Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

BCF narrative plan template

Cover

Health and Wellbeing Board(s)

Waltham Forest Health and Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

- London Borough of Waltham Forest
  - Commissioning representative
  - Public Health representative
  - Adult Social Care representative (DASS)
  - Housing representative
- Barts NHS Trust
  - Whipps Cross Hospital representative
- North East London Foundation Trust
- NHS North East London ICS (formerly NEL Clinical Commissioning Group)
  - Commissioning representative
  - Director of Local Partnerships
  - Primary Care representative
- VCS leads

How have you gone about involving these stakeholders?

Partners have been engaged in the development of the Waltham Forest BCF plan and have been asked to sign off the plan through the Waltham Forest Health and Care Partnership Board. This has ensured that the BCF plans reflect the integrated priorities of the system and have a joint ownership.

Discussions have taken place with our VCS leads to develop our structure for involving the VCS in the development of partnership priorities which will include future planning for the BCF and funding support to enable this. This plan has been shared with a group of voluntary sector organisations who are supporting us to develop our approach to wider engagement.

Executive summary

The Waltham Forest health and care system is in a strong place in our integration journey and our partnerships continue to mature and strengthen. Led by our multi-agency Integrated Care Partnership Board, the last 3 years has seen the local system adopt and agree an Integrated Care Strategy for Waltham Forest which has enabled a truly ambitious business case to be developed and agreed that looks to transform and develop how pre-emptive anticipatory and intermediate care is delivered in Waltham Forest. This is in addition to the work delivered by the Better Care Fund as a core enabler to the further delivery of our ambition to be leaders in the delivery of integrated care.

We have a clear vision which encapsulates what we want to achieve for our local population.

"Our aim is for the population of Waltham Forest to have healthier lives by enabling them to start well, live well, stay well and age well, supporting each individual through to the end of their lives. We will do this by working together, as partner organisations and with our residents, to improve health outcomes and reduce health inequalities."

The Integrated Care Partnership Board and the Health and Wellbeing Board have committed to seven key measures of success:

- Addressing historical challenges and gaps in investment
- Transforming the way we do things to deliver better outcomes for our residents
- Practically addressing significant health inequalities made worse by COVID
- Ensuring that our new hospital is viable and part of the wider community
- Developing a shared vision and narrative – making it real for residents and staff
- Agreeing how system partners will take decisions together in line with our ambitions
- Harnessing our combined resources to make it happen

Our Integrated Care Strategy is underpinned by a number of transformational change programmes as shown below (Figure 1). Our Key Priorities of Promoting Wellbeing, Care Closer to Home and Home First (Figure 2) are core to the strategy.

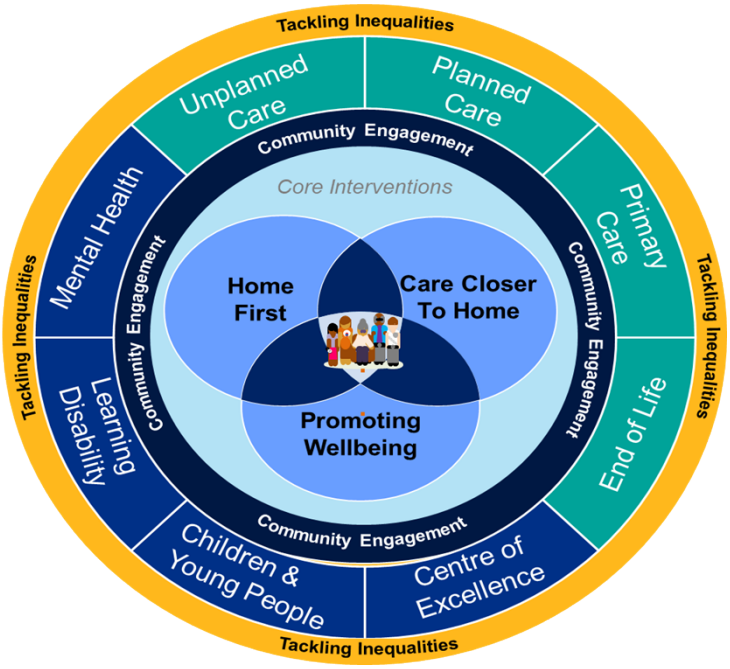


Figure 1

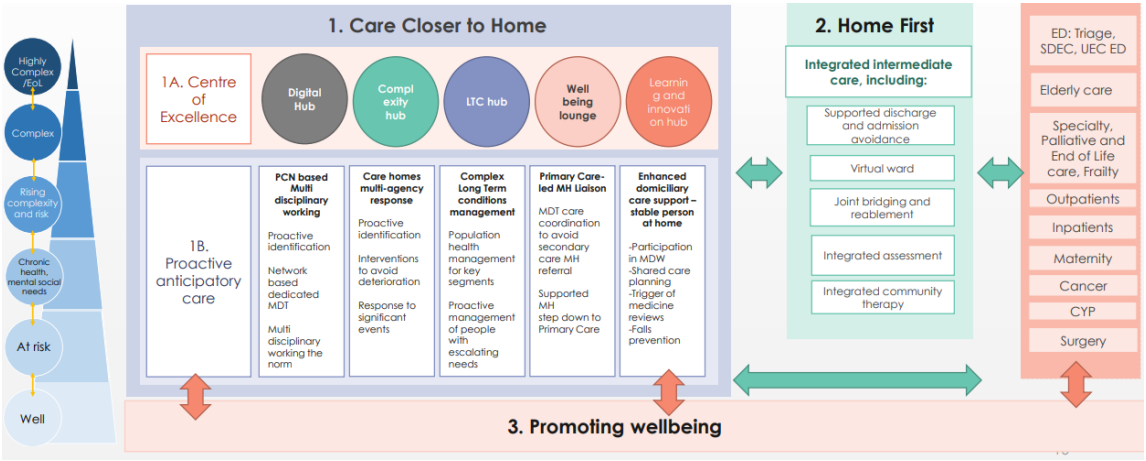


Figure 2

Given the strong local partnership arrangements, joint vision and agreed investment in future community transformation, the priorities of the Waltham Forest system remain as they were in 21/22, and the BCF plan for 22/23 remains largely unchanged as the system evolves into the new place-based partnerships and ICS arrangements and continues to build a sustainable model based on the strong base for integration that has been developed.

<u>Home First</u>

The Integrated Hospital Discharge Hub (**Schemes 6a and 6b)** remains pivotal to the work of supporting the local Acute setting, Whipps Cross Hospital, and out of borough hospitals with processes being strengthened and streamlined over the next year to continue to support the system in getting our residents home as quickly and safely as possible, into their own home wherever possible.

The Discharge Hub has been operational from 2020, initially in response to the covid pandemic and government guidance to facilitate timely discharges from local hospitals. It is

now an established model of practice and in 2021/2022 the Hub discharged 73% of people back to their usual places of residence, as people often recover better at home. This is above the 60% target as set by CCG commissioners.

The 22/23 plan retains a focus on Intermediate care services such as our NELFT-run Rapid Response Community Health service **(Scheme 17)** and Local Authority commissioned Reablement services **(Scheme 16)** within the BCF funding, both for admission avoidance as well as hospital discharge support and will continue working closely with our rehabilitation and therapy services **(Scheme 19)** as the Integrated Care transformation begins to take shape.

The reablement care provider capacity was initially increased to meet demand due to COVID; 2021/2022 capacity is over 1600 hours per week. The service has seen an increase in demand since the start of the pandemic and demand remains consistently high, 3 additional therapists have been working within the service in 2021 /2022 to manage the increased demand.

The 22/23 plan continues to use IBCF funding to invest in step-down beds, to support hospital discharge and support individuals to return to the community, also ensuring that every opportunity is taken to keep our residents out of Residential and nursing placements and in their own home, as independent as possible.

Care Closer to Home

The Proactive Anticipatory Care Closer to Home model is being developed and enhanced to identify individuals who are deteriorating, or otherwise at risk of crisis and support them with a multi-disciplinary approach.

To support this the Waltham Forest 22/23 BCF plan continues to invest in care co-ordination in Community Health Services **(Schemes 12, 13, 21 and 22)** alongside Extra Care and Homecare provision **(Schemes 3, 8, 9, 24)** that will be brought into Multi-disciplinary Team working as the Care Closer to Home transformation programme is further developed.

Promoting Wellbeing

Services addressing loneliness and social isolation in Waltham Forest fall within our Promoting Wellbeing programme, and are being funded to ensure that individuals who may be at risk of future deterioration and negative impacts of loneliness are supported to remain at home, engaged with their communities rather than accessing Primary and Community Health provision.

We have invested in our Health and Wellbeing Link Workers in 21/22 through the Improved Better Care Fund and in Older Adult befriending services through our Age UK Just Connect service **(Scheme 23)** and this will continue into 22/23, as the Waltham Forest system looks to support individuals who are presenting to the system with emerging needs to remain supported in their communities outside of formal health and social care interventions

Governance

In line with national policy, the Waltham Forest Health and Wellbeing Board has ultimate governance responsibility for the Better Care Fund.

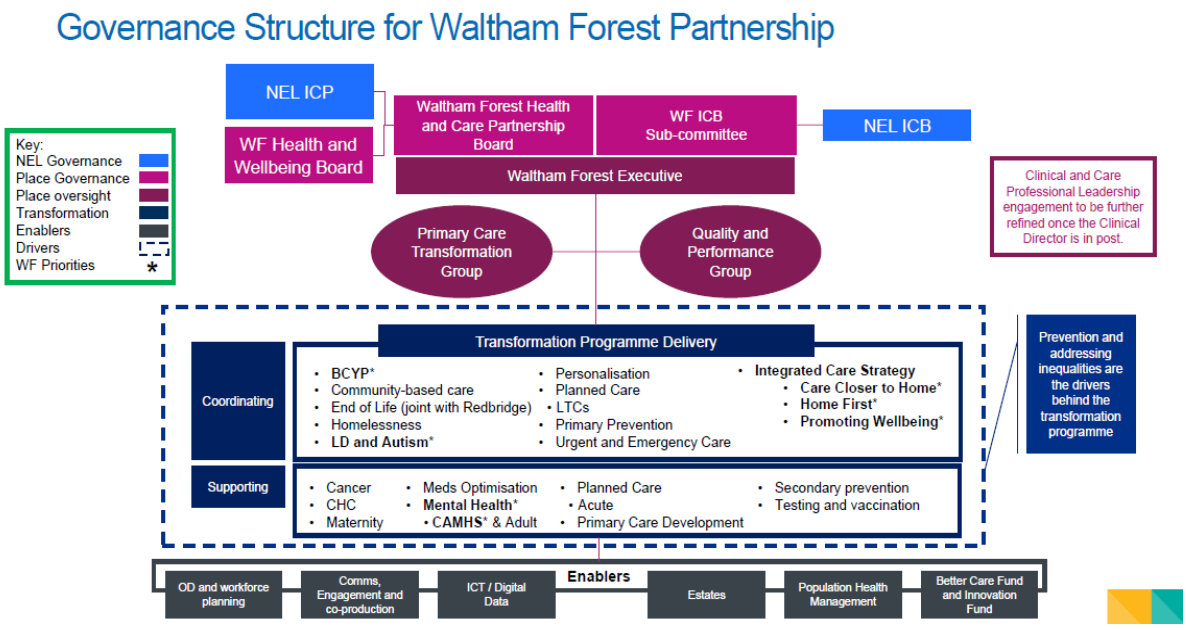
For practical reasons, governance arrangements are delegated to the Waltham Forest Integrated Care Board which is a multi-agency sub-group of the Waltham Forest Health and Wellbeing Board.

The Waltham Forest Integrated Care Board is the formal oversight and escalation forum for the management and delivery of the Waltham Forest Integrated Community Model and all cross-partnership work streams involving NHS North East London ICS (Prior to 1st July NEL CCG), the London Borough of Waltham Forest (LBWF), Barts Health NHS Trust (Barts) and North East London Foundation Trust (NELFT) and the local community. Its remit is:

- To improve the health and wellbeing of the residents of Waltham Forest
- To hold executive responsibility for borough planning and delivery of community development and integrated care provision
- To hold executive responsibility for the delivery of agreed transformation programmes
- To promote integration between community health services, primary care services and social care services
- To hold the local vision for person-centred care close to people's homes
- To involve, engage and co-produce with Waltham Forest residents
- To deliver through population-level health management approaches
- To align organisational priorities and agendas
- To escalate and address local risks and issues
- To oversee development projects for the Centre of Excellence
- To ensure the local community is engaged in system transformation

In addition, Waltham Forest Integrated Care Partnership Board provides operational oversight of the Better Care Fund programme and is responsible for;

- Providing Operational Oversight for the programme of schemes funded through the Better Care Fund.
- Monitoring progress of the schemes within the programme and reviewing their viability in meeting local expectations and requirements
- Provide a single point of reference for all matters related to the Better Care Fund.
- Ensure local compliance with national BCF Policy and Planning Framework Guidance.
- Be responsible for the annual revision, development, and submission of the BCF Plan.
- Be responsible for ensuring the timely completion and submission of quarterly monitoring returns
- Ensure BCF programme investment meets the requirements of the BCF guidance and supports wider integration within the ICS
- Ensure that a current Section 75 Agreement is in place in line with National Requirements
- Providing progress reports to the Health and Wellbeing Board



Overall BCF plan and approach to integration

Joint Priorities

Significant work has been undertaken in Waltham Forest to develop an integrated care strategy and joint approach to system transformation comprised of our key priorities.

- Home First – Supporting Admission Avoidance and Hospital Discharge, wherever possible focusing on keeping our residents at home for as long as possible.
- Care Closer to Home – Proactive Anticipatory Care bringing multi-disciplinary teams together to identify individuals who may be at risk of deterioration and support them in the community
- Promoting Wellbeing – Services and approaches that support residents to maintain their health, wellbeing and independence by intervening early and redirecting away from formal Health and Social Care

These priorities and strategy are aligned to the Whipps Cross Hospital Redevelopment Programme and new North East London ICS and Place-based Partnerships. A consolidated business case for system transformation and new models of care for Home First and Care Closer to Home was approved in January 2022 resulting in significant additional investment in Waltham Forest Community Services in 2022-23 in line with our shared vision. 22-23 sees this transformation begin and has also seen a restart of our Promoting Wellbeing board to ensure this continues to be aligned to our system strategy. All of these programmes are overseen by partners from across the local system.

Integrated Commissioning in Waltham Forest **(part funded by scheme 30)**

Waltham Forest has a fully integrated commissioning team in North-East London. Commissioning resources from LBWF and the NHS North-East London were formally

integrated in March 2020 and are led by an Integrated Director of Commissioning. The iBCF contributes to the part funding of this team who have a lead role in the borough for supporting the development and implementation of our Integrated Care Strategy and commissioning individual initiatives funded by the Better Care Fund. As well as the Integrated Care Strategy programmes, there are a number of cohort specific integrated commissioning programmes e.g. Mental Health, Learning Disability which have been led/developed/supported by the Integrated Commissioning team. Finally, the Integrated Commissioning team have led on work to deliver enabling services that are used across the system, such as the Integrated Community Equipment service **(Scheme 1)** which allows both NHS and LA staff to prescribe equipment under a single contract.

This demonstrates not only how we are enabling joint and integrated commissioning but also how BCF funding helps us to realise the benefits of stronger partnership working and joining up our planning, funding and commissioning of integrated services.

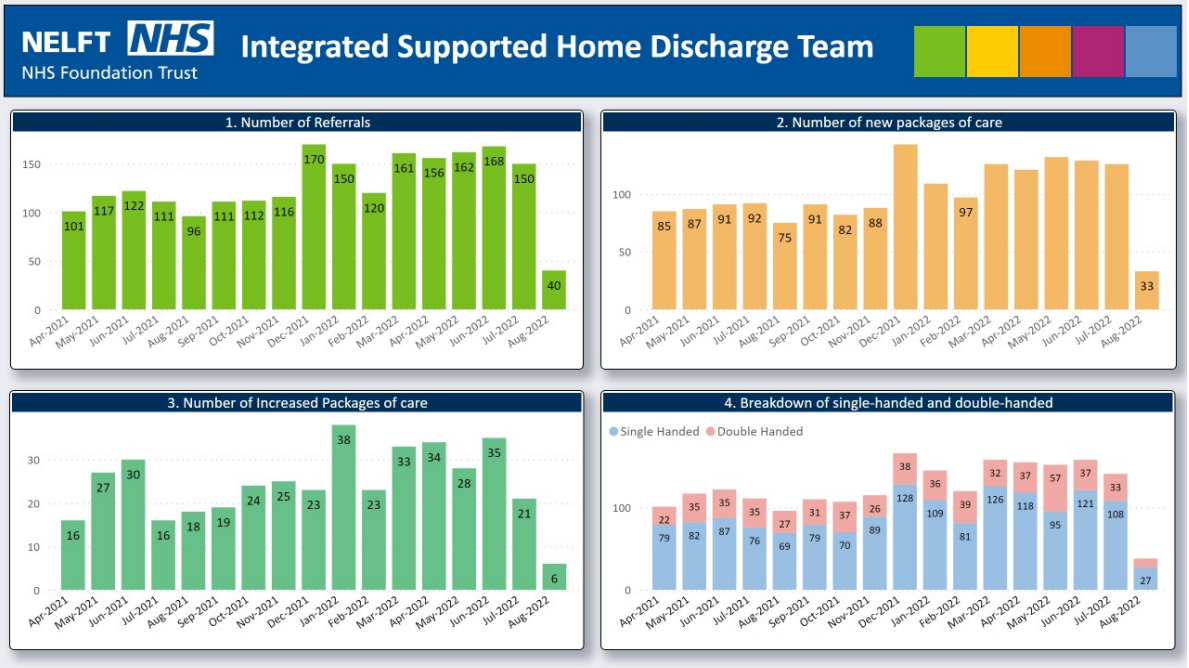
Home First

The Home First model of care that has been developed as part of the Integrated Care Business Case is in place to ensure that a system-wide approach to integrated intermediate care services is in place. The ethos of Home First is always seeking to ensure that residents return or remain at home with the right support around them, to keep them as independent that predicated on two key areas, Admission Avoidance and Hospital Discharge.

The Whipps Cross Integrated Discharge Hub (IDH), resourced by redeployed workforce across health and social care, is fully embedded in our system and following the lessons learned from the past two years is now looking at ways to enhance and improve discharge processes. The IDH now has a substantive staff team and is a key plank in the new Home First model of our Integrated Care business case, with key ambitions over 22/23 to streamline and enhance in-reach to the Hospital and reduce length of stay in hospitals wherever possible.

The discharge to assess (D2A) model **(Scheme 6a and 6b)** is now fully embedded within the system and this has been supported by bridging and reablement provision **(Schemes 15,16 and 17),** which will begin to be recommissioned over the 22/23 period to ensure that this is as streamlined a service as possible and is also available as an admission avoidance offer. Other Home First transformation schemes include: investment in the community Rapid Response team to ensure a two-hour response time to residents in urgent need in their own home and the addition of a Falls Pick Up scheme **(Scheme 20)** within Rapid Response to avoid Emergency Department attendances and acute admission.

The reablement service continues to support pathway 1 discharges for people whose function has deteriorated since hospitalisation and need new care support or additional care support on initial discharge home. The service remit has expanded since the beginning of the pandemic and 2 years on continues to provide reablement care for people requiring single handed and double handed care, Reablement care provider capacity was initially increased to meet demand due to covid, 2021/2022 capacity is over 1600 hours per week.



There has been an increase in the number of requests for double handed care upon discharge which also shows an increase in demand for the service. Additional therapy resource was identified in 2021 and 3 additional therapists have worked within the team since January 2022, this has reduced therapy waiting time for assessment following discharge. The Goal Attainment Scale (GAS) has been introduced which also demonstrates positive functional therapy outcomes for patients receiving reablement following discharge. The service supports all those along the reablement spectrum from those motivated to maximise their independence to those with limited motivation therefore some patients may not reach desired outcomes.

Our Bridging care scheme continues to run a 7-day service working flexibility to provide emergency care packages on the day for Waltham Forest residents who would otherwise remain in hospital while awaiting a care package provider to be confirmed. The service continues to enable the system to implement the 'why not home, why not today?' principle by offering timely, flexible care.

The bridging care is an integral part of the Discharge Hub and has representation in the twice daily discharge hub calls where they jointly identify and offer care support to people who can be discharged with bridging care support on the day.

In 2021/2022 the bridging service achievements are:

- Allocation software was purchased which enables electronic allocation and tags in patient's property allowing staff to scan in and out. This gives reassurance of timely completion of care visits and personal safety of staff.

- Continue to provide same day care support for patients to support discharges where a care agency has not been confirmed on the day through brokerage team.

- Work closely with Rapid Response urgent response to provide emergency care support as part of admission avoidance, additional 2.8 carers have been identified and being recruited to support this.

- Work to facilitate discharges though delivery of small pieces of equipment which otherwise patients would wait for while in hospital and this also reduces delivery costs through the local equipment company (medequip).

- Bridging carers also identify urgent needs of patients once they are in the community eg for District nurses, therapy or equipment. They also carry out joint visits, assisting other teams such as Community Rehab team/Integrated Supported Home Discharge Team in providing therapy for those that require double handed input. This reduces the risk of people being readmitted back to hospital.

The following is an evaluation of the bridging service:

Bridging Service Evaluation April 2022

The Virtual Ward service has been embedded in Waltham Forest to enable earlier discharge into the community of medically stable patients who require ongoing monitoring and oversight, particularly for pathway 0 patients. This is a key plank in our hospital discharge model and supporting timely discharge from Whipps Cross.

The priorities for 22/23 are to implement the Integrated Intermediate Care business case through the development of a new model of Intermediate Care in Waltham Forest, including rehabilitation **(Scheme 18 and 19)**, therapeutic input, reablement and clinical oversight via virtual wards. This will include the recommissioning of the reablement and bridging services within Waltham Forest, with a view to streamlining these services to ensure the best possible discharge that keeps residents at home through good intermediate care services, and to scope expansion of this into an admission avoidance offer.

People with complexity have inter-dependent multi-dimensional needs requiring a response, which goes beyond just good communication among health and care organisations. This is a move away from episodic siloed interventions in primary and secondary care, which are not helpful in managing people who genuinely require holistic interventions.

It relies on cross organisational trust and lasting relationships between staff as well as with patients and families, irrespective of location. We require easy and timely access to specialist and multi-professional input, diagnostics, physical and mental support and learning from other people with similar challenges. Digital training and social activities need to be wrapped around such patients to enable self-management and a fuller, more independent life.

Our new community model presents a significant opportunity to create a genuinely integrated system that provides person centred holistic 'care' that transcends organisational boundaries.

Care Closer to Home

The Care Closer to Home Programme incorporates both the Centre of Excellence and Proactive Anticipatory Care.

Centre of Excellence

The top 10% of people who get admitted to Whipps Cross Hospital accounted for 46% of total non-elective spend in 2019. These People typically have 30+ admissions to hospital of which a significant amount are avoidable, with a third of admissions being very short length of stays.

A key aspect of the model is to anticipate and manage escalating complexity in a person proactively before it is too late. Clinicians felt that we needed a one stop shop environment where professionals can interact, plan and mobilise enabling care without delay.

The Centre of Excellence will comprise:

- **Complexity (and frailty) hub** - Supporting people with frailty and escalating complexity to stay well and out of hospital through an integrated, single stop, enabling multi-faceted response
- **Long Term Conditions (LTC) hub** - Brings multi-specialisms and multi-agencies together to provide holistic assessment and enabling support to people with complex LTC needs
- **Wellbeing Lounge** - Providing tailored solutions to each individual's needs in the context of their everyday life and connecting them to the wellbeing network
- **Digital Hub** - Virtual remote monitoring, escalation and response unit allowing timely management of escalating needs
- **Learning, innovation and training hub** - Developing local current and future leaders and providing opportunities for cross-professional learning and development

Digitally enabled decision-making processes will reduce unwarranted variation, ensuring people get the right care, at right time, in the right place, from the right professional(s) at the right cost,

Clinicians also felt that the Centre of Excellence should preferably be on the Whipps Cross site providing a genuine interface between hospital and community services.

In the year one (April 22-March 23), work has commenced to implement the Digital Hub via remote working, with service launch expected in late summer 2022. Planning and development of the Complexity and LTC Hubs is also due to begin in September 2022.

The Centre of Excellence if successfully implemented will reduce non elective hospital activity by 10% and realize c£4m net savings – year 1 of implementation requires 1.2m investment (£3m by year 4).

This must be seen in the context of our wider integrated model and must be linked to what we do in our Primary Care Networks. The Centre of Excellence has the potential to be the control centre for population health management.

Proactive Anticipatory Care

Clinicians have defined a model of care that will connect to the Centre of Excellence and has 5 components:

a) **Multi-disciplinary team working at a network level (Linked to Schemes 12 and 13)** - The intention is to deliver a more proactive, anticipatory, and coordinated response to prevent deterioration or escalation occurring for frail and/or complex patients who are selected using a single, shared 'identification' tool and process. The first PCN MDT meetings are due to take place in Autumn 2022.

This multi-disciplinary approach comprises of three key elements:

- Proactive identification
- Collaborative decision making
- Coordinated delivery

b) **Complex LTC Management** - Primary care will have access to several options when managing individuals presenting with escalating health and care risks:

- A circle of specialist support aligned to each primary care network (PCN) comprising of a diabetic specialist nurse, a heart failure nurse, and a respiratory nurse specialist. They will be available for advice and guidance, with a named individual from each specialism, aligned to each PCN
- Specific Training Interventions where the PCN has identified specialisms where it is felt a structured training intervention from specialists would be beneficial
- Specialist support provided to Multi-disciplinary Teams - both a specialist consultant and nurse specialist will be aligned to each PCN and can be connected to provide the required support as and when is required

c) Care Homes Multi-Disciplinary Support

- Early interventions to prevent deterioration and conveyance to acute settings and responding to deterioration, once an event has occurred.
- Improving speed of discharge back to care homes
- The first Care Home MDT meetings are due to take place in September 2022, involving three Waltham Forest care homes.

d) Primary Care Mental Health Liaison

- Anticipatory multi-disciplinary working and care coordination to avoid secondary care mental health referral for people with emerging MH problems often triggered or exacerbated by other simultaneous issues e.g. social/housing/relationships
- Addressing the emerging MH problem and other issues holistically and at root cause through regular Multi-disciplinary working at neighbourhood level for selected patients that GPs are concerned about

e) Enhanced domiciliary care support (Linked to Schemes 8 and 9)

- Supporting shared care planning (Urgent Care Plan)
- Increasing skills of care workers to spot potential concerns with medicines and escalate for a medicine review to take place
- Equipping care workers to be more skilled in identifying falls risks, taking a more proactive approach and connecting with other agencies to prevent falls/repeated falls by addressing the key issue(s)
- Better engagement and support to carers to build their skills and resilience, recognising these individuals play a critical role in supporting day to day activities of looking after loved ones / family members
- Participating in Multi-disciplinary Team meetings and working

Changes to the 21/22 BCF Plan

The 21/22 BCF Plan established funding for a number of areas that supported the local systems priorities and ensured that the Waltham Forest Integrated Care strategy was delivered effectively. This strategy remains the driving force in integrated working within Waltham Forest and as the BCF underpins many services that support this strategy, the Waltham Forest BCF plan for 22/23 remains largely unchanged.

There are however changes within the various schemes of the Waltham Forest Better Care Fund that we wish to highlight;

Homecare (Schemes 8 and 9) – The London Borough of Waltham Forest has recommissioned the homecare provision within the borough, reducing the number of providers and bringing in a model in which providers will be operating within geographic lots, roughly aligned to Primary Care Networks within the borough. This approach comes into effect from the 10th October for a period of four years and will support and enable our approach within Care Closer to Home, to develop Multi-disciplinary teams around our most vulnerable residents and enhance our homecare offer, giving home care providers access to clinical support and oversight.

Dementia Advisory Service (Scheme 14) – Our post-diagnostic dementia support service has been recommissioned and now takes on an approach of supporting clients from diagnosis to the end of the dementia pathway, offering information, advice, signposting and support services as individuals seek not just to live with their condition but live their life as independently as possible and develop advanced care plans. This will be in place from 1st April 2022 until 31st March 2027.

Supported Living Mental Health Placements (scheme 25 and IBCF funding) - On the 14th January 2021, the Council's Cabinet approved the award of a new Framework Agreement covering four needs-based Lots for the provision of Supported Living Services for people with needs arising from Learning Disabilities, Mental Health, Autism and Physical Disabilities, within the London Borough of Waltham Forest.

The new contractual arrangements came into effect on the 1st March 2021 for a period of four years. The new contract included a requirement for providers to pay their carers London Living Wage. The Council commissions Supported Living to support residents who have Care Act eligible needs arising from Learning Disabilities, Mental Health, Physical Disabilities and Autism. Supported Living aims to support people to live as independently as possible, in their own home. It is the Council's intention to move toward more Supported Living placements as an alternative to residential settings

Implementing the BCF Policy Objectives (national condition four)

Objective 1: Enable people to stay well, safe and independent at home for longer

Care Closer to Home

As mentioned above the Care Closer to Home Programme incorporates both the Centre of Excellence and Proactive Anticipatory Care and these are surrounded and supported by services funded through the BCF to ensure that residents of Waltham Forest are identified proactively as being in need of health or care interventions and that the right team of professionals is brought together to ensure that care is delivered that can keep individuals well and at home independently for as long as possible.

The workstreams within the Care Closer to Home Programme such as the Enhanced Domiciliary Care support will link our BCF funded Community Health Services **(Schemes 12, 13, 21 and 22)** to enhance the skills of our care workers as they have greater access to clinical support and will also allow our residents to benefit from a more holistic approach to care and support.

The Multi-disciplinary teams (comprising of therapists, community matrons, nurses, GPs) ,that are being developed at a PCN level by Care Closer to home will work not just our community health and primary care colleagues, but also alongside Extra Care and Homecare provision **(Schemes 3, 8, 9, 24)** to allow conversations that address the whole person, making every contact count and potentially reducing the likelihood of individuals having to re-tell their story to multiple professionals.

The Frailty and Complexity hubs within the Centre of Excellence give access to consultants from Whipps Cross acute hospital, with the aim of allowing our most complex patients to continue to be seen in the community and reduce hospital admissions and improving access to strong clinical oversight in the community.

Alongside this our approach to using DFG funding will enable adaptations to be made to people's homes that will support our residents to remain home and as independent as possible for as long as possible, whilst our integrated community equipment contract (**Scheme 1)** will continue to enable aids to daily living to be prescribed by professionals across the system to support individuals at home.

Objective 2: Provide the Right Care in the Right Place at the Right Time

Home First

The Waltham Forest Home First Programme is comprised of admission avoidance and hospital discharge elements, with the aim of providing a comprehensive system-wide integrated intermediate care offer supported and led by BCF funded services.

Hospital Discharge

The Integrated Discharge Hub is the single point for all transfers of care from hospital to home or other interim or permanent destinations. It covers all discharges for Waltham Forest residents whether from Whipps Cross or out of borough hospitals. The Hub is a multi-agency response to the discharge guidance. It includes therapy and nursing staff from community health services, local authority social workers, brokerage officers, acute trust staff,

administrators and a dedicated manager. Community health providers NELFT is the lead organisation and the Hub provides a 7 day extended hours service.

The system follows the national requirement and a “discharge to assess” model is now embedded in the system, with good practice being highlighted at a National level. For Pathway 1 discharges we aim for same day discharge using either home care providers or NELFT’s in-house bridging service before this moves into reablement provision commissioned by the Council (**Schemes 15 and 16)**. However with the agreement of the Integrated Care business case and new Home First Model, work will begin in 22/23 to recommission the bridging and reablement services to create a joined up intermediate Care System that supports Waltham Forest Residents to return and stay at home.

Pathway 2 and 3 discharges we aim to place within 24-48 hours. The discharge to assess approach has led to a significant reduction in the numbers of patients at Whipps Cross with extended, unnecessary length of stays.

Patients on pathway 2 are discharged to beds at the Ainslie Rehab Unit for a period of targeted therapy-led rehab. The MDT includes social care officers who assess the person’s needs for longer term care and work with brokerage to set this up as required.

Patients on pathway 3 are discharged to an interim residential or nursing bed where the Discharge to Assess process takes place. The social workers from the Hub Active Recovery Team lead the assessment process in association with the person, their family and relevant partners.

People discharged to an interim nursing bed, who have triggered a CHC checklist, will receive a joint CHC DST assessment from health and social care assessors as set out in the National Framework at the care home. The iBCF funds dedicated social work resource to support the MDT assessment process. Should the person not trigger full CHC funding these staff will undertake a Care Act assessment and other assessments as required e.g. MCA and support the person with a move home or to the most suitable accommodation.

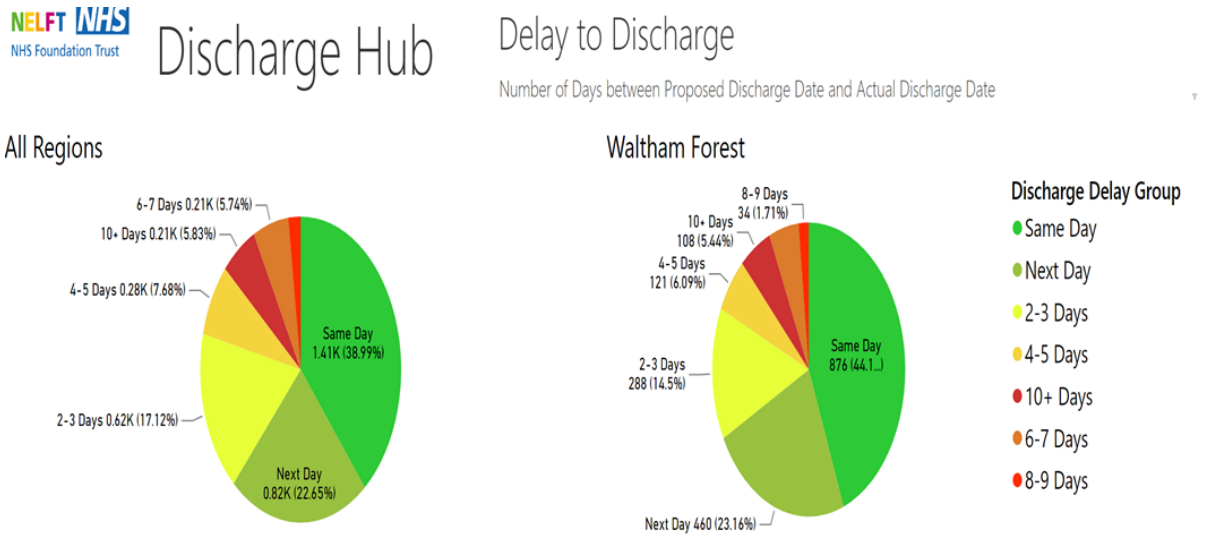
The integrated community equipment service **(scheme 1)** has revised the commissioning arrangements with the provider to enable standard deliveries over 6 days and out of hours deliveries for emergencies over 7 days. The speed of response has also been revised so that next day delivery is the standard offer, rather than the pre-covid 5 working day timeframe. This has contributed significantly to the system’s ability to discharge increasing numbers of people within 24 hours of presentation at the Discharge Hub.

The hub continues to consistently deliver high same-day and next-day discharges with over 70% of patients IDH performs very effectively and has discharged within 24 hours each month – see June 3610 people with complex health and social care packages during 2021/2022 data below, despite the increased (August 2021 to July 2022) this is 14% increase in numbers of people discharged through the Hospital post-covid as elective procedure backlogs are addressed and discharge hub.

In 2021/2022 the Hub has discharged:

> **Pathway 1 -** 2645 (achieving 73% of people discharged to their usual places of residence with support from out of borough carers)
>
> **Pathway 2 -** 668

Pathway 3 - 297



- The Discharge Hub is managing to discharge high numbers of people within 24 hours thereby demonstrating the positive impact on reducing length of stay in acute beds. The hub is achieving 44.1% of discharges on the same day and 23% the next day, showing a 16% increase in next day discharges. System partners working across the discharge hub are consistently looking at ways to improve patient experience and flow to increase the number of patients safely discharged from hospital.
- The amount of activity going through the discharge hub has been gradually increasing, with 525 people going through the discharge hub in July 2022 in comparison with the year average of 387 due to the unpredictable pressures facing NHS acute hospitals due to nationally. The IDH and system partners continue to work together using a coordinated approach that requires flexibility in use of resources to manage unexpected surges in discharge activity.

IDH Priorities

- IDH priorities for 2022/2023 are to continue facilitating safe and timely discharges, by reviewing reasons for delayed discharges and implementing changes in ambulance conveyancing. either at a system level and local level to improve discharge processes.
- To work with patients, carers and voluntary sector colleagues to gain feedback in ways to improve patient/carer experience of discharge pathways.
- To work with system partners to have a coordinated approach in managing unpredictable surges in activity.
- Developing a discharge patient leaflet for patients on pathway 1, detailing information regarding discharge and support available post discharge. The leaflet would provide information and the aim is also to reduce anxieties around the discharge process to facilitate timely discharges.

The High Impact Change model (HICM) is being embedded within the Waltham Forest System to support hospital discharge from Whipps Cross. The Home First action plan for 2022-23 includes the review of our progress against each of the aspirations. We are continuing to build upon a core Homelessness offer provided via Housing Services to develop a system-wide Homelessness & rough sleepers pathway. A dedicated Housing Officer to support discharge has been in place since January 2021.

IBCF funding is being used to fund step-down beds in residential, sheltered housing and Extra Care provision, in order to support transfers into the community within the Home First ethos, but where direct transfers home are not possible. We revised the pathways into these facilities during 2021-22. The Home First work plan for 2022-23 includes ensuring full utilisation of these facilities.

The Waltham Forest HICM is designed to support local system partners to improve health and wellbeing, minimise unnecessary hospital stays and encourage them to consider new interventions, it is a vehicle for self-improvement.

Waltham Forest progress against the 9 HICM areas are captured in the table below:

No.	Area	Action Taken	Impact
1.	Early Discharge Planning	Elective planning should begin before admission for planned care. In emergency/unscheduled care, robust systems and expected dates of discharge to be set within 48 hours.	Reduction in LOS for planned care Reduction in LOS for NOF patients, especially OOB patients Intelligence to identify delays to pathways
2.	Systems to Monitor Patient flow	Robust Patient flow models for health and social care, including electronic patient flow systems, enabling teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the patient.	Reduction in numbers of outliers Support improvement work in high activity discharge pathways Increased in-reach leading to a reduction in LOS. Placement /POC to be arranged for home wherever possible due to constraints of care home capacity
3.	Multi-Disciplinary Multi-Agency Discharge Teams (Including Voluntary and Community sector)	Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	Pilot to ran between Jan'20 - Jun'20 with a review of performance Reduction in LOS for patients waiting for care home placement Reduction in delay in waiting for assessment and acceptance on to D2A pathway
4.	Home First Discharge to Assess	Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home.	Patients being discharged to most appropriate care setting with optimisation of care at home Discharge pathway and early discharge planning earlier in-patient journey leading to reduction in delays

			Reduction in number of family/patient choice delays Regular training programme to be developed
5.	Seven-Day Services	Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	Reduction in delays waiting for care home placement Improved tracking of patient discharges
6.	Trusted Assessors	Using trusted assessors to avoids duplication and speed up response times	Reduction in delays related to care home assessments and acceptance Reduction in delays related to waiting for community equipment to be in place
7.	Focus on Choice	A robust protocol, underpinned by a fair and transparent escalation process	Reduction in delays related to pt/family choice. Challenges related to Choose policy to be identified Families and patients to be better informed of discharge choices and pathways earlier in their journey
8.	Enhancing Health in Care homes	Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes	Identify pathways or service changes to support a reduction in conveyances from care homes. Also identify the care homes which require focused attention Support case for change towards moving to a 7-day service
9.	Housing and related services	Reduction in delays through early recognition of a patients housing status and their support needs.	Pathway agreed with WFLA for housing input and updates for patients at WHX within an agreed pathway and to identify housing solutions

Admission Avoidance

We have various transformation programmes underway within Waltham Forest and across North East London (NEL) with the aim of reducing non-elective admissions. These programmes include new, or alternative pathways outside of hospital setting either through primary care services or alternative community services to reduce avoidable unplanned admissions for various conditions such as Long-Term Conditions or intermediate care responses.

Finally the new Home First model of care will bring together the rapid response, reablement and therapeutic offers within Waltham Forest to support admission avoidance by reducing individuals requiring hospital admission due to episodes of crisis, such as falls, chest pains or other ill-health episodes. This new model is being implemented in 22/23 and will build this intermediate care service to support the residents of Waltham Forest remaining and returning safely at home. The Rapid Response service is a multidisciplinary nurse lead service made up of nurses, therapists, paramedics and integrated with social workers as well as have access to short term Bridging carers and reablement carers. The multidisciplinary nature of this model aims at holistic assessments and interventions to reduce unnecessary hospital admission.

The discharge to assess (D2A) model is now fully embedded within the system and this has been supported by bridging and reablement provision. The Bridging care service runs a 7-day service working flexibility to provide emergency care packages on the day for Waltham Forest residents who would otherwise remain in hospital while awaiting a care package provider to be confirmed.

Supporting unpaid carers.

The Waltham Forest All-age Carers Strategy is currently being refreshed following its success in improving and enhancing the carers offer and processes towards supporting unpaid carers with a dedicated Strategy lead co-producing the strategy.

The Waltham Forest Better Care Fund has a specific funding line for Carers **(Scheme 26)** within the NHS minimum contribution. This funds the Universal Carers support service commissioned by the Local Authority and provided by Carers First. This provides unpaid carers with information, advice and supports them to maintain their caring role whilst also maintaining their wellbeing.

Funding towards Carers First has also enabled us to undertake a Carer Contingency Pilot, working with NHS England to develop approaches to contingency planning in the event that Carers are unwell or affected by emergency situations. This will be taken forward in 22/23 through our Carers Strategy refresh, developing an approach of embedding Carers Contingency plans in both practice and the system which will support the peace of mind and reduce mental strain for unpaid carers due to their caring role.

Waltham Forest will also be taking forward work in 22/23 with Care City in North East London to ascertain the feedback of patients and their carers within the Whipps Cross acute

trust, to further identify areas where we can support them as they navigate the health and care sector.

Disabled Facilities Grant (DFG) and wider services

The London Borough of Waltham Forest Cabinet made the decision in September 2021 to bring the Home Improvement Agency (HIA) service back in house effective from April 2022 when the current contract expired. The Council worked closely with the previous provider to affect a smooth transfer of the staff, service, and open schemes with minimal disruption to residents.

The delivery of DFG sits within the Home Adaptation Service as part of Adult Social Care and the service is comprised of the Adult Social Care Occupational Therapy Team and the Home Adaptation Team. In addition to overseeing the DFG, the Home Adaptation Service also manages, on behalf of the partnership, the Integrated Community Equipment provision **(Scheme 1)** and budget and the Council's Telecare (Assistive Technology) provision.

The service is now working collaboratively with Housing to manage the mandatory DFG process and major adaptations within Council-owned properties funded from the Housing Revenue Account. There is an internal Major Adaptation Steering Group which was set up in 2021/22 to oversee the insourcing of the service and initial delivery and service plan during 2022/23. A view will be taken later in the year with wider partners around the composition of this group and where the group should report into given the emerging ICS governance groups.

Operationally there is a Major Adaptation Panel (MAP) which sits monthly and looks at schemes over £15k in terms of grant approval. The Panel is comprised of adult social care staff and a Housing OT. In addition to grant approval and informing residents of their decisions, the MAP also deals with appeals and can offer advice and a forum to referring/assessing OTs and Technical staff. It works closely with colleagues in Children's services to manage referrals, approvals and works.

In addition, the Home Adaptation Service manages the discretionary DFG grant process, as part of the Council's Regulatory Reform (Housing Assistance) (England and Wales) Order 2022, housing assistance policy: Grants for Home Adaptations and Modifications in Waltham Forest, effective from 1st April 2019.

The following areas of support are offered:

- Major Adaptations – into owner occupied, rented and council owned properties
- Hospital Discharge Support – support for the system to manage discharges promptly and safely through flexible and targeted interventions and reduce hospital admissions and readmission
- Home Repairs and Renewals – to improve the home environment of disabled residents more quickly, taking a preventative approach
- Home Safety – support to make the home environment safe and reduce risk to residents, such as our work with HEET to provide affordable warmth for vulnerable residents

- Emergency Adaptations – assistance where work is required immediately, and it is not practicable to go through the mandatory process
- Re-housing, Relocation or Temporary Relocation Assistance Grant (Move On) – assistance to move on where undertaking a major adaptation is not feasible

During 2021/22 working closely with partners we were able to provide a total of £3.6m of support, circa £2.5m for major adaptions into all tenures and circa £800k into discretionary support, with the majority of this discretionary spend going against hospital discharge support and home repairs, renewals, and safety.

This work included working with housing colleagues and HEET (Home Energy Efficiency Training Ltd) to maximise energy efficiency funding and DFG discretionary to reach some of our most vulnerable residents and improve the energy efficiency and safety of their homes. The remaining grant was set against fees and charges.

In early 2022 we trained all our existing Occupational Therapists and Occupational Therapy Assistants to Trusted Assessor Level 4, meaning they can identify major adaptations and specify solutions as part of their wider OT assessment. This means during 2022/23 we will potentially be able to process referrals and applications for a DFG more quickly and address the current backlog in OT assessments for a DFG.

Throughout 2022/23 the service will work closely with wider partners in Health, Housing and the VCES sector to develop a new service model that allows us to better deliver on our integrated care ambitions, corporate priorities, and the opportunities to improve resident outcomes via the health and adult social care reforms.

Working with partners throughout 2022/23 we will develop and build on the current service to:

- Deliver major adaptations via the mandatory DFG and HRA process
- Provide wider social care, health, and housing information, advice, and support to help people live independently and safely via discretionary DFG
- Improve social care, health, and housing outcomes and develop an internal evidence base
- Reduce health and social care inequality that often arises due to poor housing, deprivation, and economic exclusion
- Deliver the system priorities in line with the agreed policy (reviewing the policy as our ICS plans develop)
- Contribute to other local authority and health strategies and priorities, such as, ensure a decent roof over residents' heads, improve residents' life chances and our system ambition that residents start well, live well, stay well and age well
- Deliver changes in line with legislation, policy, and guidance

During 2022/23 we will:

- Review our Adult Social Care Occupational Therapy team to ensure we have sufficient OT resources in place to meet the demand for both Care Act and DFG OT assessment. This means moving HIA transferred OT resources into the Council's OT team and as appropriate increasing OT resources. Building our OT capacity will also further support our broader partnership ambitions and plans, especially around developing an integrated therapy service.

- Subject to funding we will develop a Home Response Team that will manage, and coordinate agreed discretionary spend priorities, such as: safe, effective, and timely hospital discharge, admission and readmission avoidance and greater use of assistive technology. Creating this team will also allow us to potentially benefit from the Government's intention to fund a new service to make minor repairs and changes in peoples' homes, to help people remain independent and safe.
- Review the Home Adaptation Team (formerly the HIA) to ensure the team is geared to offering information and advice around housing options and is able to deliver the required level of capital works and major adaptations schemes in line with funding.
- Review with partners emerging and changing priorities to meet the challenge of health and social care reform and identify new opportunities for use of DFG funding (to improve housing options) and other funding associated with the reform agenda.
- We will further look at how we build off access to our Housing Contractors and how we can support the procurement of works in a timelier fashion (Dynamic Procurement System and/or frameworks) to meet the timescales for moving through the stages outlined in the new DFG Delivery Guidance.
- We will look at how we maximise in year spend against our annual DFG allocation, continue to reduce carry forward of unspent grant (to meet agreed priorities)
- We will look to develop an agreed performance and reporting framework to evidence the work of the service and how the DFG is supporting people to stay safe, well and independent at home for longer, ensuring we provide the right care, in the right place at the right time.

The service is currently working with 540 residents who it is identified require over 740 different types of adaptations, some needing just one in their property while other require a combination of adaptations. By far the most common type of adaptations are for Level Access Showers and Stairlifts (accounting for 60% of all adaptations).

Throughout 2022/23 the Council will continue to look with partners at how best we can support residents (children and adults) through the capital grant and discretionary housing assistance, including those with complex needs so they can remain at home, remain as part of their family and part of their community.

Equality and health inequalities

Waltham Forest are working with the Sir Michael Marmot Institute of Health Equity to conduct a thorough review of health inequalities in the borough and to agree a set of actions later in the year that will reduce the differences in health outcomes between different population groups. This report will inform everything we do in the health area, to ensure all of our work reduces inequality and allows all our residents to thrive. The actions will be developed with partners across the system, ensuring they are in-line with NHS Priorities and Operational Guidance, primarily digital exclusion and the targeting of prevention programmes at those at risk of the poorest health outcomes. We will also follow the Core20PLUS5 approach, prioritising the most deprived residents, ethnic minority communities and other socially excluded groups.

The population of Waltham Forest is growing, in 2021 its population was 276,350 and it is estimated to increase by 4.1 percent by 2026. The growth is unevenly distributed between age groups, while the population aged 18-64 has increased by 7 percent, there has been a

20% increase in the population aged 65-84 and a 25% increase in the population over 85 between 2010-20. The aging population is leading to increased demand and spending on health and social care services and more demand on services provided by the VCFSE sector. There are also economic impacts, with a lower proportion of the population of working age.

Waltham Forest is one of London's most diverse boroughs and the majority of its population is from minority ethnic backgrounds. The 2011 census estimated 53 percent of Waltham Forest residents are from a minority ethnic background and at that time the largest minority ethnic group fell into the 'white other' category. Most of this population in Waltham Forest are from Eastern Europe (Romanians, Hungarians, Poles, Bulgarians and Lithuanians).

The circumstances in which people are born, grow, live, work and age, and socio-economic factors or the social determinants of health, have the strongest influence on health and wellbeing. This is reflected in what has been seen during the COVID-19 pandemic. The pandemic has affected people differently and exacerbated existing health inequalities, influenced by factors like age, sex, ethnicity, job, income, where somebody lives, pre-existing conditions, disabilities and vulnerability e.g. homeless and rough sleepers.

There are wide inequalities in life expectancy in Waltham Forest. For women, Endlebury ward had the highest life expectancy over the period 2015-19, nearly 88 years compared with 81.7 for women in Lea Bridge ward, which is considerably below the English and London averages. Chingford Green and Hale End and Highams Park have the highest male life expectancy, just over 83 years, compared with 77.6 years in Hoe Street. Seven wards have lower male life expectancy than the average for England.

The proportion of those classified as overweight or obese in Waltham Forest is just under the average for London and about average compared with statistical neighbours. While rates are roughly the same as the average for London, they are high with 54% of adults classified as overweight or obese in Waltham Forest in 2020/21. There are inequalities related to deprivation in rates of overweight or obese, and for children in year 6, rates are higher than the English average and there is considerable difference across the borough. Chingford has relatively low rates at 28.8 percent compared with 45.2 percent in Cann Hall. As across England, there is an association between rates of obesity and deprivation in Waltham Forest. Our new obesity strategy, to be published for the next five year period will set out how we plan to focus our efforts on groups most likely to be living with overweight and obesity.

Across England there is a clear relationship between socioeconomic position and smoking, with smoking rates much higher among those in routine and Manual occupations. Inequalities in smoking prevalence related to employment type are very clear in Waltham Forest, with rates among those working in manual occupations roughly four times higher than those in occupations classified as managerial and professional.

Alcohol consumption increased during the first COVID-19 lockdown and subsequent analysis shows that alcohol-related deaths also increased. Analysis also shows the increase in drinking was in high-risk drinkers – the households already purchasing the highest amount of alcohol increased their purchases more than 17 times compared to those who purchased

the least alcohol. People living in the most deprived areas in England increased their alcohol purchases more than in the least deprived areas.

The 2020 Annual Public Health report 20 Questions Annual Public Health Report _FINAL_.pdf (walthamforest.gov.uk) also highlighted how the impact of COVID-19 disproportionately affected groups including men, older people, people living in more deprived areas and people from minority ethnic backgrounds, and exacerbated existing inequalities. Our recovery plans and health improvement initiatives over the coming years will seek to improve health outcomes for all of those who have experienced the worst outcomes from COVID-19.

Addressing equalities and health inequalities, both in terms of access and outcomes, is a central element of the Better Care Fund Plan going forwards. The extent of inequalities, exacerbated by Covid-19, in the Borough have been identified in the 'State of the Borough' report and further in-depth analysis will be completed later this year through our work with the Sir Michael Marmot Institute of Health Equity. We will incorporate its findings as a 'golden thread' through all aspects of our Public Health remit, our Integrated Care Strategy, and make this a core part of shaping our post pandemic BCF 'reset' agenda.