Appendix A

Better Care Fund 2021 – 2022

Narrative Plan

Wandsworth Borough Council

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1. Foreword

As Chairman of the Wandsworth Health and Wellbeing Board (HWB) and on behalf of the HWB, I would like to express our deep disappointment with the short time frame given to boroughs to complete the 2021-22 BCF Planning Template and Narrative.

I would like to receive reassurance from NHSE/I outlining the process for 2022-23, providing a forward plan of key activities and time frames that allow for the Health & Wellbeing Board to discuss future BCF submission in advance of the start of the 2022-23 Financial year.

Cllr Clare Salier, Wandsworth Health and Wellbeing Board Chairman

2. Bodies involved in preparing the plan

How have you gone about involving these stakeholders?

Historically, there has been strong collaborative working across health, social care, and the voluntary sector partners. This Better Care Fund (BCF) 2021-22 Plan reflects the ongoing work that has been designed and agreed as a whole system working in partnership.

Networks and forums are established and used to engage and involve partners. There were several whole system events during 2021-22, including a workshop involving Wandsworth system partners, St Georges Hospital and Merton partners.

In addition, there are monthly meetings across Wandsworth on developing integrated care pathways and providing intermediate care and rapid response services across Wandsworth and Merton.

During the pandemic, the majority of the meetings were delivered through virtual mechanisms which has shown to impact positively on people's ability to fully participate. Through using virtual meeting platforms, wider and consistent engagement has been achieved.

Stakeholders involved in producing the BCF Plan include:

- London Borough of Wandsworth Adult Social Care, Housing and Public Health.
- South West London Clinical Commissioning Group (Wandsworth Local delivery team).
- Central London Community Healthcare NHS Trust (Community Health provider)
- Wandsworth voluntary sector, including the Voluntary Sector Coordination Service, Enable Leisure, Age UK Wandsworth, Alzheimer's Society and Wandsworth Carers Centre.
- St George's and Chelsea and Westminster Hospitals.
- Primary Care Networks.
- Wandsworth GP Federation.
- Healthwatch Wandsworth.

3. Executive Summary

Our vision for Wandsworth is for people to remain as healthy as they can for as long as they can. We are focused on prevention, joining up care where it is appropriate to deliver a better service, and supporting and developing resilience in individuals and local communities.

The Better Care Fund (BCF) programme in 2021-22 will continue to facilitate health and social care integration. The Wandsworth BCF Plan outlines the joint intentions of Wandsworth Borough Council (WBC) and South-West London Clinical Commissioning Group, Wandsworth Locality (CCG) for achieving the long-term aim of health and social care integration and person-centred care. The BCF Plan will be a continuation from the 2020-21 Plan and represents the joint plan for integration of health and social care locally.

The key priorities for the system and therefore the focus of the BCF for 2021-22 are recovery from COVID-19, to sustain hospital discharge and flow through the system and supporting care homes.

The BCF Plan will retain a focus on improving the hospital discharge process, avoiding unnecessary admissions, and increasing the availability and effectiveness of reablement services through the commissioning of jointly led health and social care services.

During the past year, Wandsworth has been in consultation with local people and key stakeholders on what their priorities are for the local health and care system. Reflecting on evidence from the recently published Joint Strategic Needs Assessment (JSNA) and informed by wide consultation with residents, staff, and stakeholders the priorities of the Wandsworth Health and Care Plan 2021-23 are being developed.

The sustaining flow programme focuses on refining the Discharge to Assess pathways and to embed Home First principles. This builds upon the health and Social Care Discharge Hub where a single point of access was set up at the start of the pandemic. Over time, the demands on 'the hub' has increased. A proposal has been approved to increase community medical, rehabilitation and social care support, including more Social Work capacity and a dedicated Community In-reach Team and Discharge Coordinator. These are funded through Winter Pressures monies, aiming to be in place shortly. It is anticipated that the additional staffing will strengthen discharge and flow processes over winter and shore up staff capacity across the system.

Enhancing support to care homes is another key focus and during 2021-22 partners have worked together to provide resilience to the market. Care homes have been supported to report on the Capacity Tracker and to adopt new tools such as virtual monitoring tools that can provide more clinical information about the residents that aid decision making.

Throughout the pandemic, a substantial amount of work has been delivered within care homes to encourage positive uptake of the COVID-19 vaccination by both residents and care home staff. Work is ongoing to support care homes with business continuity to off-set issues arising from staff shortages that relate to the mandatory vaccine regulation.

There are physical and mental health nursing and therapy teams in place for care homes and a named GP lead for each care home. They serve to enhance access to health care and where possible, prevent avoidable admissions to hospital.

The Enhanced Health in Care Homes Agenda promotes various initiatives that have been implemented across Wandsworth and further across SWL. Initiatives include Proxy ordering, Restore 2 Training (to identify the soft signs of deterioration in residents), Digital Agenda

(compliance with Data Security and Protection Tool), e-RedBag amongst a range of other initiatives to support safe and qualitative services to our vulnerable residents.

All these initiatives build on the existing work streams within the current BCF plan and reflect the shift to 'Place based' arrangements. These work programmes have been featured within partners' COVID-19 pandemic response reports, which were discussed at discussed at Health & Wellbeing Board Business meetings.

4. Governance

The BCF is a jointly developed and agreed approach between the CCG and the Local Authority and the governance for the plan reflects this. Governance for the plan is incorporated within existing joint structures. This allows oversight of delivery and also allows for consideration of the BCF's role in supporting and enabling the broader integration agenda for Wandsworth.

The Wandsworth Health & Care Board is a group of senior leaders across the CCG, NHS Providers, the Local Authority and Voluntary Sector, who set the strategic direction for health and social care integration in Wandsworth, including providing the leadership for the Health and Care Plan.

The Wandsworth and Merton Emergency Care Delivery Board is a forum of health and social care partners across the health and social care system supporting Wandsworth and Merton residents. It undertakes the regular planning of urgent care service delivery, planning for the capacity required to ensure delivery through the year and during surge periods such as winter. The partners use this board to ensure co-ordination and integration of services to support the delivery of effective, efficient, high quality accessible urgent and emergency services to the population. Measuring performance and initiating and completing corrective action as necessary. The board seeks to ensure that responses to demand are by the whole system, underpinned by joint health and social care planning, in Primary and Acute Care, and ensuring that organisations do not work in silo.

5. Overall approach to integration

Brief outline of approach to embedding integrated, person-centred health, social care and housing services, including:

- *Joint priorities for 2021-22.*
- *Approaches to joint/collaborative commissioning*
- *Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.*
- *How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.*

Wandsworth is part of a complex system, with the Local Authority and CCG working across different geographies. Wandsworth Borough Council has been part of a Shared Staffing Arrangement (SSA) with Richmond Council since 2016 and Wandsworth CCG have a shared Local Delivery Unit with Merton CCG. NHS Community Services are largely provided by Central London Community Healthcare, who also provide community services in Merton. Wandsworth has a large Acute Hospital in the borough, St George's University Hospital NHS Trust which accounts for 65% of the borough's acute admissions. The borough has a significant flow of residents into Acute Trusts outside of the borough, including Chelsea and Westminster Hospital (12%), Kingston Hospital (8%), and all other hospitals (15%).

Working across the CCG and Local Authority footprint offers benefits as to how we engage with Acute Trusts in and outside of the borough, for example, working across Wandsworth and Merton on aligned discharge pathways from St George's Hospital, and developing closer relationships and improving pathways from Kingston Hospital. There will be further opportunities through SWL CCG to work and engage at a South-West London level.

The BCF Plan and Health and Care Plan 2019-21 are set in the context of the wider strategic landscape for health and care integration for adults in the borough. This is supported by other joint plans, including:

- Wandsworth Joint Health and Wellbeing Strategy 2015-2021
- SWL Primary Care Strategy for 2019 and beyond
- St George's Hospital Strategy 2019-2024
- Carers and Young Carers Strategy 2017-2020
- Wandsworth Health & Care Plan 2019-2021.

5.1. Wandsworth Discharge Hub

An integrated Discharge to Assess Hub (D2A Hub) was set up in Wandsworth in April 2020 in response to the COVID-19 pandemic. Led jointly by Central London and Community Healthcare Trust (CLCH) and Wandsworth Council, the hub comprises Hospital Social Work teams, Intermediate Care, Facilitated and Supported Discharge, Council Reablement and Care Workers.

The Hub provides a short-term service to support people in their own home following discharge including therapy, equipment, care provision, reablement and voluntary sector support.

More recently, the St George's Community Therapy Services have become part of the D2A Hub; Supporting the intermediate care and reablement teams to provide support to users who are at risk of falling or who have fallen.

Other initiatives to support better outcomes for users and support greater integration between health and social care include:

- Re-commissioning of 6 step down beds by Wandsworth Council to support residents to access clinical therapies post discharge if needed, with an ability to extend stays should users need longer periods in the step-down resource.
- Joint work with Care Home Therapies Team to maximise impact of step-down resource jointly funded by the CCG and the Council.
- Joint working between Community Health Provider and Social Care to ensure correct pathway responses and integrated approaches support those who enter rehabilitation or TADD beds to support people to return to their own home wherever possible, with a focus on Home First Principles and reablement.
- Health funded physio working in social care enablement team to support discharge, ensuring users are able to access therapies in a timely way.

5.2. Carers

Wandsworth Carers Centre (WCC) is commissioned by health and social care through the BCF, to provide support to unpaid adult carers. The core services include:

- Advice, information, and informal advocacy.
- Peer support.
- Respite and unplanned replacement care.
- Back care and therapies.
- Health and social care liaison and training.

WCC is well established across the health and social care system and the wider community. Residents who access the service report high levels of satisfaction and the shared view is that more carers could benefit from accessing the service.

5.3. Prevention

The NHS Long Term Plan set out an ambition to dissolve the historic divide between Primary Care, community, and Social Care Services and has a strong focus on Prevention and improved healthy behaviours. This sits alongside existing requirements in the Care Act 2014, which require Local Authorities to consider people’s own strengths and capabilities and what support might be available from their wider support network or their local community to help meet their needs and improve or maintain their wellbeing.

Taking a strengths-based approach to assessment can support people to understand their own needs and capabilities better to help them make the most of their own resources and support networks. This can enable people to improve their overall wellbeing and stay independent for longer.

Wandsworth Council is committed through its Transforming the Future Programme to further embed the strength-based approach within adult social care and enable people to be as independent as possible. As part of this programme of work, the Council has developed its ‘Front Door Pilot’ project, which aims to develop an effective service at the first point of contact to social care that is based on the principles of early intervention and prevention and strength-based approaches, that will effectively manage demand and meet more people’s needs at the initial point of contact.

Launched in October 2020, the aim of the pilot was to develop and test a Community Hub model at the Front Door that works in an integrated way with the voluntary sector, Social Prescribing Link Workers, and health partners by enabling people to stay independent and connected to their communities. The aim for 2021-22 is to build on the positive learning from the pilot to develop the future model and enable lasting culture change.

5.4. Social Prescribing

Social Prescribing is a means of enabling clinicians to refer people to a range of local, non-clinical services to improve their health and wellbeing. Recognising that people's health is determined by a range of social, economic, and environmental factors, Social Prescribing seeks to address people's needs in a holistic way by facilitating access to the right support, in the right place, at the right time.

During the pandemic, the Social Prescribing Link Workers were re-deployed to work with their Primary Care Network (PCN) to support local systems providing a pandemic response to residents. Calls were made to patients identified as vulnerable by virtual social prescribing services to support the increased number of residents reporting health issues. This integrated service provision was agreed by the Social Prescribing contract leads (GP networks and CCG) and borough wide systems partners.

In addition, Wandsworth's Social Prescribing service was extended to integrate with the Council's Front Door Pilot Team encouraging better and closer working between Adult Social Care, Social Prescribing Team, Public Health and the voluntary and community sector to support the delivery of improved Adult Social Care and Public Health outcomes. The Enhanced Care Navigation service aims to:

- Tackle health inequalities.
- Prevent, reduce, and delay the need for health and social care services.
- Create greater integration between social care and health.
- Build the strengths/ capacity of the voluntary and community sector to meet referral demand that social prescribing generates in a targeted, responsive, and flexible manner.

The Wandsworth Social Prescribing Service has been recognised for its fully integrated social prescribing model nationally and awarded the Social Prescribing Programme of the Year at the National Association of Link Worker Awards in October 2021.

5.5. Care Homes

Wandsworth Council together with health partners, and Care Homes attended a workshop on 13 September 2021to discuss and identify priorities for Care Homes for the year ahead. Key priorities were identified across Wandsworth with a view for more scoping work to take place in order to support the market in the future:

- **Equity of services to care homes across all client groups** – Consistent and tailored support for all care homes (all client groups), parity of access to services for Mental Health and Learning Disability homes.
- **Workforce resilience** - market resilience scoping to understand gaps in workforce followed by targeted recruitment campaigns and tools for care home managers to retain staff. This will be taken forward by the SWL team (Sutton Council is scoping this work).

- **Training** to improve quality of information exchanged with health and social care colleagues should focus on core elements like end of life, dementia, and increasing IT skills. Mental Health and wellbeing support for care home staff.
- **Shared processes and communication** - Single point/interface for communication with care homes is required with access and availability to shared health and care records/care home records scheme. Increase communication with Discharge to Assess Hub about placements into care homes.

Local Authority and SWL CCG are working with system partners to deliver these priorities in order to meet the EHCH framework elements.

6. Supporting Discharge

What is the approach in your area to improving outcomes for people being discharged from hospital? How is BCF funded activity supporting safe, timely and effective discharge?

6.1. Local Approach

Wandsworth borough residents' access multiple local Acute Hospital Trusts. Most people access either St George's (SWL), Chelsea and Westminster (NWL) or Kingston Hospitals (SWL). The community health provider and Social Work teams interface directly with these 3 Hospital Trusts. Discharge plans are agreed with main hospital Trusts for joint working to plan and arrange discharges, across 7 days and with clear escalation contacts and processes in place.

There is an integrated Discharge Hub in Wandsworth that works virtually together as a team and includes hospital Social Workers, Occupational Therapists, Physiotherapists and Care Workers. This provides a single point of contact for Acute Hospitals that reduces duplication and simplifies referral processes and supports joint working.

A nurse-led supported discharge team has been in place for several years working with St George's and Chelsea and Westminster Hospitals. The Community Health Team, Social Care and Hospital Discharge Teams work together to screen patients in hospital in preparation for a fuller assessment in their own home.

6.2. Looking Forward

Wandsworth, as a borough was quick to establish a Discharge Hub to meet Discharge to Assess requirements at the start of the pandemic. The pandemic has placed significant challenges on all system partners. Main areas of challenge has been the capacity within the Care Provider Market and Community Health and Social Care workforce. To mitigate these challenges and build on current arrangements to further implement the Discharge Policy, we have identified the following priorities:

- **Supporting the Home Care market** to ensure stability of the local market, including Infection Prevention Control (IPC) and effective capacity monitoring to support timely discharges.
- **Supporting the Care Homes market** to ensure stability of the local market including raising vaccine awareness, Infection Prevention Control (IPC) and supporting Provider completion of the Capacity Tracker.
- **Strengthening our reablement offer** delivered through the Council's in-house Provider and an external Provider with clear contingency plans in place to ensure sustainability of services during the ongoing pandemic.
- **Formalising arrangements for 7 day working** and extended working hours in health and social care.
- **Streamlining discharge pathways** including improving data collection and introducing smarter use of IT systems.
- **Demand and resource modelling** to ensure sufficient Therapy and Social Care staff are needed to support people in their own home or rehabilitation or Care Home settings.

The demand in pressure upon Acute Hospitals has increased during 2021-22 because of COVID-19 with later presentations of health conditions and increased frailty due to the pandemic restrictions. This, along with staff shortages, has created demand pressures across the system. In response to this pressure several initiatives have been put in place:

- Twice weekly strategic system partners meet to try to address themes for delays.
- Standardised capacity and system resilience reporting framework adopted by all partners to manage demand and flow over winter.
- A transformation programme to improve integration in discharge, formalise D2A and confirm the resources required to sustain 7-day working - joint health and social care task and finish groups that will soon be overseen by the Integrated Care System (ICS).
- Recruitment of additional medical, social care and rehab staff to develop earlier Discharge to Assess processes and a discharge co-ordination role.
- Enhanced Social Care service offer to support patient recovery, safe and timely discharge, and assessment in the right care setting.
- Funding is pooled across community health, social care, and St. George's Hospital across Wandsworth and Merton to improve service delivery.
- Additional funding allocated to support Discharge to Assess including rehab and care beds to support the increase in demand.

The key areas for supporting safe, timely and effective discharges are supporting Discharge Team, more intensive packages of care and greater access to rehabilitation and reablement services. All these initiatives are commissioned to ensure people are discharged from hospital in a timely manner and enabled to be supported safely within their own homes.

During the pandemic, some of these services have been focussed on work within the Discharge Hub to provide additional support for hospital discharges. Going forward it is proposed that this complex care management service will be further developed to create a community virtual ward and enable people to come out of hospital sooner by providing enhanced medical, nursing, and social care support in their own homes.

7. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care, and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Close working continues between Social Services Occupational Therapy, Housing, and the Home Improvement Agency to support timely responses for major adaptations. This is supported further by an Occupational Therapist working for the Housing Department.

There have been additional resources identified to support the provision of equipment during the pandemic and significant improvements have been made on the level of recycling of equipment. An additional £50,000 has been awarded by South-West London Health and Care Partnership "Winter Schemes" to support the increase in demand for Local Authority commissioned equipment.

Under the provisions of the Housing Grants, Construction and Regeneration Act 1996, the Council provides mandatory means tested Disabled Facilities Grants to assist residents with the cost of providing adaptations to dwellings or common parts of buildings containing flats where the adaptation is considered 'necessary and appropriate' and 'reasonable and practical'.

The Regulatory Reform Order 2002 (RRO) provides Local Authorities a broader freedom and opportunity to address living conditions in their area including to provide, directly or indirectly, assistance to adapt or improve living accommodation and repair living accommodation. The RRO (2002) allows local authorities to create assistance schemes using the DFG funding which help people to meet their needs without going through the full DFG process. Additional funding under the BCF has expanded the scope of help available to include discretionary DFG schemes. This widening of funding enables more people to remain independent and prevents the need for care and support for longer.

The BCF has created new opportunities for the Council to develop and fund joint commissioning plans with Clinical Commissioning Groups to meet the needs of residents across care groups. The Discretionary DFG and Housing Assistance Policy supports the development of these plans by providing the policy context for how commissioning partners will use the funding available to develop a range of DFG funded services. The broad priorities of the policy are to improve outcomes for disabled and older people, reduce admissions or re-admissions through prevention, help people remain independent for as long as possible, reduce care costs where possible and help facilitate more efficient discharge from hospital.

More specifically, the funding for discretionary DFGs sits within the BCF and funding for services is prioritised and targeted at initiatives which:

- Reduce or eliminating hospital admissions.
- Allow speedier discharge from hospital.
- Consider the long-term needs of individuals and reductions in associated treatment and social care costs; and
- Provide for works, adaptions or provision of equipment that is not provided by any other service.

Wandsworth Council implemented a Discretionary DFG and Housing Assistance Policy in 2018. The policy sets out how the discretionary funding can be used, and it includes the local agreed approach for funding in the following areas:

- Speeding up the delivery of adaptations: additional staff and/or training.
- Funding adaptations over the maximum mandatory DFG limit.
- Relocation funding.
- Hospital Discharge Grants.
- Fast Track non-means tested assistance.
- Preventative Outreach and independence assistance.
- Telecare and telehealth services.
- Adaptation of temporary accommodation.
- Provision of interim placements (for people awaiting adaptations).

Adaptations provided via Mandatory DFG are managed by the Council's Home Improvement Agency while equipment and services provided via the Discretionary DFG policy are delivered across a wider range of services including Social Services and Hospital Discharge teams.

The outcomes achieved by the Mandatory DFG and the Discretionary DFG initiatives are monitored by the CCG, Social Care and the Housing and Regeneration Department as the Local Housing Authority Spend and activity is reported to the BCF Board. The DFG Lead in the WBC's Housing Department has been involved in BCF Planning and is a core member of the BCF Programme Board.

7.1. BCF Funding for DFGs

The funding for discretionary DFGs sits within the BCF. Wandsworth Council's Discretionary DFG and Housing Assistance Policy sets out how commissioning partners plan to use increased funding to develop a range of DFG funded services with the aim of improving outcomes for disabled and older people.

The table below sets outlines the schemes that have been jointly agreed against the DFG as set out in the Better Care Fund Plan.

Disabled Facilities Grant	Budget 2020-21	Budget 2021-22
Major Adaptations – Housing	£1,051,014	£1,051,014
Adult Social Care – Equipment, Minor Adaptations and OT staff recharges	£613,000	£613,000
Better at Home Service	£90,000	£90,000
Total DFG allocation	**£1,754,014**	**£1,754,014**

The Occupational Therapy Service works in partnership with Home Improvement Agency (HIA) to aid prevention, admission avoidance and to support clients to continue to live as independent as possible. Examples of use of DFG funding are set out below:

- Occupational Therapist identified that a client was at risk of falling while negotiating the stairs which would lead to a possible hospital admission. This resulted in a recommendation for stair lift with a referral to the HIA to provide a stair lift.

- Client identified with difficulties accessing the bath, putting him at risk of injuries resulted in a recommendation for a level access shower to be completed with the adaptation provided by the HIA.
- Wheelchair user was unable to access the community due to step or stairs – recommendation made for the provision of a permanent ramp or a step to be provided by the HIA to enable client to live independently.

The Better at Home service works to support older people to live independently in their home through a number of services including discharge coordination, voluntary sector navigation and handyperson support. DFG funding is used to purchase key safes as well as additional handyperson services focused on preventing falls. Key Safes are crucial to many older people living at home as they are a useful means of providing access to their home for services such as homecare, nurses or paramedics and family members

The total number of home adaptation/ housing assistance policy interventions of all types provided in 2020/21 and paid for out of the DFG allocation was 76. In the first two quarters of 2021/22 there have been 29 minor adaptations and 32 major adaptations.

8. Equality and Health Inequalities

Briefly outline 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. This should include

- *Changes from previous BCF plan.*
- *How these inequalities are being addressed through the BCF plan and services funded through this.*
- *Inequality of outcomes related to the BCF national metrics*

All partners have been ensuring that there is a shared understanding of the population of Wandsworth, and that health inequalities are being addressed. Equality assessments are carried out on programmes within the BCF and are incorporated within each partner organisation's Public Sector Equality Duty.

The COVID-19 pandemic has highlighted areas of health inequality and by taking a population health approach we have a much greater understanding of where we have pockets of inequality and have developed strategies to engage with these communities and understand what is important to them and what the barriers and challenges are to align our commissioned services appropriately. Specific areas of inequality have been highlighted within the vaccination programme rollout, and partners are working together using shared resources and intelligence to target support to where it is most needed in ways that reach the specific groups identified.

An important way of addressing health inequalities is improving access and reach into local communities. This is planned to be achieved through integrating Falls Prevention and voluntary sector services across Wandsworth. This will bring together the specialist services provided by St George's Community Therapy Services and the exercise classes provided by several different voluntary sector groups. The specialist Falls Service will share expertise with the smaller voluntary groups and the groups will increase the scale and reach of the Falls Prevention services.

Health and Social Care partners have been working with St George's Hospital and the voluntary coordination service to deliver this integrated approach by March 2022. This will address inequalities by supporting specifically those services working in geographical areas known for high levels of deprivation and or identified as having a high incidence of falls and hospital admissions as a result of a fall.

Delivering equitable services to clients in mental health and learning disability care homes has been identified as another priority for this year and next, as this was highlighted as a gap during the pandemic. This will be achieved by funding additional therapy and nursing services for these care homes, building on the current service delivery model provided to care homes for older people.