Better Care Fund 2022 - 2023

Narrative Plan

London Borough of Wandsworth

Introduction

Health and Wellbeing Board Chair's Foreword

As chair of the Wandsworth Health and Wellbeing Board I am pleased to confirm that the Board has reviewed and agreed all aspects of the BCF submission and supports officers across the partnership involved in delivering programmes that meet the BCF outcomes. The short timescale for submission has once again created unnecessary pressure for this important multiagency submission to be completed.

Integrated working

Historically, there has been strong collaborative working across health, social care, and the voluntary sector partners. This Better Care Fund (BCF) 2022-23 Plan reflects the ongoing work that has been designed and agreed as a whole system working in partnership.

The borough has established networks and forums that are used to engage and involve all partners. There have been several whole system events during 2022-23 including the work to refresh the Wandsworth Health and Care Plan 2022-24, development of the Anticipatory Care Model of Working, a focus on improving discharge to assess, reviewing and updating the reablement and intermediate care offer. These partnership arrangements have been further strengthened by the transition to the Integrated Care System (ICS) and the Wandsworth Borough committee.

During this time, much of the local engagement work with partners was achieved through virtual mechanisms which has been shown to achieve wider and consistent engagement locally.

Stakeholders involved in producing the BCF Plan include:

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

Sign-off of the 2021-22 BCF plan had been reviewed by the partners above, and regular reporting on the progress of the BCF locally in Wandsworth has been reported through to the Health and Wellbeing Board and the Wandsworth Health and Care committee. When the draft BCF guidance had been released for 2022-23, a review group was convened comprised of Kingston, Richmond and Wandsworth Councils (social care and housing department), NHS South -West London ICB and Kingston Hospital. Specific workstreams for finance, metrics

and demand and capacity were set up, comprised of the members above and including community health providers.

The draft BCF plan for 2022-23 was reviewed by the Wandsworth Health and Care Committee in September 2022, with the committee being appraised of progress before signoff by the Wandsworth Health and Wellbeing Board.

Executive summary

The shared vision is for Wandsworth to be a place where people are supported to live healthy, fulfilling lives in thriving communities. As a system, we work together to make a difference to the people of Wandsworth to ensure everyone has the chance to:

- Have the same life chances, regardless of where they are born or live.
- Live healthy, independent, fulfilling lives.
- Be part of dynamic, thriving, and supportive communities.
- Have equal access to health and social care services.

The Better Care Fund (BCF) programme in 2022-23 will continue to facilitate health and social care integration and address the requirements for integration as set out in the Health and Care Act 2022, the National Operating Plan for the NHS, The Fuller report, the Health and Social Care Integration White Paper and Adult Social Care White Paper. The BCF Plan outlines the joint intentions of Wandsworth Borough Council (WBC) and South West London ICB (Wandsworth) for achieving the long-term aim of health and social care integration and person-centred care. The BCF Plan is a continuation from the 2021-22 Plan.

Joint priorities for the coming year include

- Developing a shared ***frailty pathway*** to support maximising independence and proactive management.
- Implement ***long term conditions*** model encompassing prevention and tackling health inequalities in access and health outcomes
- Implement an ***anticipatory care*** model across Wandsworth including Primary Care Networks, community health, social care and voluntary services to proactively manage people with rising health and social care risk and complexity before exacerbation or emergency hospitalisation.
- Support and manage ***hospital discharge*** to ensure that people only stay in hospital if medically needed.
- Continue to expand and develop the ***Rapid Response*** services and incorporate this into the hospital at home/virtual ward service to maximise opportunities to avoid hospital admissions where medically possible.
- Improve and develop the ***reablement and rehabilitation*** offer to maximise people's independence and well-being and links with the hospital at home, complex care services.
- Continue to improve the ***mental health*** of the population, focussed on a range of prevention and early intervention approaches

- Ensure the needs of **carers** are considered in all service development and delivery specifically where more home based care is being undertaken.
- Continue to support the local home care and care home ***market*** in to improve the quality of care and support for residents.
- Continue to develop the ***enhanced care in care home*** teams across nursing, therapy, and older people's mental health and to develop similar provision in care homes for people with Mental health and learning disabilities.
- Improve mechanisms for **sharing information** across health and social care; hospital, community and care home sectors
- Support the **Social Care Reform** priorities.

Governance

The Wandsworth BCF is a jointly developed and agreed approach between the South West London ICB, the Wandsworth Health and Care Committee and the Wandsworth Council. The governance for the plan reflects this and is incorporated within existing and emerging joint structures to involve all partners in the formation and implementation of the plan in 2022-23 and to monitor progress throughout the year. This allows oversight of delivery and allows for consideration of the BCF's role in supporting and enabling the broader integration agenda for Wandsworth. The Wandsworth Health and Wellbeing Board has ultimate ownership of the BCF and is responsible for scrutinising and signing off the BCF Plan in public.

The Wandsworth Health and Care Committee is a group of senior leaders across the ICB, NHS Providers 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 (ECDB) is where health and social care partners across the health and social care system undertake 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. In addition, a temporary programme structure has been put in place to oversee the hospital and community transformation programme and will include all partners and clinical leaders across Merton and Wandsworth. This board will be accountable to both Wandsworth and Merton committees and report into the Health and Wellbeing Board as appropriate. 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 and measuring performance and initiating and completing corrective action, as necessary. The Board seeks to ensure that responses to demand are whole system ones, underpinned by joint health and social care planning, in primary and acute care, and ensuring that organisations do not work in silos.

Overall BCF plan and approach to integration

All partners across the health and care system are committed to developing an integrated approach across health and social care. This can be demonstrated in several ways at system and place level.

Wandsworth Health and Care Plan 2022-2024

A key development has been the refreshed Health and Care Plan for 2022-2024 which has been developed and consulted on in partnership. The draft plan has been approved by the Wandsworth Health and Wellbeing Board and is a refresh of some of the existing priorities with a new focus on tackling health inequalities across the life course, tackling obesity, improving mental health, and improving the lives of carers. The Health and Care Plan 2022-24 includes a system population health approach working to reduce health inequalities (including for those people with learning disabilities), support to people to stay well, build community resilience and enable people to make informed choices and focus on what matters to them, widening choice available, methodology to identify gaps in commissioned services, and to promote mental wellbeing and support those who experience poor mental health to avoid mental health crisis. The plan will guide and ensure that health inequalities drive the commissioning and improvement developments.

A delivery plan is being developed mapping the actions and will provide a framework to support implementation and evaluation. Many of the actions align to existing programmes of work, such as social prescribing and the borough's dementia strategy, whereas others may require a new programme for work to be established. Delivery will be reported into the Health and Wellbeing Board and the partner organisations. Health and Care Plan system indicators and metrics are reported into the Wandsworth Health and Care Committee, alongside the BCF metrics.

Joint Priorities 2022-23

The joint priorities are all partly funded and supported by the BCF. The delivery is through a range of existing and emerging groups and committees. The agreed priorities and development are outlined below.

1. Support and manage ***hospital discharge*** with a focus supporting demand management within the acute hospital to ensure that people only stay in hospital if medically needed and continue with the commitment to the home first principle.
2. Implement ***long term conditions*** model encompassing prevention and tackling health inequalities in access and health outcomes and to influence their behavioural choices and support identified populations to self-manage.
3. Improve and develop the ***reablement and rehabilitation*** offer with the aim of expanding and integrating the delivery to ensure better outcomes for people. This will link in with the provision of housing adaptations via the Disabilities Facilities Grant, equipment, and technology to support people to remain independent in their own homes for as long as possible.

4. Implement the ***anticipatory care*** model in the 9 Wandsworth Primary Care Networks (PCNs) with community health and care teams, and continue to develop our Social Prescribing and Enhanced Care Navigators
5. Developing a shared ***frailty pathway*** to support maximising independence and proactive management. This includes the enhancement of the falls prevention service and the continued admission avoidance work with London Ambulance and in St Georges Hospital Emergency department.
6. Developing complex care management service building on the pilot that has been in place over the COVID pandemic, of a ***Community Virtual Ward/Hospital at Home*** service.
7. Continue to expand and develop the ***Rapid Response*** service in partnership with London ambulance and acute hospitals, to avoid unnecessary hospital admissions.
8. Improve and develop ***mental health*** support in line with the mental health Transforming Care Programme
9. Continue to support the ***local home care and care home market*** in partnership with ICB in order to improve the quality of care and support in care homes.
10. Improve mechanisms for **sharing information** across health and social care.
11. Support the Adult **Social Care Reform** priorities such as the 'Market Sustainability and Fair Cost of Care' programme and the preparation for the social care charging reform. This work will also include delivering the digital and data ambitions set out in the Adult Social Care Reform and Integration White Papers and developing a joint approach to tackling workforce pressures across Southwest London.

Approaches to joint working and collaboration

The system approaches to collaborative working are supported by the South West London ICB and Wandsworth Health and Care Committee. Partnership work involves a number of joint plans and working groups including the community and hospital transformation programme board and the Intermediate care task and finish group and other groups will be set up as the programme evolves.

By developing our local hospital at home services alongside our pathways for the supporting the frailest in Wandsworth, we hope to:

- Deliver out of hospital care and reduce demand for acute and social care services
- Integrate care that is responsive to help people stay at home for longer
- Increase retention of staff in community health and care settings, develop rotation with acute partners and better career progression processes.
- Strengthen collaborative partnerships for mutual learning
- Reduce health care inequalities for patients in the service
- Provide safe, effective, person centred care
- Use technology where effective
- Continuous evaluation and improvement of the service
- Support the development of workforce through new ways of working

Implementing the BCF Policy Objectives

Developing our discharge planning programme.

We held a local workshop with key strategic partners with the aim of improving proactive discharge planning across Merton and Wandsworth, and pathways with a view to bring together a programme of work that will review existing pathways and look at opportunities to support integration across Partner organisations where appropriate. A number of initiatives have emerged from this work which will be developed throughout 2022/23 which will assist with implementation of the 10 best practice initiatives as detailed in the 100 day challenge. Locally we are benchmarking our system against these initiatives and will work towards implementation by 30 September 2022 in preparation for anticipated Winter Pressures. Improvements have already been made with the Transfer of Care (TOC) team at St Georges Hospital which has seen an improvement in the discharge processes and a reduction to some of the delays in the system. We continue to work with system partners to create more joined up services over the next few months.

Maximising independence

The shared vision is for Wandsworth to be a place where people are supported to live healthy, fulfilling lives in thriving communities. As a system, we work together to make a difference to the people of Wandsworth to ensure everyone has the chance to:

- Have the same life chances, regardless of where they are born or live.
- Live healthy, independent, fulfilling lives.
- Be part of dynamic, thriving, and supportive communities.
- Have equal access to health and social care services.

The Better Care Fund (BCF) programme in 2022-23 will continue to facilitate health and social care integration and address the requirements for integrations as set out in the Health and Care Act 2022, the Health and Social Care Integration White Paper and Adult Social Care White Paper.

Across Wandsworth a system-wide approach to ***Long Term Conditions*** supports the development of behaviours and lifestyles that enables our population to make choices within a healthy community environment facilitated by the wider determinants of health. Alongside the ongoing work undertaken by public health including programmes aimed at obesity management and healthier lifestyles there are a number of BCF programmes aimed at personalised care and support, to maximise the independence and wellbeing of the population. A key aspect of this includes the work undertaken via our Disabilities Facilities Grant programme of work to assist residents with necessary housing adaptations. In addition, we have a jointly funded equipment provision which provides equipment to enable people to remain as independent as possible in their own homes. Demand on for equipment has increased year on year since the start of the COVID-19 Pandemic. This is likely to increase due to the impact of the Discharge to Assess process and increases in activities focused on admission avoidance.

Care technology is offered to residents as a preventative service or as part of an ongoing package of care to allow people to live a full and independent life as possible. Social care staff can purchase a range of technology, including smart watches, tablets, and smart speakers. To reduce digital exclusion, the Council has commissioned a comprehensive voluntary sector offer to provide support to residents around the three core components of digital inclusion: Accessibility, Connectivity and Digital Skills. Digital inclusion services are designed to help older and vulnerable residents access mainstream digital technology to live independently whilst learning lifelong digital skills.

Our ***reablement/rehabilitation offer*** is being reviewed with the aim of expanding the range and access to support available in people's own homes as this delivers better outcomes for people and their carers.) Alongside this provision, a newly enhanced Rapid Response serviced was launched in January 2022 and offers 2 hour response 7 days a week to avoid hospital admission. This is a vital service which is part of our ambition to maximise independence and proactively manage people who are frail with complex health and social care needs. Research has shown that this cohort of the population benefits from proactive support which provides care in their own homes and avoids unnecessary hospital admission. An important part of this programme is the admission avoidance work with London Ambulance where rapid response is considered as an alternative to conveyance to hospital.

Implement the ***Anticipatory Care*** model in all 9 Wandsworth Primary Care Networks (PCN) and community health and social care is planned for the autumn, pilot projects in end of life care were set up during COVID and now awaiting confirmation of national guidance. The model builds on the work of the pilot sites and aims to identify people most at risk of deteriorating health and well-being in order to undertake early intervention and prevention. It ensures that people can be better supported at home, harnessing the strengths within the communities, and proactively managing people with rising health and social care risks and complexity before exacerbation or emergency hospitalisation. The anticipatory care work builds on an existing programme in primary care known as PACT or ECP which has been in place for over 5 years. This involves regular multidisciplinary team meetings to plan and review care for people and will promote closer working and joint case management across community, primary care, and social care. We will continue to develop our Social Prescribing to address people's needs in a holistic way by facilitating access to the right support, in the right place, at the right time. The current service which enables clinicians to refer people to a range of local, non-clinical services to improve their health and wellbeing via link workers within each Primary Care Network. This works closely with our Enhanced Care Navigators who support people to access the right care in the right place to reduce health inequities and promote independence and well-being.

Many people with ***mental health disorders*** have experienced a further deterioration in their mental health and well-being as a result of the pandemic. Treatment and support services are reporting unprecedented levels of demand, as well as increased complexity and lengthening waiting times. The focus of the BCF plan is on improving range of prevention and early intervention approaches, including programmes aimed at building emotional resilience of young people through training teachers as mental health first aiders, improving access for Black, Asian, and Minority Ethnic young people to mental health services. Talk Wandsworth, the Improving Access to Psychological Therapies (IAPT) services provide psychological therapies to people with anxiety disorders and depression. The service will continue to strengthen its links with community organisations, through dedicated wellbeing workers,

improving recovery rates. The development of a multi-agency mental health strategy will help to provide a co-ordinated approach to reduce the burden of mental ill health in Wandsworth.

To deliver more personalised care and to ensure that people are kept at the heart of delivery of health and care services, the partnership is committed to improve mechanisms for ***sharing information*** across health and social care. The Urgent Care Plan (UCP) for London will support people to live at home for longer, taking account of their wishes. The UCP has gone live on the 27 July 2022, and is accessible to NHS 111, the London Ambulance Service, acute hospital emergency departments, social workers, community services and GP Practices. Care Homes who had access to Coordinate my Care have access, and there is a workplan to onboard those care homes who comply with the Data Security and Protection standards and to support care homes who are not at these standards so that these can be met .Work is also underway to pilot access for Care Homes to Connecting my Care (the Shared Care Record in South West London, which will eventually share across the whole of London). Projects to enhance the Shared Care Record are being led by the NHS and are at early stages. The initial focus is on sharing with Social Care providers to prevent hospital admissions and to support more effective hospital discharge services.

Sharing information and data safely and effectively is a key enabler to support truly personalised care. We are working on developing a set of population level data to support work locally which is led by NHSE.

The ambition is to develop ***neighbourhoods*** (as set out in the Fuller report), across Wandsworth which brings together partners from across health, social care, community and voluntary sector and within the local population to create a new way of working. The neighbourhood model signifies a fundamental shift in focus from the treatment of individuals to improving wellbeing of the whole population and rebalancing and realigning the system to ensure the right activity takes place in the right place.

A key priority for social care is to support the Adult **Social Care Reform** priorities, such as the 'Market Sustainability and Fair Cost of Care' programme and the preparation for the social care charging reform. The intention is for all parties to "arrive at a shared understanding of what it costs to run quality and sustainable care provision in the local area that is reflective of local circumstances" for residential and nursing care for older people age 65+, and domiciliary care age 18+. This work includes developing a joint approach to tackling workforce pressures across South West London and the development of a ***Workforce Strategy*** for SWL working with the South London Partnership. To ensure we deliver the ambitions for digital and data set out in the Adult Social Care Reform and Integration White Papers, we are working in partnership across SWL ICS to enable a step change in how digital services support the delivery of integrated care, promoting the health and wellbeing of our SWL population and ensuring they are able to remain living independently at home, for as long as possible. An Integrating Care Digital Delivery Group (ICDDG) has been set up to provide strategic direction, alignment, and oversight of the delivery of digital transformation priorities and programmes within the SWL Integrating Care Programme including Care Homes and Virtual Wards, Discharge to Assess, Telemedicine/Telecare/Assisted Technology, Person self-management & self-monitoring and Digital Care Planning. The group includes local authorities across SWL to support a co-ordinated digital vision and delivery.

Improving Hospital discharge

Wandsworth borough residents access multiple local acute hospital Trusts. Most people access either St George's hospital (SWL), Chelsea and Westminster (NWL) or Kingston Hospitals (SWL). The community health provider and local authority staff interface directly with these three hospital trusts. There is an integrated transfer of care hub in St Georges hospital which includes hospital Social Workers, Occupational Therapists, Physiotherapists and nurses working as case managers to improve the quality and flow to reduce duplication, streamline referral processes and support joint working.

Ensuring there is sufficient capacity in the homecare market to support 'home first' principles is vital in our hospital discharge work. The local authority has undertaken several initiatives in partnership with health to ensure sustainability of these services and to support demand management.

In addition, a nursing supported discharge team has been in place for several years working with St George's and Chelsea and Westminster hospitals. In future the nursing discharge team, social workers and the hospital discharge team are planning to work more closely together to better support the screening of patients in hospital in preparation for a fuller assessment in their own home.

During 2021-22 system pressure has been fuelled by the increased frailty of people seeking care and support. This, along with staff shortages, has created pressures across the system and several initiatives have been put in place:

- Striving to provide 7 day discharges across the health and social care system ..
- Weekly strategic system partners meetings to understand and address discharge delay themes
- Continuing to deliver standardised capacity and system resilience reporting shared with all partners to better understand capacity against demand to improve management of flow.
- The ICS transformation programme aims to improve hospital and community processes and identifies improvements in integrating systems and resources to meet the new levels of demand in the system.
- Close working with providers to ensure responsive delivery of health and home care to support hospital discharges and avoidable hospital admissions.
- Additional rehabilitation support by repurposing current bedded rehab capacity into more home based services

The existing complex care management service will be further developed building on the pilot that has been in place over the COVID pandemic, of a ***Community Virtual Ward/Hospital at Home*** service. This will enable people to have hospital care provided in their own home so that they either can come out of hospital sooner or avoid a hospital admission. Enhanced medical, nursing, and social care support is provided to people in their own homes, and with access to telehealth where appropriate. Early indications from the pilot show a reduction in length of stay in comparison to the acute setting, supports admission avoidance and has evidenced a number of bed days saved for the system. As such, we view the hospital at home and virtual ward programme as a key strategic initiative which will underpin our wider community services transformation programme. Therefore, in line with

local and National direction we plan to expand on the success of the pilot programme increasing service to take up to 80 beds by 2023.

Delivery against the High Impact change model

Changes to the Transfer of Care hub at St Georges has enabled earlier discharge planning through

- Case management releasing time for discharge case coordinators to focus on patients discharge earlier in their journey
- Early notification process being implemented (Social Work allocation, Key safes, amenities)
- Daily meetings with system partners moved to the afternoon for patients on pathway 1 to prepare for next day discharge. Previously this was a meeting for same day discharge
- A discharge task and finish group is to be set up as part of the bigger transformation programme in hospital and community services in Merton and Wandsworth, this is to meet the 100 day challenge and to further deliver the High Impact Change Model.

Demand and capacity monitoring is now shared across system partners using a modified RAG system to better understand system pressures and respond quickly through mutual aid with system partners. Home first and MDT working is in process with the repurposing of 16 bedded rehab beds to a more home-based approach to care delivery. This will be piloted from Oct to Jan with an intention to go with a new integrated service model to implemented by March 2023 if not sooner.

Flexible working remains a priority for the system and the number of weekend discharges is improving but remains gaps in implementation across system partners. Trusted assessment processes to be revisited as part of the discharge task and finish group work with frontline staff across the system. As part of this group, housing partners will consider how to improve their links with discharge processes earlier in the process

Engagement and choice will also be a key area for development and primarily through earlier discharge planning with patients and their family about their possible discharge choices and for this to commence earlier in the hospital stay. In terms of engagement, this will be undertaken through the community and hospital transformation programme where a public and patient engagement process is already in place to support the programme.

Improving discharges back to care homes is in process through the full implementation of Enhanced health in care home initiatives including:

- improved use of Red bag and e Red bag,
- use of NHS mail, a GP lead per care home,
- in reach teams across pharmacy nursing, therapy, dietetics and older people MH services
- Rolling out remote monitoring in care homes supported by training and set up delivered in each home

Supporting unpaid carers.

The Wandsworth support for Carers is funded through the BCF and delivers support services to anyone providing unpaid care within Wandsworth Borough or registered with a Wandsworth GP. It is jointly commissioned by the local authority and the ICB. It is estimated that over 19,000 adult Wandsworth residents are informal carers. Almost 25% of these residents are registered with the Wandsworth Carers' Centre (WCC). The main aim of these services is to support carers to deliver quality care for their loved ones whilst maintaining their own health and well-being. Unpaid carers deliver services that are worth six times the budget for social care, supporting their capacity to keep on caring is fundamental to reducing the demand on the health and care system.

The service consists of a lead service provider (WCC) who delivers the following services for carers:

- Information and advice for those seeking help in their caring role.
- One-to-one and group emotional support for carers and former carers including specialist support for carers outlined above and young carers
- Training for carers.
- Carer awareness training for professionals.
- Respite through caring cafes for carers of people living with dementia
- Complementary therapies including massage and reflexology
- Back care treatment for carers
- A choice of additional respite care in addition to the statutory respite provision. The lead provider sub-contracts with a private supplier to provide 5,000 hours of respite care to carers.
- Better links with other services including the Alzheimer's Disease society and Social prescribing to provide support indirectly as well as directly.

Wandsworth is involved with London School of Economics research on digital needs for unpaid carers caring for people with dementia and is working to increase the number of carers receiving statutory carer's assessments, as well as improving recognition of unpaid carers in GP settings. Work is continuing through the South West London ICB to support carers who are caring for people at the end of their life, including how the Urgent Care Plan for London can support carers.

The Carers' Strategy is being updated to take account of the challenges that emerged under Covid-19 and to embed the ambitions to enhance the offer to carers. Following consultation, the new strategy will be published by March 2023.

Disabled Facilities Grant (DFG) and wider services

Under the provisions of the Housing Grants, Construction and Regeneration Act 1996, the Council provides mandatory means tested Disabled Facilities Grants (DFG) 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 additional BCF funding enables more people to remain independent in their own homes for longer.

The use of the Discretionary DFG funds include funding of major and minor adaptations and the provision of a handyperson scheme to support people's independence and to facilitate discharge from hospital to their own homes. During the current year, 101 requests were received by the Home improvement agency. The most frequently requested adaptations are level access showers and stair lifts with an average DFG cost of £8,700 each. A total of 45 adaptations did not proceed following a referral into the home improvement agency mainly because the people were unwilling to engage with the means testing financial assessment or are unwilling to pay the client contribution to the adaptation costs. Some of the funds associated with the BCF are used to waiver contributions clients where people do not have family or an advocate or are struggling to provide information requested. The decision making on discretionary DFG's is shared between housing and social services with a focus on maintaining independence and supporting safe hospital discharge. The Housing Improvement agency perform well on undertaking adaptations. They have recently appointed a specialist Housing Occupational Therapist into the team. The OT agrees changes and amendments to adaptations thus speeding up the process and reducing delays in the completion of the work. There are plans to introduce a new grant for dementia clients when they are first diagnosed, which will allow them to purchase basic equipment such as white boards and telephones which will improve the quality of their lives. The planning for this has been collaborative across a wide range of stakeholders and the aspiration if for this to be completed by the December 2023.

Assistive technology, including telecare and telehealth is used both to support people in communities and as part of the effective hospital discharge. In addition to telecare options which are offered to people to support their independent and reduce reliance on services, the Council have commissioned Alcove and Rethink Partners to deliver a Digital Care Demonstrator. The Digital Care Demonstrator expands the product range to over 50 devices including sensors, falls wearables and smart devices. Alcove (our Technology partner) provide an end-to-end service, including referral, installation and follow up on the digital products, The care technology packages can be customised to people's needs and thus promote independence. The work is supported by change consultants, Rethink Partners, who will be shaping and organising support and training for social care practitioners and providers to help achieve the culture change needed to accelerate use of technology.

Wandsworth Joint equipment provision is a jointly commissioned service across 21 boroughs. Wandsworth is part of the London Community Equipment Consortium Framework led by the 'Bi-borough' (Royal Borough of Kensington and Chelsea and Westminster City Council). Both health and social care practitioners make use of this service which delivers minor equipment, supports minor adaptations in people homes as well as some specialist equipment. This provision supports people at the point of discharge from hospital, community health provision and adult social care.

The Wandsworth Joint Community Equipment Contract has piloted the 'Next day as standard speed' for delivery, collection, and repairs since 1st November 2021. This replaced the former 5 days as standard speed and the aim was to provide a better service to the service users through them receiving items that support their needs swiftly and efficiently the next day. It is a cost neutral project where costs of speeds that were being spent previously have not increased but a quicker service is being provided to service users the next day.

The contract is monitored through quarterly monitoring meetings with the provider and the prescribers, depot meetings, analysis of the invoices and activity, complaints, and queries, and through the WICES board.

Equality and health inequalities

Promoting equality for all residents in Wandsworth is at the heart of all our plans. Equality assessments are carried out on programmes within the BCF and are incorporated within each partner organisation's Public Sector Equality Duty, which are being brought together through the Health and Care Plan to ensure that any gaps can be addressed by the Place Based Partnership Committee. A notable example of this is the equality impact and needs analysis of the Wandsworth carers hub, which has reported extensive findings and improved outcomes for protected groups within Wandsworth.

Through the development of PCNs we are adopting a population health approach to understanding at a local level where our inequalities lie and tailoring our services to address these inequalities. This has meant that there is a commonly held view of the population, and that health inequalities are identified, and addressed by the system. The Anticipatory Care model will be implemented in all local PCNs to support people with emerging risks.

The system is utilising population health management to identify underserved groups such as those identified through the Core 20 plus 5 work throughout South West London and through the Wandsworth Health and Care Committee. It is expected that one outcome of anticipatory care within Wandsworth is to increase the number of patients within the anticipatory care cohort from most deprived areas (identified by the Index of Multiple Deprivation), and to reduce the variation of emergency admissions for ambulatory care sensitive conditions between the least and the most deprived areas.

The population health workstream has enabled the health and care system across Wandsworth to identify and support different local areas though several workstreams promoting Long-Term Condition management (including obesity) involving specific PCNs and local community groups, with a focus on addressing health inequalities. A task and finish group on working to improve outcomes for people living in mental health and learning disability homes is also underway. This will help inform how the care home support teams can improve their service offer to these homes.

During the COVID-19 pandemic, the need to share management and population data was identified and is being addressed by ensuring that all system partners have the same view of ICB-held information to plan and support the population of Wandsworth. This work identified areas of variability for COVID vaccine penetration linked to deprivation, where council and ICB

staff members joined with community groups to undertake health fairs and other forms of outreach. Work is continuing using the South-West London ICB Health Insights team to identify linked areas with worse health outcomes within the borough and carry out pieces of joint work between NHS and the Council to understand and to work together to reduce inequalities in these areas, linked to NHS annual health checks and other interventions.

Public Health Wandsworth is leading on a number of strategic priorities to support the health inequalities work in the borough and continues to publish local programmes and has a role to influence and support health inequalities through the social determinants of health across the council in housing, education, social support and access to services. The Public Health team has recently published a mental health strategy, incorporating a population wide mental health needs assessment to support future service transformation and commissioning intentions. The BCF scheme to improve mental health support in the community is focused on prevent escalating need. There is an enhanced offer for unpaid carers to ensure we provide equity of support for this group of people.