City & Hackney Place-based Partnership

Better Care Fund
Narrative Plan 2022-23

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The City and Hackney Place-based Partnership

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 (formally the Integrated Care Partnership Board). The board have agreed a set of strategic focus areas and work is now underway to agree an Integrated Delivery Plan that describes how we will deliver this strategy.

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 meetings
- City and Hackney Health and Care Board

Hackney's Population Changes ONS Census 2021

- In Hackney, the population size has increased by 5.3%, from around 246,300 in 2011 to 259,200 in 2021. This is lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.
- Nearby areas like Tower Hamlets and City of London have seen their populations increase by around 22.1% and 16.6%, respectively, while others such as Islington saw an increase of 5.1% and Haringey saw smaller growth (3.6%).
- There has been an increase of 17.8% in people aged 65 years and over, an increase of 6.3% in people aged 15 to 64 years, and a decrease of 3.3% in children aged under 15 years.
- The female population is an estimated 135,300 compared with the male population of 123,900.
- Hackney had a population density of 13,611 residents per sq km and it remains the 3rd most densely populated local authority after Tower Hamlets and Islington. Hackney has 106,100 households compared with 101,690 in 2011.

Office for National Statistics 2021

City of London's Population Changes ONS Census 2021

- In the City of London, the residential population size has increased by around 15%, from 7375 in 2011 to 8,600 in 2021. This is higher than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800. However, our small population size can create significant percentage changes.
- Nearby areas like Tower Hamlets and Hackney have seen their populations increase by around 22.1% and 5.3% respectively, while others such as Islington saw an increase of 5.1% and Haringey saw smaller growth (3.6%).
- There has been an increase of 165 in people aged 65 years and over (1035 and 1200 for 2011 and 2021) and a small increase (2%) in those aged 0 – 19. The biggest proportion of the population is of working age.
- The female population is an estimated 3,800 compared with the male population of 4,800.

Office for National Statistics 2021

Key Priorities for the 22-23 BCF

- Support delivery of the City and Hackney Partnership Integrated Delivery Plan
- Reduce health inequalities
- Work to support place-based partnership transformation programmes around relevant “big ticket items”
- Neighbourhoods continues to be a strategic priority for City and Hackney.
- Review the hospital discharge infrastructure from end to end and implement recommendations to improve efficiency and effectiveness of hospital discharge

Key changes since previous BCF Plan

Funding remains in place for implementation of care act duties, carers services and reablement in addition to other core community services.
The Hospital discharge scheme is being updated in the City of London

- A small portion of funding has been held back to support discharge and other system pressures. We are in the process of establishing whether we need to support pressures or to repurpose to something new. Some potential areas are:
    - Hospital discharge independent review
    - Additional funding to the Integrated Community Equipment Service to meet increase in costs attributed to health equipment

Governance

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.

The LBH Assistant Director ASC, Finance and BCF Lead meet 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 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.

Overall BCF Plan and Approach to Integration

Our BCF Plan supports integration across the health and social care system and partnership in a number of significant ways, including:

- Joint 2022-23 Priorities outlined in our Place Based Plan (See following slides)
- Approaches to joint and collaborative commissioning including hospital discharge
- Commissioning of a joint review of the discharge infrastructure to inform future commissioning and service design and delivery
- Joint review of the High Impact Change Model and Discharge 100 Day Challenge
- Joint work around Discharge of Homeless people with Housing Needs and Benefits team
- Joint approach to addressing equality and health inequalities

The 22/23 City and Hackney Place-based Partnership Priorities

Sources of strategy themes which our place-based partnership must respond to

NEL ICS partnership priorities

Employment and workforce
To work together to create meaningful work opportunities for people in North East London

Long term conditions
To support everyone living with a long term condition in North East London to live a longer, healthier life

Children and Young People
To make North East London the best place to grow up

Mental Health
To improve the mental health and well being of the people of North East London

Local health and wellbeing strategic focus areas (Hackney and City of London separate strategies)

- **Improving mental health and preventing mental ill-health**
- **Increasing social connection**
- **Supporting greater financial wellbeing**

HW strategies currently being refreshed

NHS Long Term Plan chapters / aims

- A new service model for the 21st century
  - Boost **out of hospital care**
  - **Reduce pressure** on emergency hospital services
  - People get more control and more **personalised care**
  - Greater focus on **population health** and move to ICSs
- More NHS action on **prevention and health inequalities**
- Further progress on care quality and outcomes
  - **A strong start in life for CYP**
  - Better care for **major health conditions**
- **NHS staff** get the backing they need
- **Digitally enabled care** goes mainstream
- **Financial balance**, efficiencies and better use of investments

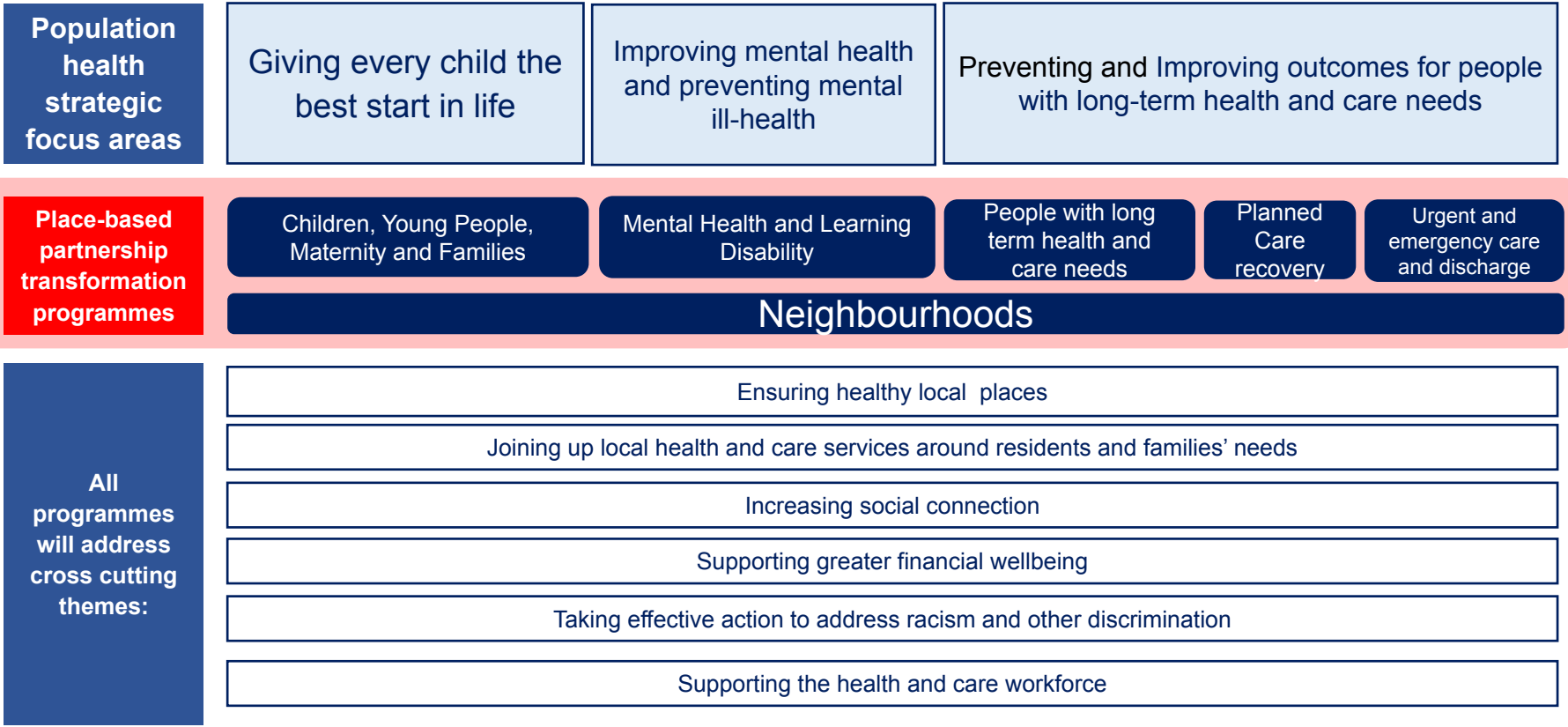
City and Hackney Borough-based Partnership Strategic Plan and Priorities

Local identified priority outcomes and delivery priorities in response to strategies

Outcomes — City and Hackney Outcomes Framework

Delivery Group — Integrated Delivery Priorities 2021/22

Mapping place-based transformation programmes to population health focus areas



The Integrated Delivery Plan

The Integrated delivery Plan is a two year, partnership plan that describes what we are doing together to achieve our strategic priorities. it 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. Many areas of the plan will be driven by, or link to NEL-wide programmes, though we have only captured the City and Hackney element of these.

The plan is being developed in two phases – phase one has focused on actions to directly support improvements against the strategic focus areas. A second phase, currently underway, will capture what our strategic enablers (workforce, digital, communications and VCS) need to do to support delivery.

The plan is a living document that supports delivery – as such it will iterate over time. That said, we are aiming to have agreement on the main areas of delivery by end of September.

Big Ticket items

The plan describes a large amount of work across the partnership. Following discussions with senior leads, we have identified a number of Big ticket Items – these are the areas where we expect to see the most transformation and where we need to work together to deliver.

Neighbourhoods

Neighbourhoods continues to be a strategic priority for City and Hackney. The programme is a key enabler for our model for out of hospital services, local resident / community engagement and addressing local health inequalities. While there is a specific work plan for the programme, it should also be seen as a broader cross-cutting approach that informs our approach to all of our strategic priorities.

The neighbourhoods work is funded via the BCF funding streams

Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

1. Enhanced Community response

Urgent community Response: Wherever it is appropriate to do so, we want to support people in crisis at home as a safe alternative to ED. We will increase activity in our urgent community response services, whilst ensuring that 90% of people referred are seen within 2 hours. We also aim to improve post crisis care to ensure full recovery, support independence and reduce risk of future crisis. This should result in better outcomes for patients as well as reducing pressure on our urgent and emergency care system. **Paradoc and IIT Rapid Response is funded by the BCF**.

Virtual Wards: We are introducing a new model of community based care whereby people can be safely cared for and monitored at home as an alternative to hospital admission. This will deliver on the NHSE asks around Virtual Wards, as well as building on existing local plans around enhanced community support.

The outcomes we expect our work to drive include:

- Ensuring that people with long term health needs are better supported in their own home through a more personalised and proactive approach, therefore avoiding further crisis
- Recover more quickly from crisis / acute episode
- Maintain health – return to pre-morbid health
- Live independently for longer - improved wellbeing
- An improved health-related quality of life for people with long term conditions
- Reduced mortality / morbidity from emergency presentations

Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

2. Homelessness and vulnerably housed

This programme of work involves partnership working across health, social care and housing to ensure the vulnerably housed with City and Hackney have integrated health, housing, care, employment and community pathways that support a sustainable move away from homelessness resulting in improved health and social outcomes.

The outcomes we expect our work to drive include:

- 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

The Pathway Homeless Team which operates within the Homerton Hospital and City & Hackney Centre for Mental Health is funded by the BCF.

Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

3. Long Term Conditions

Working with partners across the System, we aim to continue to drive up the quality of care and outcomes for people living with long term conditions (LTCs). This programme of work aims to embed preventative approaches, increase standards and reduce variability in access to high quality care, and increase the proportion of patients feeling supported to manage their LTCs. We are enabling this through;

- Continued commissioning of the LTC contract for City & Hackney practices to deliver high quality preventative care above their core contracts, with a new focus on embedding risk stratification approaches and addressing inequalities;
- Roll out of, and increasing referrals into local and national programmes of education and self-management support for LTCs, including digital technologies to support this;
- Drawing upon the expertise and resources of people with LTCs and their communities to help achieve the best possible outcomes and drive reductions in inequalities.

The outcomes we expect our work to drive include:

- 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)

The Adult Cardiorespiratory Enhanced + Responsive Service and Asthma service are funded by BCF.

Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

4. Discharge

We are working together as a health and care partnership to ensure that our discharge best meet the needs of our residents.

We are enabling this through the development of structures, processes and pathways that will support safe, effective, efficient (timely) discharge from hospital.

Our approach of

- ***Home first principle** is to ensure patients do not stay in hospital bed any longer than necessary*
- ***Maximising reablement potential** is to promote independence*

The outcomes we expect our work to drive include:

- 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

Slide 23 identifies the services funded by the BCF which support discharge.

Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

5. Personalised Care

Our approach to Personalised care is built around the person and their family - it allows people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences.

The outcomes we expect our work to drive include:

- The provision of an increased access to wider services
- Ensuring there is a maintained operating plan trajectory
- An increased % of people reporting they feel involved in their own care (GPPS)

Neighbourhoods Programme

Funded by the BCF, Neighbourhoods has the following transformation priority areas which will support the development of an outcomes framework that describes how the delivery plan will drive longer term population health outcomes.

1. Addressing Rising Need: includes co-designing and embedding in each neighbourhood an anticipatory care pathway
2. Driving and improving multidisciplinary teams: aligning mental health teams with MDMs and MDMs working effectively with anticipatory care pathway
3. Supporting the neighbourhoods workforce: Theory of change and outcomes framework co-produced and agreed
4. Embedding a structure for resident involvement in neighbourhood decision making -Aligning the City and Hackney review of resident involvement and the PCN DES on Resident engagement with the models of resident engagement.

Supporting Discharge

How the BCF Supports Discharge

Specific Schemes funded by BCF to support discharge:

- Age UK - Take Home and Settle (LBH)
- Discharge Coordinators (predominantly LBH; but City residents in the Homerton)
- Pathway Homeless Team (predominantly LBH; but City residents in the two Trusts)
- Funding increased demand to support eligibility criteria (LBH)
- Interim accommodation (LBH)
- Funding of increased care package costs to support discharge (LBH)
- Hospital Discharge Scheme (CoL)
- Care Navigator (CoL)
- Strength-based Practitioner post in the rough-sleeping homelessness service (CoL IBCF)
- Support for complex packages, particularly during winter pressures (CoL & LBH iBCF)

Discharge group

The Hackney Discharge group has been overseeing hospital discharge policy and performance for the Homerton Hospital for a number of years and includes the following members and partners:

- NHS North East London ICB
- London Borough of Hackney Adult Social Care
- London Borough of Hackney Housing Needs and Benefits Team
- Homerton Healthcare NHS Foundation Trust
- East London Foundation Trust
- Age UK East London
- City and Hackney Healthwatch
- Experts by experience

This group is well established and has built up a strong working relationship. The group meets bi-monthly, however operationally we have a weekly ‘stand up’ meeting with operational leads from partners to update on current performance and assist unblocking any issues.

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. **Area for development:** Need to review how the Carers requirement in the White Paper is met as part of involving carers and family in discharge planning.
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 facilitators, with LBH as the lead commissioner but intelligence fed form 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.
3	Multi-disciplinary work	COVID underlined the importance of this approach inducing working with Age UK, Housing colleagues, and hospital teams. Discharge hub is based on an MDT approach and daily calls include voluntary sector, discharge planners, social workers and homecare bridging service provider. Assessors using strength based approaches. **Area to develop:** (1) Further work with trusted assessor to support out of borough cases. (2) To review practice against BCF Transfer of care hub quick guide.
4	Home First (Discharge to assess)	Homecare providers, the homecare Bridging Service and our Rapid Care service delivered by our Integrated Independance Team (IIT) ensure people are discharged first and then assessed either in their own homes or in temporary accommodation before onward move to more permanent suitable accommodation or support post discharge. This is standard practice wherever safe to do so. **Areas to develop:** link to virtual wards as a step down from hospital and evaluate the virtual ward pilot and how it supports home first.
5	Flexible working patterns (Formally 7 day working)	COVID showed us that 7-day working and extended hours can make a big difference to hospital flow. Updated guidance suggest not necessarily needing 7 days or 24 hr but to look at system blockages and where extra resources are needed. Hackney is identified as a good example on the Better Care Exchange website for our 'Continuous Cycle' how to improve flow - following our development of weekend discharge hub and brokers. **Area to develop:** Review work patterns as part of the discharge review.

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. **Area to develop: review impact of approach/materials prior to end of the 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 their is a DES Supplementary Care Home service which helps to reduce unnecessary hospital admissions and support flow of information post discharge.
9	Housing and related services (Added 2019)	Extensive work has gone into this area jointly supported by Adult Social Care, NEL ICP 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 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	Our care navigator is based on hospital wards and co-ordinates with hospital discharge teams to undertake early discharge planning. This role is being reviewed and will be defined further with more of a strengths based approach to identifying appropriate discharge pathway etc. We are now also getting social workers in to hospitals to visit people earlier to facilitate a return home without D2A where appropriate. One of the areas we are doing work around is equipment – expensive and unnecessary equipment is being ordered to facilitate discharge but involvement of the OT at an earlier stage means that as part of discharge planning more appropriate equipment is purchased, through a more efficient route.
2	Monitoring and responding to system demand and capacity	Not relevant for City.
3	Multi-disciplinary work	We have always worked in a multidisciplinary team but a new and welcome addition is a Neighbourhood MDT where complex cases, including any complex discharges are considered. Both social workers and the OT are involved along with a range of health professionals.
4	Home First (Discharge to assess)	A new rapid response service in place providing up to 72 hours of assessment and then onward pathway.

5	Flexible working patterns	We piloted extra out of hours social worker capacity to facilitate discharge but there was low demand for this. We have now amended this to provide additional capacity later on Friday evening to manage any discharges coming up over the weekend and to cover Bank holidays and weekends if required. Our raid response service is also flexible and steps in to help facilitate hospital discharge when required.
6	Trusted assessment	It is recognised that we need to build in more Trusted Assessment Capacity into our model and all the Adult Social Care Team are due to get Trusted Assessor Status. Currently, capacity for this consists of two strengths based practitioners and two OTs.
7	Engage and Choice	The strengths based approach is used as part of early discharge planning to ensure people have some engagement and choice around the appropriate pathway.
8	Improve discharge to care homes	All of our care home provision is spot purchased so this is built into early discharge planning with commissioner part of panel discussions and notified of any potential care home placements in order to start early planning.
9	Housing and related services	We delayed a review of our DFG process for a variety of reasons but are aiming to undertake it within the financial year. None of our hospital discharges have needed a DFG but we have undertaken some deep cleans and provided equipment to facilitate discharge. We also work with our housing service on urgent adaptations and our OT is involved in this. Our early intervention project is also able to provide things that could facilitate a return home e.g. a microwave.

Supporting Unpaid Carers

Carers - LB Hackney

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 3 conversation model:

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

The key features of the service are as follows:

- *Carers assessment*
- *Carers reviews*
- *Support planning*
- *Assigned practitioners for carers; however, this shall change to Lead Worker for LBH ASC teams when the Three Conversations Model is fully implemented.*
- *Contingency planning*

Hackney

support information advice Carers FIRST
FIRST Choice for Carers
Supporting Carers in Hackney

Carers – City of London

Part of the minimum NHS contribution is used to support the City Connections service which provides support to informal carers wellbeing. The service is also piloting an extended carers support service with more specific support to carers. This pilot will be delivered through a specific carers organisation based in a neighbouring borough.

The Care Navigator is also able to identify informal carers through their work and refer them to City Connections or to Adult Social Care for a carer's assessment.

Where an informal carer is assessed and has a support plan, support options include universal services such as City Connections and personal budgets at different levels which are non-means tested.

The Disabled Facilities Grant and wider services

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.
- ASC OTs carry out assessments under the Housing Grants Construction and Regeneration Act 1996 and make recommendations to enable people to live as safely and independently as possible, often preventing or delaying care packages or residential care. The recommendations with specification, drawing and quotes are sent to the Private Sector Housing who work with the Millbrook Home Improvement Agency (HIA). The HIA tender the adaptation works following approval by PSH.
- Hackney has a a weekly meeting with all parties involved to approve spend, and resolve the blocks in cases that are not progressing. Monthly contract meetings provide updates, monitor case progress, discuss solutions and spend.

DFG Planned spend – LB Hackney

New guidance came out this year on time frames - In support of this the London Borough of Hackney are changing the way we do assessments and putting money into the OT services to recruit more OTs to reduce the waiting times. This supports timely hospital discharges, including a specific post to help move people who have been placed in temporary accommodation to aid discharge.

We will be carrying out a Policy review in 2023 - working towards developing a more streamline service in line with the new policy.

Assistance with Hospital Discharge to help prevent delays in discharge from the hospital due to the person's home not being suitable. The works can include deep cleaning, decluttering, minor adaptations, boiler repairs/replacement, etc.

We published a local policy which was approved by the Mayor to remove the means testing of grants up to £10k making the process much more efficient and quicker for residents.

DFG Planned spend – City of London

The City of London has been planning a review of DFGs and the process but this was held in order for it to be part of a new ASC Transformation and Change Programme.

DFGs in the City of London are processed well and within time but numbers are low. Part of the review will be to identify how we can increase awareness and take up of DFGs.

As noted in the HICM self-assessment, we provide deep cleaning, de-cluttering and aids and minor adaptations to facilitate discharge. To date we have not had to do any major adaptations in order to facilitate discharge.

The review of DFGs will also look at how we can use some surplus DFG funding more effectively. We will look to develop a Housing Assistance Policy to allow this. One potential area is to support those who are self-funders to have the project support to manage the DFG and works.

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

Equality and Health Inequalities

Equality and health inequalities

The priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services are set out in the City and Hackney place based plans as outlined in the next slide.

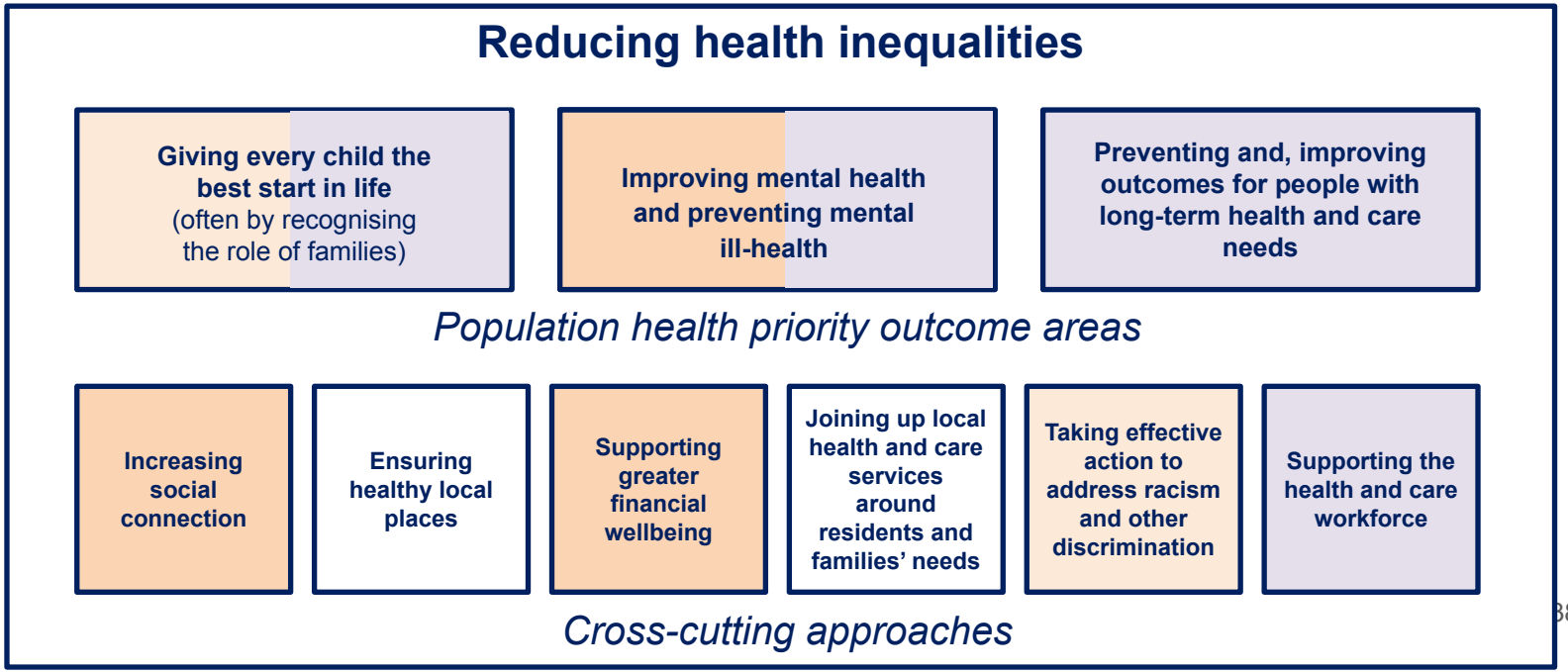
To support the NHS operating plan priorities and the national ICS CORE20PLUS5 framework, the partnership has also received £900k from the NEL Health Inequalities Fund. This funding sits outside of the BCF.

We are going to use approximately £500K of this money to fund a rigorous and systematic approach to embedding proportionate universalism in City and Hackney in order to support people to improve outcomes proportionate to their level of need. We are aiming to become a ‘Marmot place’ by taking a proportionate universal approach to service provision, but also about taking partnership/cross-sectoral action to achieve the six Marmot goals.

Part of the money would fund the infrastructure to enable this and the majority of the money will be to support the implementation of initiatives to enable a proportionate universal approach to reducing health inequalities.

Another £400K will go towards funding 6 different schemes: 1. Funding meaningful children and young people input to the piloting of CAMHS Youth Health Hub; 2. Funding community engagement and the piloting grassroots initiatives to improve childhood immunisations coverage; 3. Interventions to support City and Hackney homeless population; 4. Community chest for social prescribing; 5. Foot care for housebound patients; 6 Improving access to employment support for residents with SMI.

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 at a BCF Level

Specific BCF projects which help to address health inequalities:

- The Pathway Homeless Team support homeless people through their hospital stay, and after discharge to Lowri House and other community settings
- Continued delivery of the DES Supplementary Care Homes Service for older adults
- Implementation of a neighbourhood approach to population health that addresses the variation seen between populations at the 30-50,000 level. Evaluation of Neighbourhoods approach produces regular updates on how inequalities are being addressed through the model.
- 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.
- Discharge review will include getting an informed picture of deprivation, and whether all patients are getting an equitable discharge to assess offer
- Strength-based Practitioner post in the rough-sleeping homelessness service (CoL IBCF)