Appendix 1

Better Care Fund 2025 - 2026

Narrative Plan

London Borough of Wandsworth

March 2025
FINAL VERSION

Appendix 1

Section 1: Overview of BCF Plan

The overarching ambition within the BCF is that of embedding an integrated approach to health and care. The system is committed to collaborating with all partners across health, adult social care, public health, the voluntary sector, and the wider population along with their families and carers to understand what is important to them and work collectively to best deliver outcomes across the population. The commitment of partners across the health and care system to developing an integrated approach across health and social care can be demonstrated through jointly agreed plans and delivery systems such as the Joint Local Health and Wellbeing Strategy [Joint Local Health and Wellbeing Strategy - 19 Steps to Health and Wellbeing] which is monitored though the Wandsworth Health and Care Committee and the Wandsworth Health and Wellbeing Board.

The plan will guide and ensure that health inequalities drive the commissioning and improvement developments. Many of the actions build on 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. The plan for 2025-26 builds on previous BCF plans and the services which are delivered through the Better Care Fund programme.

Priorities for 2025-26

All partners across the health and care system are committed to developing an integrated approach across health and social care.

Support the shift from sickness to prevention

- Reduce emergency hospital admissions through greater utilisation of **Urgent Community Response services** and ensuring its functions are more integrated within existing hospital and primary care pathways to maximise opportunities to avoid hospital admissions where clinically possible. Ensure greater use of alternatives to admission such as Same Day Emergency Care (SDEC) and wider urgent treatment provision.
- Develop and improved shared frailty pathway through the **South West London model of frailty** to deliver interventions which support people to live fulfilling lives. This includes a proactive approach to falls prevention and promoting healthy aging.
- Providing a range of **prevention and early intervention** approaches to support people with Mental Health issues, dementia and Learning disabilities as well as address the needs of segments of the population underserved by current services, such as the work on immunisations and screening through the Joint Local Health and Wellbeing Strategy.
- Build on **long-term conditions** management in the borough encompassing prevention and tackling risk factors through to managing advanced disease, identifying and addressing inequalities in access and health outcomes.

- Ensure the **needs of carers are always considered** in service development and delivery. This includes supporting carers through support, information and advice and access to assessment and respite services.
- Transform existing proactive care services into **neighbourhood health and care services**, involving and engaging with Primary Care Networks, community health, social care and voluntary services to deliver early interventions which will prevent emergency hospitalisation.

Support people to live independently and the shift from hospital to home

- Continue building capacity and capability in **Community Virtual Ward and Hospital at Home services** to maintain people within their own homes or to be able to care for people in their own homes with enhanced support and monitoring.
- Improve and **integrate the reablement and rehabilitation offer** to maximise people's independence and wellbeing and links with the hospital at home, complex care services.
- Improve mechanisms for **sharing information across health and social care**; hospital, community and care home sectors and by doing so improve our understanding of population health and care needs, better support to underserved communities and identifying those most at risk of inequalities and worse health and care outcomes. Embed use of digital records and population health and care management to support new ways of working to increase discharge responsiveness.
- Ensure **greater availability of community equipment** and adaptations through use of occupational therapy and disabled facilities grants.
- Support and **improve system management of hospital discharge** based on the review of the St George's Hospital Transfer of Care Hub to streamline communication and improve interfaces across the hospital, community and social care services so that more people can safely go home with the appropriate support.
- Continue the work to **support mental health discharge and independence** through the mental health discharge and reablement team and South West London mental health step down and crisis beds.

Key changes since previous plan

Since the 2023-25 Better Care fund plan was written and the discharge fund elements were incorporated into the Better Care Fund, there has been a move locally to align workstreams, impacts and outcomes of the BCF to the work of the urgent and emergency care board, making best use of the available resources to manage additional demand across the BCF and other funding streams such as the South West London ICB UEC funding to support winter. This has enabled a greater understanding of discharge response times locally, compared to other metrics such as the proportion of people who do not meet the criteria to reside.

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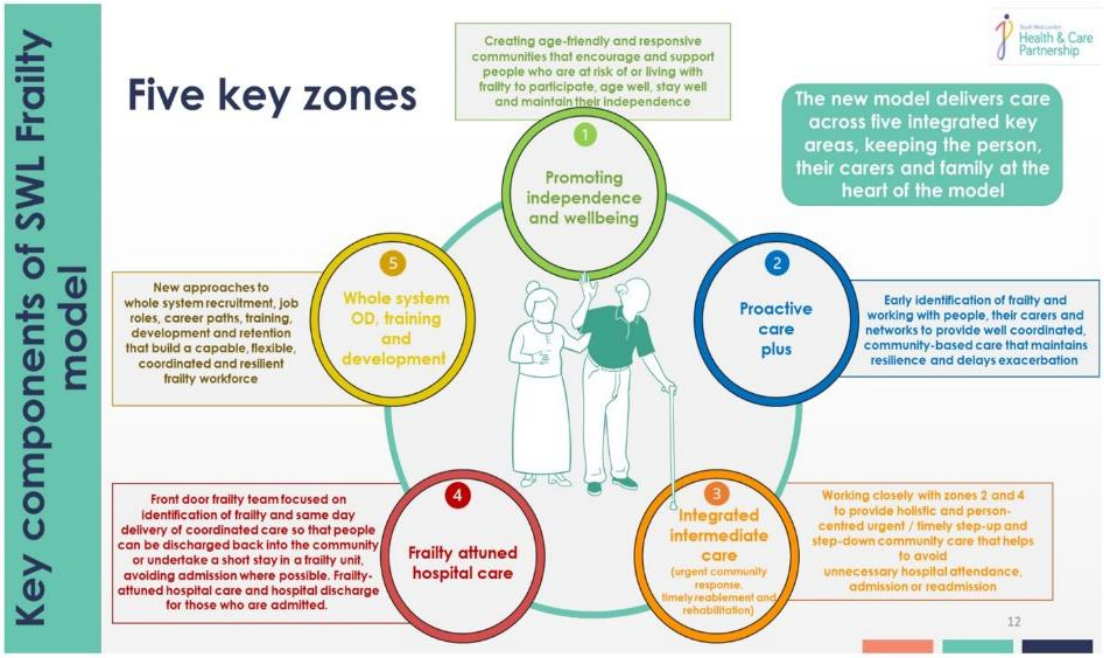
A South West London review of the BCF was carried out to ensure that the funding was aligned with areas that would have the greatest impact on urgent and emergency care. The capacity and demand work for intermediate care has also enabled much greater planning across services and has supported system wide conversations to highlight delays and constraints.

1. **Supporting Discharge**

   In autumn 2024 a review into the ways of working within organisations within the transfer of care hub at St George's Hospital was funded by the discharge fund portion of the BCF. This set out a series of opportunities and recommendations for all partners and areas within St George's to work together as a single functional team, to improve communications and to smooth the flow of discharges. These recommendations are summarised below, and work in continuing to implement them:
   - D2A guidance to improve the information shared with partners.
   - Clearer roles and responsibilities within the transfer of care hub
   - Better understanding of the availability of services in the community

2. **South West London Model of Frailty**

   The South West London model of frailty is an agreed priority for the borough, developed through work across stakeholders in 2023-25 and is detailed above, with local actions to ensure that people are supported across the five frailty zones, delaying progression into moderate or severe frailty across the five key zones, below:.



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3. Local Joint Health and Wellbeing Strategy

The Local Joint Local Health and Wellbeing Strategy - '19 Steps to Health and Wellbeing' – is the Health and Wellbeing Board's five-year plan setting out how partners across the borough including the voluntary and community sector will work together jointly to meet the health and wellbeing needs of Wandsworth residents. This plan addresses the health and wellbeing needs of residents identified in the refreshed Joint Strategic Needs Assessment for Wandsworth (JSNA), published in 2022. The priorities identified were agreed by the Health and Wellbeing Board, and the strategy follows the following principles.

- Tackling inequality
- Focus on prevention
- Empowering communities
- Holistic approach to individuals and families
- Place integration

4. Wandsworth Provider Alliance

From October to December 2024 providers in Wandsworth worked together to explore the purpose, scope and governance for a Wandsworth Provider Alliance. This was in response to national and local requests for all systems to: Develop a plan for how its Primary Care and Community Care organisations, Provider Collaboratives, and Place arrangements will develop, and how they will be commissioned and resourced to work to shape integrated care. Providers have worked together through a series of workshops to define the purpose of the Alliance so that it would serve a unique role within South West London. It is likely that Wandsworth Provider Alliance will provide an essential forum through which the delivery of work programmes expected to be contained within the upcoming 10-year plan can be organised, overseen, and delivered.

5. Neighbourhood Health and Care Services

There has been a great deal of work to develop integrated neighbourhoods and to develop a jointly held system wide view of available services to support residents. Partners across the borough are working to transform proactive care services and supporting case management activities across the borough into a foundational neighbourhood health model, comprising and best utilising a consistent system wide population health model as above to design and deliver the most appropriate care for residents locally. The Wandsworth integrated care steering group is taking this work forward locally.

Population health and care management has developed due to the Client Level Data returns from Adult Social Care being incorporated into the South West London ICB Health Insights team, and work is continuing to develop system wide understanding of need through a health and social care data group. This will enable better support and management to individuals who need proactive management of their care and would therefore be highlighted as needing to be supported by into proactive care service MDTs, whether for frailty, long term condition management, mental health crisis or social isolation.

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Approach to joint planning and governance

The Better Care Fund plan for Wandsworth has been jointly developed and agreed between NHS South West London ICB and Wandsworth Council using existing governance structures within Wandsworth Place to involve all partners in the formation and implementation of the plan and to report on progress throughout the year.

The governance for the plan is incorporated within existing joint structures including the Merton and Wandsworth Urgent and Emergency Care (UEC) Delivery Board, the Wandsworth Health and Care Committee, the Oversight and Delivery Group and the Wandsworth Health and Wellbeing Board, which enables the system to have ongoing oversight of delivery of the BCF plan throughout the year. This also allows the consideration of the BCF's role in supporting and enabling the broader integration agenda for the borough. The Wandsworth Health and Wellbeing Board has ultimate ownership of the BCF and is responsible for scrutinising and the signing off the BCF Plan in public.

The BCF oversight and delivery group has been established to manage the BCF planning and reporting process, and key partners across the system contribute to planning, reporting and oversight of corrective actions relating to the BCF metrics. System partners have been involved in the BCF end of year submission for 2023-24 and the planning for 2025-26, including the intermediate care demand and capacity plan.

The Wandsworth Health and Care Committee is a group of senior leaders across the local health and care system responsible for setting the strategic direction for health and social care integration in the borough, including providing leadership and oversight for planning locally, including the Health and Care Plan refresh. Prior to formal sign off by the Wandsworth Health and Wellbeing Board, the 2025-26 BCF template and narrative will have been reviewed and discussed by the Wandsworth Health and Care Committee to ensure that the agreed BCF aligns with the priorities that have been agreed by this committee.

The Local Merton and Wandsworth UEC Delivery Board includes executive partners across the Merton and Wandsworth health and care systems. The Board undertakes planning and oversight of urgent care service delivery, which includes UEC metrics and assurance that the outcomes within the BCF support the UEC ambitions for 2025-26. The deliverables of the UEC Delivery Board include oversight of the 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 chart below describes the governance of the BCF alongside summarised responsibilities:

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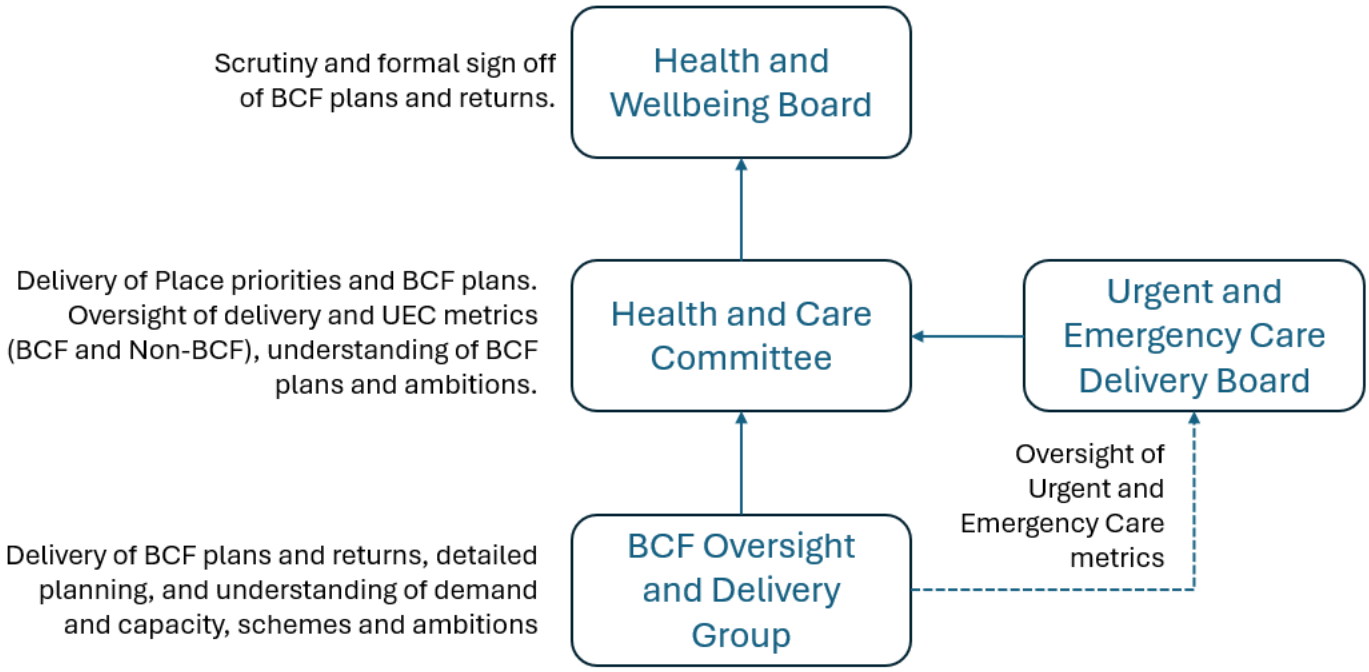

Alignment with improvement of urgent and emergency flow

Planning within the Better Care Fund aligns with the ambitions for urgent and emergency care across the borough, taking learning from the UEC programme in 2024-25 and from the BCF across 2023-25. The ambitions for the discharge ready date and emergency admission reduction metrics have been reviewed in line with the Merton and Wandsworth UEC Delivery Board expectations for Same Day Emergency Care, admission avoidance and improving discharge pathways.

In addition, the average time in days between referral and service start (within the BCF intermediate care demand and capacity template) has been reported to the UEC DB regularly as this average has reduced compared to the demand and capacity planning baseline and so also this demonstrates the impact of the BCF schemes supporting discharge from acute hospitals. Wandsworth urgent community response services have seen a 22% increase in demand, which has enabled a further 340 people to be supported at home rather than needed to be managed through urgent and emergency care services.

The mental health step down beds funded by the BCF across Kingston, Richmond, Merton, Sutton and Wandsworth have enabled people to be discharged safely from secondary mental health beds and have avoided admissions for a mental health crisis. The BCF funded mental health discharge team has enabled a reduction in the time between referral to discharge in South West London and St George's mental health beds which is comparable to the reduction in the same metric in acute hospitals working closely with the Trust interface team.

There are four local priority areas for urgent and emergency care for 2025-26. These are:

1. **Emergency Department and flow**
   - Accelerating the use of Same Day Emergency Care, and rapid treatment at ED

- Reviewing, relaunch and embedding of interpersonal standards and the review of majors
- Implementing learnings from strike actions

2. **Length of Stay and Community response**
   - Review and improve repatriations to other acute hospitals.
   - Optimisation of equipment provision and increase availability of QuickStart.
   - Standardisation to reduce length of stay, including at the Queen Mary's site.
3. **Effective Discharge**
   - Improved use of care technology and early notification of discharge
   - Criteria led discharge.
   - Maximising use of Virtual wards
   - Develop and optimise Transfer of Care Hub
4. **Frailty**
   - Increasing the use and developing joint model for Virtual wards
   - Rapid access frailty clinic and same day emergency care
   - Co-ordinated in-reach to ED to ensure increase same day discharge.

These priority areas are supported via existing BCF schemes or funding into community and other services where appropriate. The quantifiable impacts of these priority areas have been reflected in the BCF metrics for the borough in 2025-26, either through a reduction of emergency activity or via improvements in the response time to discharge. The impacts will be reported via the Merton and Wandsworth UEC DB and the BCF oversight and delivery group.

Priorities for intermediate care

At present, the borough continues to meet demand for intermediate care and supports around 12,500 people each year through step up (hospital discharge) or step down (community services), provided by NHS community providers, Mary Seacole bedded rehabilitation at St George's Hospital, the Council or voluntary sector provision. The BCF intermediate care demand and capacity planning demonstrates that while the numbers of people being supported into intermediate care are as expected, there has been an increase in people being supported through wider social support or through the Urgent Community response services in the borough.

While health and care services in the borough are not as joined up or effective as they could be, there is a commitment of partners to working collaboratively to simplify, streamline and maximise resources across providers to deliver the best outcomes for residents and to reduce inequality of access.

The newly convened Wandsworth provider alliance has been formed to increase collaboration and to collaboratively improve services by overcoming strategic and operational barriers while making the best use of collective resources and by developing local pathways that support older people and adults in Wandsworth:

- Deliver out of hospital care that reduces demand for acute and social care services, developing proactive care services into neighbourhood health and care services.
- Integrate care that is responsive to help people stay at home for longer, such as the reablement and rehabilitation offer delivered through CLCH (QuickStart and Maximising Independence) and the Council.

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- Increase retention and improved career progression processes and embedding new ways of working.
- Strengthen collaborative partnerships for mutual learning, and service improvement.
- Reduce health care inequalities for people within the service, as demonstrated through the JSNA and the Local Health and Wellbeing Strategy.
- Provide safe, effective, person-centred care.
- Use technology where appropriate and effective.

The Wandsworth equipment service is provided through NRS and has delivered equipment to be able to support around 5,500 people to remain at home as independently as possible. Occupational therapy teams work closely with housing teams to deliver major and minor adaptations through the Disabled Facilities Grant (DFG). The Disabled Facilities Grant is utilised in the borough to support people to remain independent in their own homes for as long as possible, working with therapy and hospital discharge teams to assist residents wherever possible 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’.

Care technology and equipment is currently being provided by the Council and is utilised to support people’s independence within the borough. The Council intends to deliver a single care technology offer, working in partnership across the borough which supports more people to live independently as possible in their communities, and reduce the need for long term care such as residential care.

Engagement exercises have been conducted with internal and external stakeholders such as the voluntary sector, digital champions, people with lived experience and with system partners to work jointly on care technology initiatives. An operational plan is being developed to increase the proportion of people benefitting from this offer, and to ensure that this offer is embedded.

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Section 2: National Condition 2 – Implementing BCF Objectives

Sickness to prevention

Almost half of the Better Care Fund is being spent on Priority 1: Proactive Care to those with complex needs, demonstrating a strong focus on prevention in the borough.

The existing Enhanced Care Pathway (ECP) and Planning All Care Together (PACT) MDTs supporting people with increased needs and long-term conditions are being reviewed to ensure that they meet the needs of neighbourhood health and care services and Primary Care Networks, community health, social care and voluntary services are all engaged to deliver early interventions which will prevent emergency hospitalisation. Social prescribing services are active in the borough offering enhanced care navigation, enabling health and adult social care professionals to refer people to a range of local, non-clinical and non-statutory services to improve health and wellbeing.

The Joint Local Health and Wellbeing Strategy (JLHWS) is targeting a range of interventions to increase prevention activities in the borough. These include areas such as screening, adult immunisations (covid and flu) long term condition management, physical activity, smoking and alcohol, and mental health/ suicide prevention. The Joint Local Health and Wellbeing Strategy is owned by the Health and Wellbeing Board, and progress is reported to the board regularly.

All system partners contribute to the JLHWS, and work has been continuing to deliver outreach and community engagement activities were delivered to improve uptake of vaccinations in areas and groups with lower coverage as an example of a prevention activity which promotes equality and is working to reduce inequality.

The final version of the South West London Mental Health Strategy was published in July 2023 and 2024-25 is the second implementation year. This strategy acts as a focus for the system to identify priorities, respond to challenges, drive forward transformation and address population health needs in collaboration with service users, stakeholders and partners. There has been significant work carried out across the system, and this has delivered the following for people with serious mental illness in the borough:

- Embedding of peer support and welfare advice services within community services in partnership with wider voluntary and community provision.
- Launch of Enhanced Response Practitioners (ERP) service to support reduction in crisis presentations.
- Proactive system-wide work around discharge and flow.
- Launch and embedding of the NHS 111 ‘press 2 for mental health’ pathway.

In addition, From Brazil to Battersea is an innovative scheme brings community health and wellbeing workers right to the heart of those neighbourhoods where health inequalities lead to lower life expectancy, compared to more affluent areas locally. It is a partnership project, which brings

together the Battersea Primary Care Network, South West London ICB, Wandsworth Council, Wandsworth Community Empowerment Network, and other community organisations. Community health and wellbeing workers visit people in their homes to provide advice and connect them to NHS, council, and voluntary sector support. The workers focus on every aspect of life that can influence health, including housing, employment, social isolation, and financial pressures, linking people with the help they need.

Hospital to home

Proactive care services are in place across the borough, delivering integrated care to people with long term conditions and for those in care homes. Integrated care pathways are being developed and working relationships are being improved between organisations, collaborating at neighbourhood and place level to deliver care that is more person centred, deliver better outcomes, and provide better experience for staff and residents. The move to neighbourhood health and care services will increase the numbers to people supported, as well as reducing variation of delivery, enabling more people to be cared for at home, as well as enhancing care management.

This work is supported by an expanded and joined up care technology offer (Section 1: Priorities for Intermediate Care) and home adaptions provided by disabled facilities grants and the provision of community equipment.

The successful mental health discharge pilot funded in 2024-25 will offer mental health reablement services to maintain people in their own homes, as well as expanding the mental health step down bed offer to support people in crisis and avoiding admission to secondary mental health beds.

The virtual ward (step down) / hospital at home (step up) service provided by CLCH will be maximised to support transfers home or to support more admission avoidance in conjunction with the Wandsworth urgent community response services currently available across the borough, building on the increased numbers of UCR contacts by those services seen in 2024-25.

Support for carers is a key area to manage hospital to home and the carers offer is funded through the BCF. The service delivers support services to anyone providing unpaid care within Wandsworth Borough or registered with a Wandsworth GP. It is jointly commissioned by the Council and the ICB.

The Wandsworth Carers Centre provides 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.
- Better links with other services including the Alzheimer’s Disease society and social prescribing to provide support indirectly as well as directly.

In addition, the social care accelerating reform fund has awarded grant funding for two projects; an online carers support platform and a carer identification and support project, with the aims of increasing identification of carers and to offer faster and more targeted support to them.

Joint approach to best value

The Better Care Fund Plan has been reviewed to support people to live as independently as possible and to shift to prevention from sickness. The existing schemes have been evaluated to ensure that they support the work of the BCF, as well as supporting the place priorities and urgent and emergency care system (section 1). This has built on the South West London review, as well as other reviews such as those carried out within the refresh in 2024-25 as part of the 2023-24 BCF.

These reviews and evaluations will continue throughout 2025-26 through the existing governance groups detailed in the approach to joint planning and governance (section 1), which will continue to monitor and report the impact of the BCF locally and nationally as part of the BCF returns.

In addition, a series of market management activities and forums are being set up across the Councils and ICB in South West London to support wider market management, aligning with borough-based market sustainability and improvement plans.

Metrics ambitions support alignment to system partner plans

The ambitions for the metrics have been planned to align with the priorities for urgency and emergency care through the Merton and Wandsworth urgent and emergency care board and set in conjunction with the local acute Trust and with South West London ICB.

The ambition for emergency admission has taken the 2024-25 baseline and has then taken account of 65+ population growth. The UEC DB ED and flow programme to reduce emergency admission has then reduced the overall levels of emergency admissions as per local planning assumptions. This has included work to expand the criteria to admit for the emergency department and work to manage ambulance conveyances by increasing the numbers seen via see and treat.

The UEC ambition to increase the proportion of people being seen and discharged through same day emergency care has been factored into the discharge ready date (DRD) metric, although the ambition has been mitigated by any data quality issues in the DRD metric and the limited baseline information available, and to ensure consistency with increases in internal efficiencies. Other work to reduce the time between referral and discharge has been factored into average days between referral and service start/ discharge within the step-down section of the intermediate care demand and capacity plan. All three sections have been planned in conjunction with one another and to reflect the wider UEC delivery plans, such as work to streamline discharge and support into SDEC.

The residential admissions metric has been planned in conjunction with recent deep dives and actions to manage demand, alongside the South West London model of frailty, The metric has been planned to consider the demographic challenge around the growing number of older people in the borough.

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Home first approach

The borough is committed to supporting people to remain at home and to enable a home first approach wherever possible to allow people live as independently as possible. At present, 28% of expenditure within the BCF is to support home based intermediate care services.

Intermediate care planning within the BCF demonstrates that 86% of the people discharged from hospital via discharge to assess (D2A) pathways go directly home (pathway 1), and the borough supports around 94% of all adults discharged from hospital go back to their usual place of residence. The response times between referral and discharge for people going directly home on a D2A pathway 1 have also reduced by about 9% compared to 2023-24.

Of those people discharged from hospital on a pathway 1, over 90% of people receive reablement or rehabilitation at home, which has increased from 2023-24. 85 % of people ending reablement in a planned way in the borough need less or no long-term services compared to the services received when discharged, with an average decrease in long term care needs of around 80%.

Work is continuing to support the recommendations of the St George's Hospital transfer of care review to streamline communications in order to increase the opportunity to discharge home if possible, as well as to increase the numbers of people being seen in frailty Same Day Emergency Care or to expedite support into the Emergency Department to discharge home without the need for an emergency admission.

Community equipment is provided via the joint equipment contract with NRS, which has provided nearly 16,000 equipment orders for around 5,500 people, as well as managing collections, repairs and maintenance. A dedicated care technology offer is available and is being expanded as part of a single care technology offer across the borough.

The Disabled Facilities Grant is utilised in the borough to support people to remain independent in their own homes for as long as possible, working with therapy and hospital discharge teams to assist residents wherever possible 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'. Adaptation referrals are mainly from occupational therapists and similar staff groups, and the most frequently requested adaptations being level access showers and stair lifts.

The Housing Improvement Agency has supported residents with issues ranging from energy security, advice on financial issues such as wills and power of attorney, benefits and debt issues, support with onsite builders, health information and disability law services, allowing residents to receive a holistic offer from the team.

Consolidated discharge funding

The BCF expenditure schemes have been reviewed to ensure that they meet the policy aims of the BCF, and to understand how and if these schemes now meet the priority areas. Evaluation of

impact has been reported via the BCF oversight and delivery group, with wider impacts being identified through the urgent and emergency care delivery boards and other forums.

The removal of the grant conditions of the discharge fund has enabled two main changes in how the mental health discharge schemes operate. The scope of the mental health step down beds and the mental health discharge team have been expanded to allow the step-down beds to manage those people needing a bed due to a mental health crisis, and there has been a mental health discharge team pilot to incorporate mental health reablement. Both changes should allow a greater number of people to be supported by these schemes and will support both the Mental Health Trust and acute hospitals when people in crisis would otherwise present. This is expected to have a positive impact.

Intermediate care capacity and demand

There has been a great deal of work formulating and testing the activity and response times for the 2024-25 intermediate care demand and capacity plans for step up (community) and step down (hospital discharge). Partners across the system such as the Council, NHS community services, ICB continuing healthcare teams and voluntary services have inputted activity into the plans for 2024-25, which have been reported through the quarterly BCF returns, demonstrating small amounts of variation against planned levels and positive impacts of the average days between referral and service start/ discharge.

On this basis, the reporting for the period April – December 2024 has been forecasted forwards to give a 2025-26 baseline for 2025-26, with ONS population growth added to this forecast to form the basis of the intermediate care demand and capacity plans for 2025-26. The demand has then been profiled using emergency admissions for the last four financial years, which has then been shown against the expected capacity to manage this expected demand. This work has then been reviewed by partners across the system to ensure that any capacity surplus or deficit reflects current understanding of where there are services experiencing constraints. Capacity for therapy support to rehabilitation and reablement are managed through operational meetings and capacity is shared with the South West London surge hub.

Overall, there is a very small capacity surplus for some months, but in the main, capacity matches demand over 2025-26. Where short term variation in demand is experienced by services, the system works together to manage this, and to mitigate any risk, meeting to agree actions and outputs. This has recently been the case for developing actions in community and adult social are services to support full capacity protocols within the new OPEL (Operational Pressures Escalation Levels) framework.

Appendix 1

Section 3: Local Priorities and Duties

Promoting equality and reducing inequalities

Addressing health inequalities and promoting equality for all residents in the borough is at the heart of all system planning. A population health approach has been adopted to increase understanding at a local PCN level where inequalities lie and tailoring services to address these inequalities, which has enabled early planning and development for neighbourhood health and care services. 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 population health workstream has enabled the system across the borough to identify and support different localities though several workstreams promoting Long-Term Condition management (including obesity) involving specific PCNs and local community groups.

Equality assessments are conducted 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 Wandsworth Health and Care 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.

One of the key principles within the Joint Local Health and Wellbeing strategy is to tackle inequalities, providing support to those who need it most and to work towards creating a fairer and more equal community. Progress on the JLHWS is regularly reported to the Health and Wellbeing Board which includes equality reporting on the steps within the strategy.

Engaging or consulting

South West London Integrated Care Board is committed to ensuring fair and accessible services for everyone who uses the health services within South West London, patients and staff. The Equality Act 2010 requires the ICB to take a proactive approach to equality and diversity.

The general equality duty requires the ICB to eliminate unlawful discrimination, harassment and victimisation; advance equality between all people; foster good relations between communities, tackle prejudice and promoting understanding.

As part of discharging these duties, Equality Impact Assessments (EIA) are carried out at the start of a policy being written or a new service being planned, EIAs assess the impact of the ICB's actions on people from the protected characteristics as identified in the Act. In addition to this they show how ICB policies and practices would further, or have furthered, the above aims EIAs are expected to form an integral and implicit part of planning, discussion and design of a policy or service; EIAs must therefore be completed before the development of any action plans and used to influence subsequent objectives and development of policies.

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Completing an EIA involves anticipating the consequences of functions and policies and making sure that, as far as possible, any negative consequences are minimised and opportunities for promoting equality are maximised. Equality Impact Assessments will also indicate positive consequences which can be used as best practice and shared across the organisation.

Reducing inequality in access to NHS services

The prevention of risk factors associated with, and improved management of symptoms of long-term conditions, requires a consistent and integrated approach between systems partners. Locally partners are focused on addressing inequality in access and/or health outcomes. Core20PLUS5 data has been used to support targeting areas of inequality of access to focus on prevention, early intervention and identification and self-management. This workstream has also ensured that data from Adult Social Care vis the Client Level Data returns will enable the borough to better understand and plan services to reduce variations in inequality to services. The Local Health and Wellbeing Strategy has already supported this work when understanding the variation of immunisation and screening rates by area and cohort to respond locally.

The population health workstream across South West London ICS has enabled the health and care system across the borough to identify and support different local areas though several workstreams promoting Long-Term Condition management (including obesity). This work has involved specific PCNs and local community groups, with a focus on addressing health inequalities. The approach to tackling obesity will be further considered as part of the model for neighbourhood health and care services. Social prescribers can refer into supportive services.

The borough is utilising population health management to identify underserved groups such as those identified through the Core20PLUS5 workstream throughout South West London and through the Wandsworth Health and Care Committee. This information will be used when developing the neighbourhood health and care services offer in the borough, to increase the number of people within the proactive care cohort from the 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 borough is committed to reduce the variation in support for discharge in mental health as well as acute settings and continues to fund the mental health discharge and reablement services working with South West London and St George's Mental Health Trust to support people being discharged from secondary mental health beds and to ensure ongoing support where needed.

Supporting and involving unpaid carers

Across the health and care system there are a range of services for unpaid carers which enable them to continue to provide quality care for their loved ones whilst maintaining their own health and wellbeing. As 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 for health and care services. It is estimated that 22% of people aged over 65 provide unpaid care in the UK. According to the 2021 Census there were more people providing unpaid care in most deprived areas compared to the least deprived areas.

Appendix 1

The needs of unpaid carers are considered in all services with a focus on providing support to carers to continue in their caring roles and/or to balance their caring role with a life outside caring work. Services offered to unpaid carers include Carers assessments and support plans, respite services including regular respite in people's own homes, carers breaks and day care services.

The Wandsworth Carers Centre is partly funded via the BCF as part of the systems commitment to empower unpaid carers, as set out in the adult social care reform white paper, 'People at the Heart of Care.' The carers centre delivers support services to anyone providing unpaid care within Wandsworth Borough or registered with a Wandsworth GP. It is jointly commissioned by the Council and the ICB. Wandsworth carers centre has over 5,700 unpaid carers registered as members and 59.7% of the 1,471 unpaid carers known to adult social care have had their needs as a carer assessed/ reviewed. Circa 600 unpaid carers attended peer support groups coordinated by the Wandsworth Carers Centre; 100 carers regularly attend dementia cafes with the person they care for; 700 unpaid carers are supported to have a short break/respite.

The Wandsworth Carers Centre provides 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.
- 5000 hours of home respite provided through a partnership with Bluebird Care
- Professional networking for organisations in order to develop better links with other services who provide support indirectly as well as directly to unpaid carers.

Additional support is being commissioned via the Local Authority BCF Grant within the hospital for unpaid carers and has enabled some complex discharges where families and carers needed support in deciding next steps for the person being discharged through the period which would have been delayed without carer support being in place.

Local Authorities in South West London in collaboration with all six local carers centres and the South London Partnership, were awarded grant funding through the Accelerating Reform Fund to develop two projects:

1. Online Carers Assessment Platform
2. Carer Identification and Support

South West London's Online Carers Assessment project set ambitious goals, both short term:

- Reduce waiting times for carers assessments and reviews
- Increase immediate access to community support
- Increase access to benefit and financial entitlements
- Increase GP registrations
- Facilitate support plan changes as circumstances change

Appendix 1

- Identify how information can be shared with health care systems to support person-focused integrated care

The discovery phase of the project featured in-depth interviews with 25 carers recruited through the six participating Carer Centres. The following key themes emerged from this research:

- Unpaid carers neither think of themselves as “carers” nor consider their own needs
- Carers access support only when caring is already impacting them physically and mentally
- They find understanding and accessing appropriate support challenging
- When accessing support, carers emphasise the importance of guided conversations: to help identify their needs; to help navigate support options; to acknowledge and empathise

A separate Carer Journey workshop was conducted with front line staff from the six Carer Centres, confirming key themes from carer interviews.