **right place, at the right time and with the right support** that maximises their independence and leads to the best possible sustainable outcome.

The evaluation will support this through:

- Creating a **shared understanding** across the local system.
- **Identifying and prioritising** areas of potential improvement, including information sharing solutions.
- **Quantifying the potential that exists** within each opportunity and detailing what challenges need to be addressed to deliver this.
- **Assessing the readiness for change** to understand the capability, capacity and specific barriers needed to be overcome.
- **Understanding and addressing the impact of inequalities** on experience and outcome for different communities and patients.
- **Providing an opportunity for a greater level of personalised care.**

Diagnostic Stage

What is the ‘wicked problem’ we need to solve?

Supporting people out of hospital and establishing the right ongoing care are not mutually exclusive or conflicting.

But in the current climate of increasing demand and financial challenge, these two elements can feel like interconnected but opposite forces. Despite this both objectives are working to a key shared outcome; to maximise a person’s independence and ability to live happy healthy lives.

The next stage of the hospital discharge model must build on the strong foundations of partnership working to create a harmonious relationship between these two key objectives.

The ongoing national funding to support discharge provides an opportunity to do things differently to make this happen.

Where are we now?

Strengths in current practices

- Hospital spells at the Homerton are shorter than the average length of stay in other comparable hospitals, and London and national averages
- Collaboration and team working takes place across a multitude of organisational and system boundaries that in other places and historically have been siloed
- This is made possible by a well tested and developing infrastructure to connect the different parts of the system together
- There are a broad and varied range of services, including a mixture of intermediate services, to help people out of hospital
- This is supported by examples of shared/joint financial mechanisms
- The vast majority of people in hackney return home

Challenges and opportunities

- There is an increasing level of complexity in the needs of people leaving hospital, this is leading to increases in delays of discharging people
- This is driving the need for increasingly complex levels of care being established to support people home, and fewer people returning to their normal place of residence
- There is a risk that this is increasing the level of dependency of people discharged from hospital, reducing independence and creating a financial pressure
- While residential care demand matches capacity, affordability of placements is becoming an increased pressure on the system and are often outside of Hackney
- There is an opportunity to increase the number of people supported through reablement
- Key processes and enablers for people with complex needs can delay discharges including brokerage, equipment and transport

Where do we go next?

Strengthening the community 'pull' out of hospital:

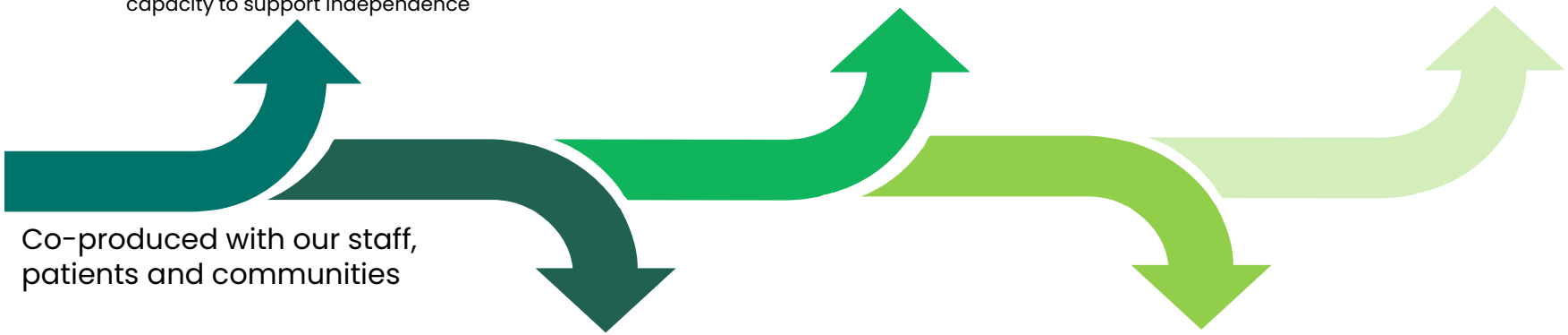
working together to utilise system capacity dynamically to best meet the needs of the patients and get people home as quick as possible, and developing greater intermediate capacity to support independence

Supporting complex cases:

creating quicker decision making and developing more flexible capacity in the system for both interim and long-term care that supports D2A, maximises independence and provides consistency of care

Utilising estates:

bringing staff together around the patient, capitalising on co-location and sharing of space where it will be of benefit to the patients/residents



Co-produced with our staff, patients and communities

Addressing inequalities:

ensuring that our pathways have greater scope for personalisation, helping to support both our diverse communities equally and supporting our vulnerable residents

Data and digital tools:

focus on pragmatic digital and data tools to support better visibility of patients across the system and allow a collective management of cases across teams and organisations

Things to consider from the diagnostic

Those with reablement potential are **able to access care** that supports a journey to/towards independence

Care decisions to be taken **'as close to the patient' as possible**

Utilisation of the voluntary and community sector to support people back home and in a way that is culturally aware

Access to equipment to support people's needs at the right time and in the right place

Developing intermediate care services to meet all needs

Utilising interim care in a way that supports discharge from hospital and flow from interim to long-term care

Flexible utilisation of all intermediate and interim support to ensure patients receive the best care option at the time

New or extended roles to work differently

Greater capacity for specific teams

Co-location of staff at Homerton Hospital, with the appropriate access to resources and IT

An **active and brave approach** to managing risk

'Live' system data sets

A **co-produced approach** to patient choice, and the involvement of families and carers

New **ways of working** together

Skills and training for staff (e.g. Mental Health training)

Collaboration between and integration of key teams

Digital tools to provide a shared visibility of demand across the system and shared case management

Reliability of transport from hospital with more direct access from the community services

Moving on from the diagnostic

Suggested programme plan

Workstreams and associated changes

Working with patients

- Greater communication on discharge updates
- TOCH hotline and information pre-admission

Integrated TOCH

- Implement case load system
- Greater integration of IIT, IDS and Rapid Care
- Integration of neighbourhood and council teams
- Integration of VCSE colleagues

Independence Journey

- Increase reablement and rehab capacity for complex cases
- Establish performance framework to reduce care package
- Develop capacity on wider wellbeing support
- Increase access to equipment
- Support people out of interim beds to back home

Streamlined long-term care assessments

- Implement policy and process for TOCH to deliver restarts
- Reduce panel stages where appropriate
- Implement trusted assessor models

This plan is the outcome of an extensive programme of engagement, including 1:1 interviews, focus groups and a system-wide workshop to improve the patient experience of discharge from the Homerton in Hackney.

Discharge Funding

We have set out in the BCF Spending plan our initial spending plans to support safe and timely discharge.

Our initial plan was to continue to fund the majority of the winter pressure schemes that have been funded through various po ts of non-recurrent funding throughout the last few years, in order for us to receive the review done by PPL. This will help commissioners plan how to fund any transformation needed and re-allocate budgets accordingly.

Q1 and Q2 funding will be spent as outlined in the spending plan.

Over the period of Q3 and Q4 we will see a change in funding as we transform the discharge pathway. Areas that we want to rev iew spend include:

- Temporary accommodation post discharge (Scheme numbers 30 to 38)
- Bridging service (Scheme number 39)
- Review Mental health schemes as the roll out (Schemes 53 & 54)
- Increase access to reablement

The funding will help deliver the changes we wish to see which are covered in the previous slide (Slide 26)

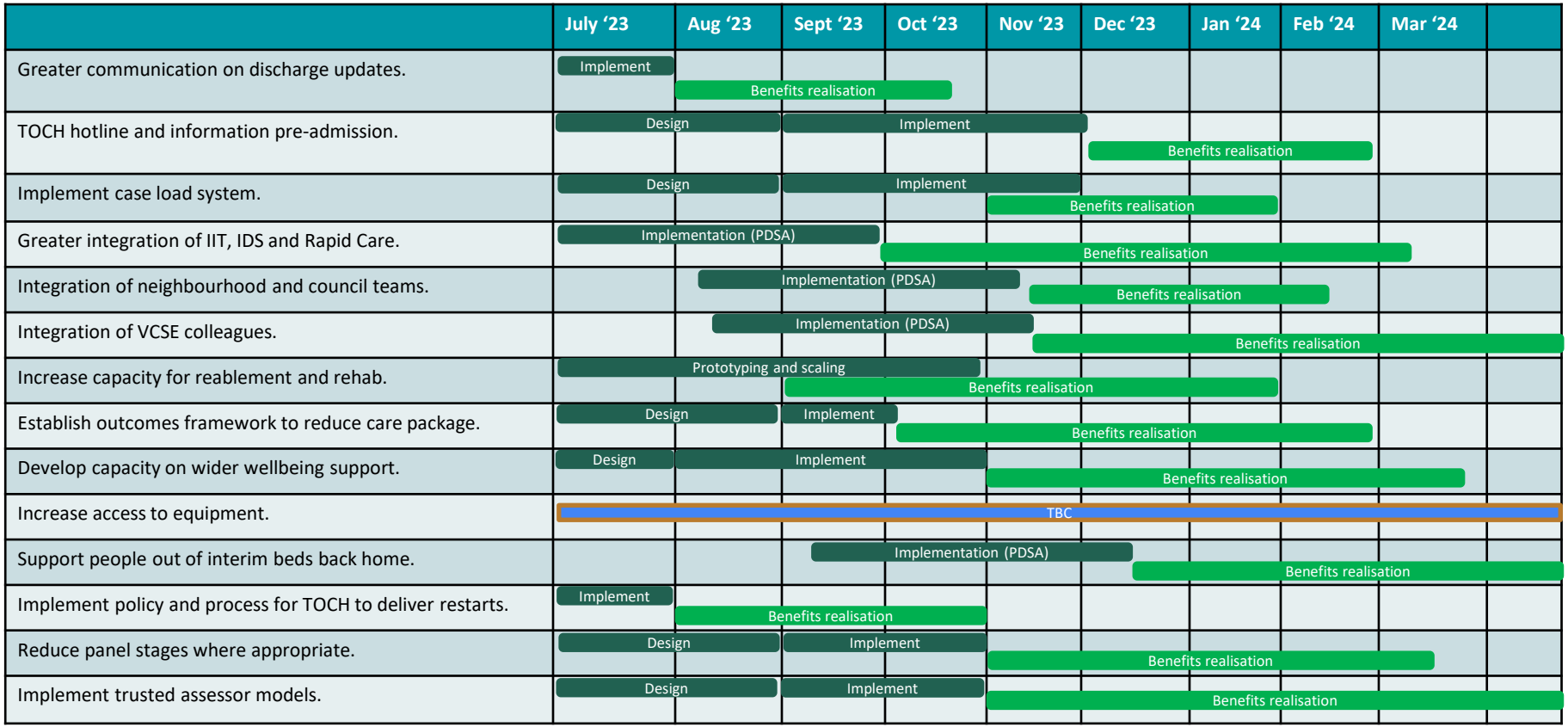
Change		Details of change	Benefits
Working with patients	Greater communication on discharge updates.	• Communications to be provided to patients and families by ward staff and/or TOCH staff as discharge plans develop (e.g. updates from board rounds).	• Greater experience for patients and their families. • Patients maintain agency through being involved in the process. • Increased capacity for the team through reduction in family queries. • Staff have a better working experience, resulting in greater staff retention.
	TOCH hotline and information pre-admission.	• A transfer of Care Hub phone hotline to be introduced to provide updates to families and carers on patient progress. • The hotline would also provide information pre-admission to connect people in to community support, potentially helping to avoid admission.	• Greater experience for patients and their families as they're kept updated and connected to additional support. • Increased capacity for ward staff through reduction in family queries. • Better working experience for staff, resulting in greater staff retention. • Higher utilisation of community assets.
Integrated TOCH	Implement case load system.	• Management of a single case load across all teams, covering all discharge pathways • A proportionate digital tool that will enable this to happen (interim tools may be required)	• Flexible use of staff capacity ensuring a system, pragmatic and practical approach to tackling pressure points collectively • Greater working experience for staff through collaborative approaches to tackling capacity issues
	Greater integration of IIT, IDS and Rapid Care.	• Building on successful collaboration to date to continue to break down barriers between teams • More flexible use of staff across the discharge pathways	• Flexible use of staff capacity ensuring a system, pragmatic and practical approach to tackling pressure points collectively • Greater working experience for staff through collaborative approaches to tackling capacity issues
	Integration of neighbourhood and council teams.	• Integration of NHS neighbourhood representatives with the Transfer of Care Hub • Integration of key council teams (e.g. Move on team) to the transfer of care hub (named individual per team). • To create explicit links with Out of Borough Transfer of Care hubs or discharge functions (named links)	• Smoother patient pathways in to the community, with the right care provided from discharge • Increased experience for patients as they're able to receive tailored support • Better working experience for staff, resulting in greater staff retention
	Integration of VCSE colleagues.	• Identification of VCSE partnerships to support discharge • Integration of VCSE colleagues to transfer of care hub, including organisations linked to key communities.	• Providing a broader range of support for patients, tailored to their care needs and aligned to their cultural/social preferences • Cost effective care

Change		Details of change	Benefits
Independence journey	Increase capacity for reablement and rehab.	• Developing increase capacity for complex cases to go through reablement and rehab; including outcome based contracts and explicit incentives regarding care package reduction. • Thresholds and process aligned to support more complex cases	• Increased independence for the patient, resulting in a better quality of life and long term outcomes. • Reduction in long term care costs as a result of patient independence.
	Establish performance framework to reduce care package.	• Establish a clear and straightforward outcomes framework for care for all internal reablement and rehab support, to promote care reduction (aligned to increasing independence levels) during intermediate care	• Increased independence for the patient, resulting in a better quality of life and long term outcomes. • Reduction in long term care costs as a result of patient independence.
	Develop capacity on wider wellbeing support.	• Develop capacity in cost-effective support focused on wider wellbeing (e.g. house maintenance, daily tasks, social isolation) to recognise and reduce the impact these have on health.	• Reduction in care costs. • Culturally sensitive and personalised support, resulting in an improved patient experience.
	Increase access to equipment.	• Increase access to equipment- available to all staff that are 'leading' discharge planning (ward staff, transfer of care staff, neighbourhood teams).	• Reduction in lost bed days due to equipment. • Greater experience for staff as less cumbersome process in place.
	Support people out of interim beds back home.	• Support people in interim beds to return back to usual place of residence through collaboration in the transfer of care hub. • This could be facilitated by community in-reaching and support from other groups.	• Increased patient flow through the system. • Reduction in lost bed days caused by delay in bed availability.
Streamlined long term care assessments	Implement policy and process for TOCH to deliver restarts.	• Develop and implement policy and processes to allow all transfer of care hub staff to restart packages of care, allowing a streamlined approach with effective risk management.	• More efficient and effective use of team • Less delays due to reduced process points
	Reduce panel stages where appropriate.	• For cohorts of patients where appropriate risk share can be identified and implemented, reduce panel stages in care package delivery.	• Reduction in lost bed days due to reduced assessment process time.
	Implement trusted assessor models.	• Streamline and align long term care assessments wherever possible • Implement trusted assessor models within Hackney – allowing wider staff roles to assess patients, dependant on their needs • Implement trusted assessor models for out of borough patients – agree with key borough social care teams that a trusted assessment can be used for certain levels of need/cohort of patients.	• Reduction in lost bed days due to reduced assessment time. • More efficient and effective use of team; including reduced duplication of assessments

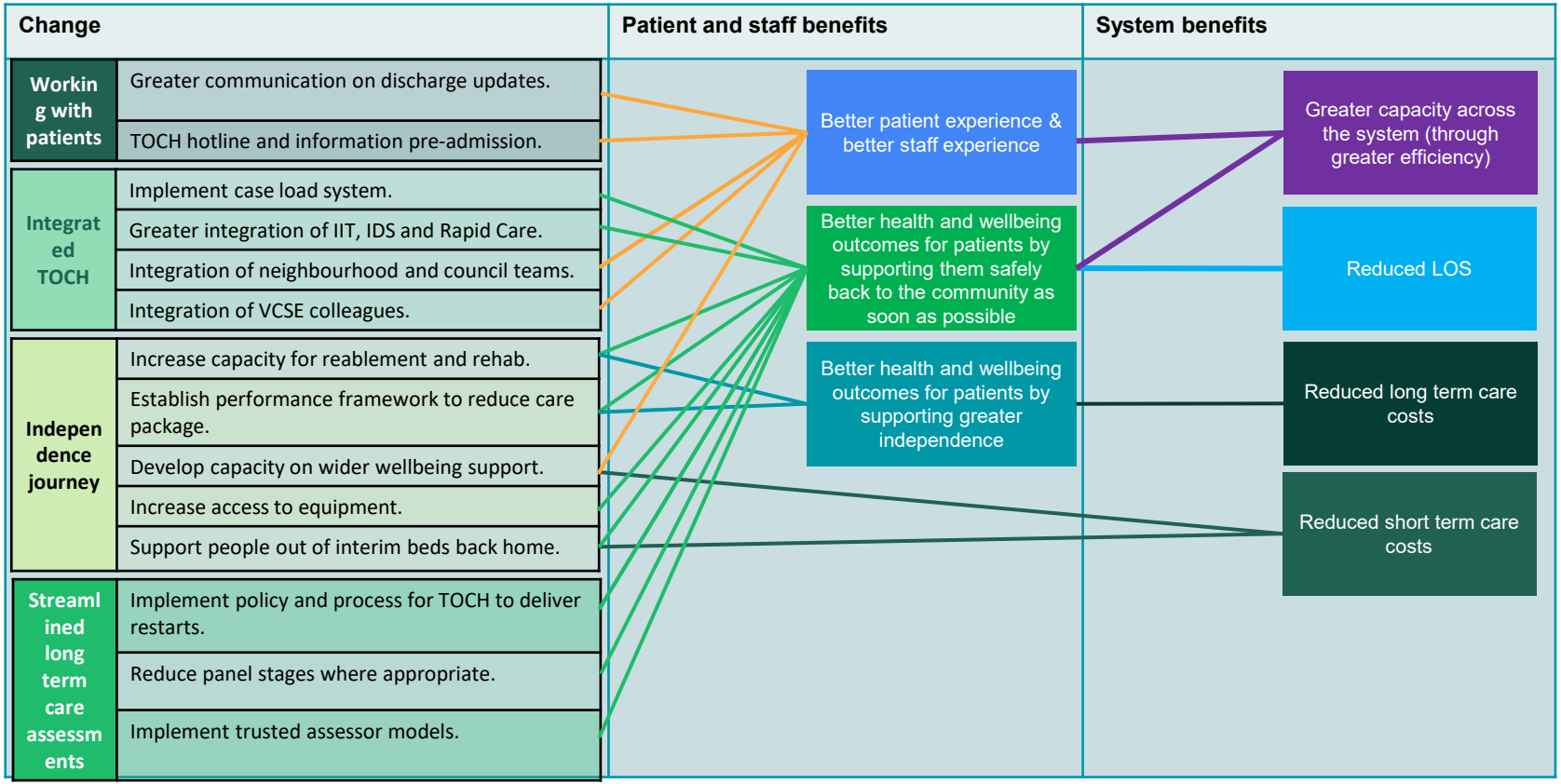
Provisional timelines

Benefits realisation

Implementation



Benefits map



Hospital discharge - City of London

There were 107 hospital discharges in 2022/23 through the following pathways:

- Pathway 0 - 53
- Pathway 1 - 41
- Pathway 2 - 7
- Pathway 3 - 6

Our Discharge scheme provides an intensive discharge to assess offer and includes reablement and domiciliary care. As can be seen above, we adopt a home first model wherever possible and have a rapid response service that can provide up to 72 hours of care to facilitate Discharge to Assess etc. However early discharge planning means that we have often assessed people, at least initially, before they leave hospital. The providers of the rapid response service also provide our reablement service and this has added flexibility to meet people's needs.

The Care Navigator plays a key role in facilitating safe hospital discharge and the rapid response service has been strengthened to respond to the more complex cases which are discharged into the community as part of early discharge.

We have excellent performance on the 'still at home 91 days after discharge' metric (each quarter is always more than 95%) and we are also able to avoid hospital admissions with the use of our rapid response service.

The Adult Social Care Discharge Fund will be used to further support early discharge planning and our home first approach. The ICB allocation has been agreed by all partners across NEL and does meet the needs of the City.

Whilst it is low, that is partly because the City of London Corporation are not providing some of the infrastructure or step down capacity that their patients will benefit from – so for example they do not have an integrated discharge hub, but patients are managed through the Homerton or Royal London (or UCLH) hubs, likewise City do not directly procure step down beds but will access beds procured by other boroughs.

High Impact Change Model self-assessment
London Borough of Hackney

1	Early discharge Planning	We continue to identify who needs support early to ensure appropriate pathway in advance.
2	Monitoring and responding to system demand and capacity	We continue to have a joint approach to developing step down facilities, integrated health and social care support and work with Age UK. We are jointly planning step down care facilities, with LBH as the lead commissioner using intelligence from front line staff on weekly stand up calls and complex cases being fed back to commissioners. **Area to develop:** we need to develop stronger real-time data about demand and capacity - we hope taking an NEL wide approach this will become easier, along with the fortnightly reporting.
3	Multi-disciplinary work	Our review has concentrated on this and the future development of a transfer of care hub.
4	Home First (Discharge to assess)	The review also looked at this - we have built capacity in the market and have a resilient homecare market supported by a bridging service. THe bridging service is under utilised and is not particularly a reablement model - we wish to increase the numbers of people being discharged home first with a reablement package.
5	Flexible working patterns (Formally 7 day working)	The services operate 7 days per week

6	Trusted assessment	During COVID this worked well although more homes are now requiring that they conduct their own assessments. The difficulty for Hackney is we don't have many care homes in borough so a trusted assessor model for care homes is difficult to pursue.
7	Engage and Choice	Extensive work was carried during 2021-22 using social marketing techniques to co-design patient and family/carer information leaflets, posters and prompts for staff to promote the idea of discharge home to your own bed if possible. Materials have been printed and delivered to Homerton Hospital in July 2022 and again in 2023. Rapid change in staff has led to them not being used consistently and a refresh on getting the message across throughout the hospital is needed this year.
8	Improve discharge to care homes	We work on an individual basis with local care homes to improve relationships and processes which support discharge from hospital. Each care home also has an aligned GP and there is a DES Supplementary Care Home service for our nursing homes which helps to reduce unnecessary hospital admissions and support flow of information post discharge.Market developments with the Fair Cost of Care have improved the availability of care homes as new fees have been agreed.
9	Housing and related services	Extensive work has gone into this area jointly supported by Adult Social Care, NEL ICB and LBH Housing teams. We have established a Pathway Homeless team for homeless citizens, a step up and down accommodation based service and Routes to Routes link workers. We have also completed an evaluation of the first year of service. We also have a number of temporary housing with care flats available as part of our discharge pathway, 2 accessible flats for working age adults with mobility issues and, Ageing Well funding is supporting an early intervention hoarding project pilot.

High Impact Change Model self-assessment City of London

1	Early discharge planning	We proactively manage early discharge planning in a number of ways: - Identification of cases through the care navigator and co-ordinating of the planning across social care, primary care services and the voluntary sector. Also allows identification of carers - Social workers visit people whilst still in hospital to facilitate a return home without D2A where appropriate - Involvement of OT at earlier stage as part of discharge planning and more equipment is purchased through a more efficient route - Expanded service with new homelessness social worker with link to ASC team (Schemes 1,2 and 4,19 and 20)	Next steps: Care navigator service to be recommissioned in 2024 as part of City Connections contract
2	Monitoring and responding to system demand and capacity	There are no acute hospitals within City of London boundaries	Next steps: N/A
3	Multi-disciplinary work	We are proactively involved in: - Practice MDTs - Social Worker and Care Navigator attends - Neighbourhood MDMs - Team Manager and Deputy Team Manager attend. Social workers present complex cases with multi disciplinary agreement on who will lead on the case and assign actions to different partners. This has improved working relationships and accountability (Schemes 1,2 and 4,19 and 20)	Next steps: Continue to engage with MDMs and range of health professionals.

4	Home First (Discharge to assess)	A rapid response service is in place providing up to 72 hours of assessment and then onward pathway. Also prevents admissions to hospital by providing care interventions. (Scheme 4)	Next steps: Keep under review
5	Flexible working patterns Discharge scheme.	Our hospital discharge service model provides a full discharge service 9-5 Monday to Friday with a clear expectation that there is flexibility outside of these hours subject to demand. Friday pressure points are expected and ASC cover enables weekend discharge arrangements to be secured. Our Rapid Response provider can support pre-arranged weekend discharge. (Scheme 4)	Next steps: Continue with discharge service model and rapid response provision.
6	Trusted assessment	There are two strengths based practitioners and 1.6 occupational therapists (OT) plus an additional 0.6 OT funded through iBCF. (Scheme 6)	Next steps: Consider training all staff in team to be trusted assessors
7	Engagement and Choice Discharge scheme. LA discharge fund. ICB discharge fund.	The strengths-based approach is used as part of early discharge planning to promote engagement and choice around the appropriate pathway. (scheme 4, 19 and 20)	Next steps: Continue to develop and implement a strengths-based approach.

8	Improve discharge to care homes	There are no care homes within City of London boundaries and all of our care home provision is spot purchase. This is built into early discharge planning with commissioners. Our brokerage pilot is designed to improve the efficiency of the process of purchasing placements, especially when placements are rapid. The pilot will also strengthen quality assurance. (Scheme 3)	Next steps: evaluation of pilot
9	Housing and related services	We are reviewing our DFG process and developing a Housing Assistance Policy to make best use of our DFG as many people are self funders. None of our hospital discharges have needed a DFG but we have undertaken some deep cleans and provided equipment to facilitate discharge. We work with our housing service on urgent adaptations to our own stock and our OT is involved in this. Our early intervention project can provide things that facilitate a return home e.g. a microwave, supporting a better discharge pathway. (Scheme 5)	Next steps: DFG review and development of Housing Assistance Policy

Disabled Facilities Grant (DFG) in Hackney

Aim The Disabled Facilities Grant (DFG) provides funding to enable disabled residents to live in their homes as safely and independently as possible.

The local authority Occupational Therapists ot@hackney.gov.uk carry out assessments and make recommendations for a range of adaptations such as wet floor showers, ramps, stair lifts, ceiling track hoists and through floor lifts. The adaptations are then sent to the Private Sector Housing Team (PSH) pshgrantsfolder@hackney.gov.uk who arrange for the works through the commissioned Home Improvement Agency (HIA)

London Borough of Hackney (LBH) has a **Housing Grants and Assistance DFG policy** which is underpinned by the council's vision of "building to make Hackney a place for everyone" and objectives set out in Hackney Community Strategy 2018-2028 such as helping disabled people to stay active and healthy, both physically and emotionally. The policy uses the powers set out under the Regulatory Reform Orders to provide more flexibility in the delivery of the DFG. The policy was signed off by housing authorities in LBH.

Key inclusions in the policy

- Joint working with health to prioritised assessments and adaptation delivery for residents discharged from hospital - which include works such as deep cleaning and boiler replacements.
- The £10,000 is not means tested, and this will be reviewed in September 2023
- Relocation grants of maximum £20,000
- Innovative adaptations designs for Hackney's 'period' housing stock

DFG - City of London

As noted in the HICM self-assessment, we provide deep cleaning, decluttering and aids and minor adaptations to facilitate discharge. To date no major adaptations have been required to facilitate discharge. Most of our DFGs come from housing association stock in the City of London - the private sector is very small and most owner occupiers would be self-funders and do not approach in the first place.

The OT works well and closely with our housing department to support appropriate adaptations in our own stock.

DFGs are held and managed within our ASC Team and the use of an external support agency. Through our other work such as the MDMs and MDTs and general collaboration with health, where appropriate, there is joint working around adaptations.

There were 9 DFG cases in 2022-23. 1 was for an under 18 year old, 1 was for the 19-64 age range, and 7 were for 65 and overs. 5 had been completed, 1 was closed, 3 remain open.

However, we want to do more. The City of London is reviewing its DFG process as part of its ASC Transformation and Change Programme. The review includes analysing and learning from good practice, identifying how we can increase awareness and take-up of the DFG, especially with regards to the use of assistive technology and infrastructure and developing a Housing Assistance Policy to help encourage greater uptake and use surplus DFG funding more effectively to meet wider needs (e.g. self funders).

Tackling Health Inequalities in City and Hackney

The **direct** harms of COVID-19 disease and the **indirect** effects of lockdowns and other restrictions have affected some groups much more than others, including:

- Our diverse, ethnic communities
- Older people
- Children / young people (educational and employment impacts)
- Residents of care homes / settings
- People with pre-existing health conditions
- Men (diagnoses and deaths)
- Women (social and economic impacts)
- People at risk or poor mental health
- People living in poverty or on low incomes
- People in 'key worker' roles and / or insecure employment
- People living alone or socially isolated
- Marginalised groups such as homeless people, asylum seekers, prisoners, street-based sex workers

The breadth and depth of the impacts of COVID-19 emphasise the need for collective, system-wide action to address health inequalities that have been starkly exposed by the current pandemic.

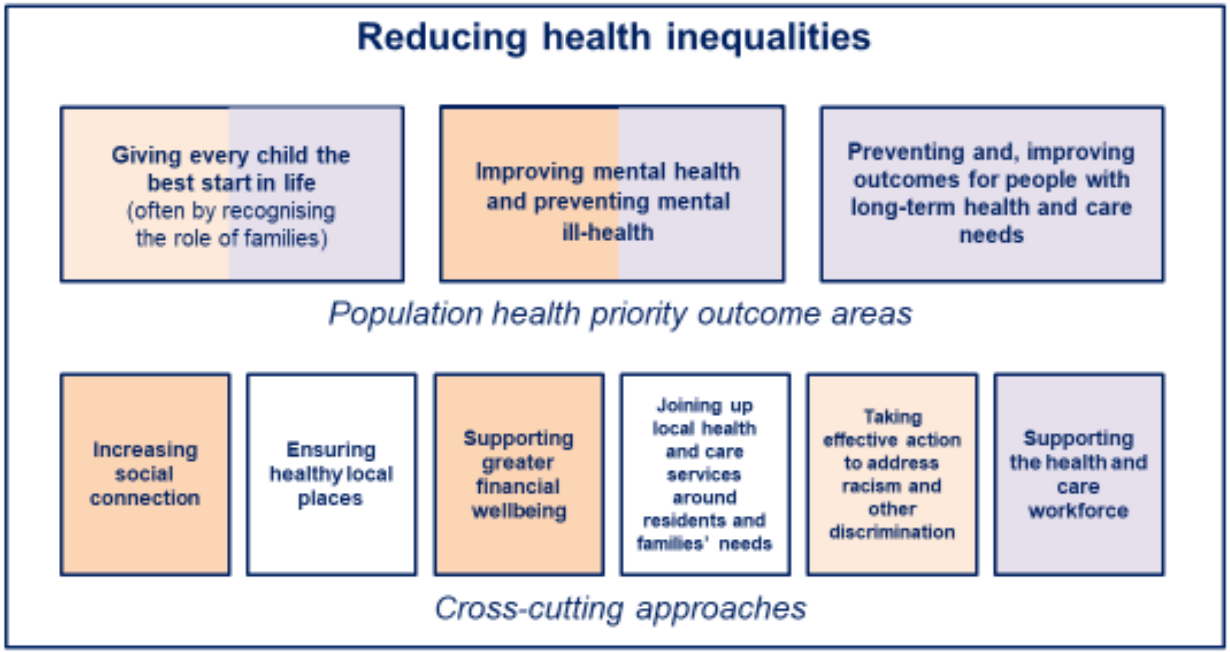
The City and Hackney Place-Based Partnership and both Health and Wellbeing Boards have adopted a population health approach that aims to improve physical and mental health outcomes, promote wellbeing, and reduce inequalities.

The City and Hackney Health Inequalities Steering Group has been convened to ensure our collective efforts have maximum impact, and that we make best use of our combined resources, through collaboration and a partnership approach.

Ten broad areas for local system-wide action to tackle health inequalities in City and Hackney

Act: Health Inequalities Steering Group leadership and mobilisation of system resources	1. Inequalities data and insights	Routine collection and analysis of equalities data and insight to inform action
	2. Tools and resources	Develop / enable system-wide adoption of tools to embed routine consideration of health equity in decision-making
	3. Tackling structural racism and systemic discrimination	Adopt a partnership position and action plan to tackle racism and wider discrimination within local institutions
	4. Community engagement, involvement & empowerment	Build trust and adopt flexible models of engagement to work in partnership with residents to improve population health
Sponsor: Led from elsewhere, but Health Inequalities Steering Group role to champion, facilitate partnership working, ensure focus on reducing inequalities	5. Health (equity) in all policies	Ensure wider policies and strategies explicitly consider and address health inequalities
	6. Anchor networks	Anchor institutions collectively use their local economic power to lead action on reducing social inequalities
	7. Strengths-based, holistic approach to service provision	No wrong door access to support residents to address wider health and wellbeing needs, include building a preventative approach across all public services
	8. Staff health and wellbeing	Build on COVID-19 risk assessments to provide ongoing support for wider staff wellbeing needs
Watch: Monitor progress of existing partnership work to tackle inequalities	9. Tackle the digital divide	Pool system resources to address the 3 dimensions of digital exclusion: skills, connectivity, and accessibility
	10. Tailored, accessible info about services & wider wellbeing support	Produce information in community languages that is culturally appropriate and responsive to local diverse needs

Strategic focus areas for the City and Hackney Place-based Partnership



= Hackney HWB focus area

= Hackney HWB specific 'lenses': (approaches to reducing health inequalities)

= NEL ICS four partnership priority areas

= reflecting LTP response / long term C&H partnership ambitions / Neighbourhoods Programme vision

Equality and health inequalities

National priorities (e.g. Core20Plus5), local data on health needs, insight on what is important to residents, and insights from the voluntary sector have informed partnership decisions on non-recurrent funding to support projects that need investment to address health inequalities.

Where any new BCF schemes are developed or commissioned an Equality Impact Assessment (EIA) is carried out. None of the schemes in the BCF are identified as having a negative impact on any protected characteristic groups. Several of the services (e.g. CoL care navigator scheme) are universal and available to those who require it.

The following BCF schemes play a core part in reducing health inequalities and disparities for the local population, taking account of people with protected characteristics:

- DES Supplementary Care Homes Service for older adults (CoL scheme 16 , LBH scheme 23)
- Neighbourhood approach to population health that addresses the variation seen between populations at the 30-50,000 level (CoL scheme 18, LBH scheme 10)
- End-of-life care through St Joseph's Hospice and Marie Curie Rapid Response End of Life service (CoL scheme 10/22, LBH 14/54)
- Adult Cardiorespiratory Enhanced and Responsive Service (ACERS) and Asthma services aim to reduce inequalities in management of long-term conditions CoL 7/9, LBH 11/13)

Equality and health inequalities - BCF

- The Homelessness Pathway team and Lowri House step-down accommodation which supports the more at risk homeless and disenfranchised population often missing out on any healthcare. (LBH Scheme 21; 22 & 29).
- As part of the PPL discharge report, we asked the review team to consider equality of access to discharge services. During the transformational work to redesign discharge services in the Homerton and LBH we will conduct an Equality Impact Assessment (EIA) to ensure equal access (LBH)
- Carers support service is now provided by Tower Hamlets Carers Centre who can provide a more culturally appropriate service to reach carers on the east of the City of London who were often hidden. The service has now engaged with 45 new carers, 38 of whom are from more the east of the City (CoL scheme 6)
- Rough sleepers: Strength-based Practitioner post in the rough-sleeping homelessness service and access to primary care services. Some of our IBCF money has established integrated health and care work for rough sleepers which has been continued with specific rough sleeping funding (CoL scheme 6)