Better Care Fund 2022 - 2023

Narrative Plan

London Borough of Merton

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Introduction

This narrative plan summarises the work taking place across multiple agencies to support the residents of Merton to stay well, safe and independent at home for longer and receive the right care, in the right place, at the right time.

This document should be reviewed alongside the completed Better Care Fund (BCF) Planning Template, which is an excel spreadsheet that includes the financial breakdown of the BCF along with the performance plans relating to key metrics and how the area will meet the key planning requirements detailed in the BCF Policy Framework and the BCF Planning Requirements for 2022/23. The submission also includes, for the first time, a demand and capacity template for intermediate care which although is not part of the assurance process for BCF, its completion is part of the requirements.

Organisations Involved in Drawing Up the Plan

This plan has been jointly developed between South West London Integrated Care Board – Merton place and London Borough of Merton (LBM) and aligns with Merton's Health and Care Plan and the work of the Merton Health and Care Together Partnership. This involves a wide range of partners including St George's University Hospital NHS Foundation Trust, South West London and St George's Mental Health NHS Trust, Central London Community Healthcare NHS Trust, Healthwatch Merton, Epsom and St Helier University Hospitals NHS Trust, Merton Health, Merton Connected – Merton's Voluntary Sector Committee and representation from Primary Care Networks.

To support the refresh of Merton's Health and Care Plan which feeds into the development the Better Care Fund Plan, workshops were held virtually during August/September 2021 with over 100 attendees from local health, care, voluntary and community sector groups and patient and public representation as well as feeding in the results from surveys, engagement themes and follow-on conversations.

In Merton, the Director of Community and Housing oversees social services and housing, and this enables closer alignment of goals and close working between social care and housing, including the Disabled Facilities Grant (DFG) in both the development of plans e.g. the use of the DFG and in every day working e.g. in supporting discharges. The Assistant Director for Commissioning in the Department has oversight of the HIA commissioning process and is the strategic lead for BCF.

LBM is a non-stock owning authority and works with a range of social and private landlords to meet housing needs.

Involving Stakeholders

Health and care organisations in Merton have been working together closely for many years and there is a huge amount of partnership work underway across a broad range of partners and colleagues including public health, the voluntary sector, Healthwatch, mental health providers, primary care networks, community and secondary care providers, local communities and many others. The pandemic has brought us even closer together and accelerated system learning.

Leaders from these sectors in Merton have come together as a new team to lead Merton in the new South West London Integrated Care System (ICS). Part of this work has been to take stock of progress with the local health and care plan which was developed in Merton in partnership during 2018-19. The Merton Health and Care Plan describes our vision, priorities and actions to meet the health and care needs of local people and deliver improvements in their health and wellbeing through the life stages of: start well, live well and age well. Our Joint Strategic Needs Assessment (JSNA) (and particular health inequality data) is the starting point for this refresh.

A series of workshops took place over August and September reviewing this work and two workshops in particular focused on the age well programme. This work builds on all the engagement done to develop the original plan, and gave key stakeholders, communities and groups across Merton a chance to discuss collectively what they feel key actions are going forward.

The BCF is a key enabler of this work and the priorities in this submission reflect the work and agreed priorities within Merton's Health and Care Plan, which works alongside local Emergency Care Delivery Boards, Transformation Boards and the programmes of work underneath this to support the delivery of the aims and objectives of the Better Care Fund.

Executive Summary

A number of the challenges during the pandemic have continued, whilst alongside this, the work to address a backlog of activity brought about as a result of the pandemic. In Merton we work very much on the needs of our local population. Being without an acute trust in our borough, we work closely with other areas across SW London, particularly Wandsworth where there are benefits of working at scale.

There are ongoing challenges to maintain flow, with Trusts reporting more complex and frailer patients being admitted and reduced staffing capacity across the system due to sickness absence and staff vacancies. In spite of this, we have maintained a high performing discharge model and work is taking place to improve proactive discharge planning across Merton, which will assist with implementation of the 10 best practice initiatives as detailed in the 100-day challenge. Improvements have already been made with the Transfer of Care (TOC) team at St Georges which has seen an improvement in the discharge processes and a reduction to some of the

delays in the system. We continue to work with system partners to create more joined up services and find a financially sustainable way to fund discharge to assess systems set up with temporary funding during the pandemic.

A successful Hospital at Home/Virtual ward pilot programme was established across Merton and Wandsworth during the pandemic to support the local system pressures and optimise the capacity in hospital and community services, providing care for our patients in the most optimal setting. Early indications from the pilot show that the service has reduced length of stay, supports admission avoidance and has evidenced a number of bed days saved for the system. As such, we view the hospital at home and virtual ward programme as a key strategic initiative which will underpin our wider community services transformation programme across Merton and Wandsworth. Therefore, in line with local and national direction we plan to expand the pilot programme increasing service to take up to 80 beds by 2023.

To enable more people to maintain their independence for longer, in addition to supporting Home First models, we aim to improve the health and wellbeing of Merton residents through enhanced access to community and voluntary sector services and greater sharing of assets and expertise as well as reduce health inequalities e.g. through the Implementing South West Merton PCN "Tackling Neighbourhood Health Inequalities" project working with Wimbledon Guild and use of population health management to reduce social isolation and improve access to services supporting those with frailty.

Along with the introduction of national anticipatory care guidance, we plan to expand the Integrated Locality Team model into lower risk cohorts to enable more people to benefit from proactive and preventative services and more personalised care and build on the expanded offer from rapid response services, enhanced support to care homes, improving dementia and end of life care to enable more people to be supported in their usual place of residence where possible and appropriate.

The funding allocation continues to support social care maintenance, NHS commissioned out of hospital services, managing transfers of care and support actions/services that promote timely patient flow through hospital and back into community settings as well as support for unpaid carers and working closely with the voluntary sector to build capacity in the community.

Workforce challenges have been present for some time and have been exacerbated by Brexit and the pandemic, so we continue to try and find innovative ways to recruit and to retain and value our existing workforce.

Governance

The overarching plan for Merton is our Health and Care Plan, with the BCF a key enabler of this, so the initiatives and services funded through the BCF reflect the priorities agreed within the Health and Care Plan. The engagement surrounding this

has been highlighted in section 1 of this plan and this is alongside the multi-agency work that takes place through local Emergency Care Delivery Boards, Transformation Boards and the programmes of work underneath this to support the delivery of the aims and objectives of the Better Care Fund.

Discussions have taken place across the relevant agencies in order to draw up these plans and before final submission, the BCF Plan will be presented and approved at the Senior Management Teams of both the SWL Integrated Care Board (Merton and Wandsworth place) and London Borough of Merton, at the newly formed Merton Health and Care Committee and at The Health and Wellbeing Board on Tuesday 20th September 2022.

In addition to the governance described above to align the BCF with local priorities, the BCF Plans are monitored and reviewed at the BCF and Section 75 Review Meetings, where the CCG and London Borough of Merton are key representatives. The Assistant Director for Commissioning in the Department has oversight of the HIA commissioning process and is the strategic lead for BCF. Director of Community and Housing oversees Social Services and Housing, and this enables closer alignment of goals and close working between social care and housing, including the DFG in both the development of plans and in every day working e.g. in supporting discharges.

This is also where there is oversight of the incorporation of the BCF into the Section 75 agreement. As we develop plans going into 2023-25, Merton Health and Care Partnership will be increasingly important in building our future BCF Plans around the Integrated Care System priorities and aspirations as this includes key stakeholders from across all local organisations.

Overall Approach to Integration

After talking to our community in Merton, we have collectively refreshed our vision to: 'Working together to reduce inequalities and provide truly joined up health and care services with and for all people in Merton, so they start, live and age well in a healthy place'

The priorities initially with Merton's Health and Care Plan were to have Integrated Health and Social Care. This has been updated now to reflect the work already undertaken and to enable a focus on supporting older people to access community resources, improve access to and information on integrated services and being more focussed on frailty.

The workstreams in place to achieve this involve multi agencies and for 22/23 include:

Proactive and preventative services, Integrated Locality Teams, providing proactive care for those at highest risk by providing personalised care and support in people's own homes, priorities for this include building on online resources so there is a greater understanding of the work of the teams and to expand the support as part of

the anticipatory care work to other potentially lower risk cohorts. BCF funding includes:

- A wide range of services from Central London Community Health, our community provider.
- Full year funding now allocated to the increase in capacity within the Health Liaison Social Work Team that started in 21/22
- Continuance of Age UK living well co-ordinators and Alzheimer's Society co-ordinators linked to PCNs
- Continued support for the most vulnerable through the Community Response Hub
- Improved response to crises and more effective reablement- working with the expanded rapid response service to respond to crises and work more closely across health and social care offers, including use of 24-hour care for short periods if required (linking to virtual wards as appropriate).
- Increasing the capacity within social work and significant recruitment to the reablement team which includes support for admission prevention.

Co-ordinate My Care has now been replaced by the Urgent Care Plan. Whilst a huge amount of work has taken place to ensure the successful transfer, changing practice across multiple agencies and individuals takes time; in the longer term this will be a key tool to support cross agency information sharing.

Improving discharges with improved joint pathways with integrated teams enabling faster discharges from hospital with the full implementation of discharge to assess and the focus on increased access to reablement alongside domiciliary packages of care where required.

The aim is to continue to build on this in 22/23 and maintain the flow within the challenges of increased pressures and workforce challenges.

- Funding Intermediate Care provision, working on home first models through increases in rehabilitation and reablement (linked to discharge to assess) to enable faster discharges from hospital- work has started on a redesign of these services which should enable a more integrated and cost- effective model
- Increase capacity over 7 days and for community equipment
- Daily discharge discussions and escalation meetings to support patients to be as independent as possible.

Support for the most frail and those with the highest need for services –

- Integrated working across agencies to support improved quality of care and reduce unnecessary admissions to hospital by offering enhanced support to care homes including a care home support team which is now in place.

Implementing the BCF Policy Objectives

Merton's overall approach to enabling people to stay well, safe and independent at home for longer and provide the right care in the right place at the right time is:

- to support older people to access community resources, e.g., through the continuation of the Community Response Hub funded through the BCF.
- Work with the voluntary and community sector partners to expand personalised care approaches, reflected in the prospectus of community partners funding, supported via BCF.
- Jointly designing services to enable people to receive support at home where appropriate e.g. virtual ward.
- The use and further development of Integrated Locality Teams that provide holistic and personalised support to those most of risk and expand the cohort of people to benefit (through the anticipatory care work) from this multi-agency, multi-disciplinary approach utilising/ providing input across primary, community, social and voluntary sector services as needed. These teams are PCN based and wrap around the needs of the person.
- Merton is addressing health inequalities in a range of ways including use of population health management to enable a focus, both at place and at PCN level and a series of workshops focusing on use of this approach to support those with frailty are about to take place.
- Develop a greater understanding of why people are admitted to hospital and what more we may be able to do at the front door of hospital to avoid unnecessary admissions and where needed, provide greater support at home.

Supporting timely discharges is a key element of the BCF. We held a local workshop with key strategic partners with the aim of improving proactive discharge planning across Merton and Wandsworth, and pathways with a view to bring together a programme of work that will review existing pathways and look at opportunities to support integration across partner organisations where appropriate, reviewing our position locally against the High Impact Change Model. A number of initiatives have emerged from this work which will be developed throughout 2022/23 which will assist with implementation of the 10 best practice initiatives as detailed in the 100-day challenge and the delivery of the high impact change model. Locally we are benchmarking our system against these initiatives and will work towards implementation by 30th September 2022 in preparation for anticipated Winter Pressures. Improvements have already been made with the Transfer of Care (TOC) team at St Georges which has seen an improvement in the discharge processes and a reduction to some of the delays in the system. We continue to work together across the system to create more joined up services and enable people to receive the right care, in the right place as timely as possible.

Changes have also been made to the discharge and escalation calls to support reducing length of stay and patient flow and review of practice will continue in order to ensure the multi-agency teams are working most effectively together. There are

weekly strategic system partners meetings to understand and address discharge delay themes. Capacity and system resilience reporting is shared with all partners is in place to better understand capacity against demand to improve management of flow and priorities include ensuring there is a consistent approach to this across 7 days and what more all agencies can do to support avoiding unnecessary hospital admissions.

The discharge work programme will form a key element of our newly formed transformation structures, to improve pathway definitions and understanding across partners, as well reconciling the number of patients flowing through pathways recording by respective organisations through the work being undertaken to better understand demand and capacity requirements within intermediate care.

A significant transformation piece has started across Merton and Wandsworth review intermediate care and look at the opportunities for providing more home-based support so the requirement to submit capacity and demand for intermediate care services is very timely and will be reviewed by the Intermediate Care Task and Finish Group. This, along with the other developments including Virtual ward described in the executive summary, will report into a newly formed Hospital and Community Transformation Programme Board which will oversee delivery of the wider transformation schemes, with Merton Health and Care Partnership overseeing those specific to Merton.

Supporting Unpaid Carers in Merton

Merton Carer Strategy 2021-2026 was approved by Merton's Health and Wellbeing Board in 2020. In the first year of the strategy, 11 priorities were highlighted. Four multi-agency subgroups have been established, aligning to the 4 key themes of the Strategy shown below:

Journey to date.

Identification, Recognition, and Contribution
The aim is to improving identification in General Practice by revising the Carer Premium Specification and establishing quarterly monitoring for carers information.

Workshops have taken place to map current statutory duties and carer pathways best practice shared guidance shared with staff to support carers of adults. Carers information is currently being updated across all key local websites (including GP practices, Council, Health services, MH Trust and other partner websites).

Health, and Wellbeing of Carers
There is a plan to implement Carers Cards in partnership with Carers Support Merton and SWL and St George's Mental Health Trust. Promotion of carers emergency/contingency plans continues with
Merton one of six pilots nationally to improve the integration of carers contingency plans and how they are shared with health, care and voluntary sector partners. Findings will inform ICS approach going forward.

Realise and release potential
There are a range of schemes to improve services for carers. They include:

- new arrangements for carers parking permits and Direct Payment processes.
- Health and Wellbeing Activities for Carers,
- Co -produced carer health questionnaire to prioritise carers health needs which is being piloted
- General Health and Wellbeing services now including specific information on carers (e.g. One You Merton-self-care for carers).
- As part of the new Health on the High Street Programme, mapping the current health and wellbeing activities for carers in Merton.
- Supporting carers to develop their digital skills and a good understanding between partners of the current offer and pathways e.g. Merton Mencap have created a video for carers that explains how technology supports day-to-day life.
- Mapping all local offer for carers to support with their caring role and to access work

A life alongside caring

- Involving carers in the co-production and monitoring of services that have an impact on them.
- Developed and circulated a key messages poster to all providers A break from caring and mapping the offer short breaks offer in Merton, and ensuring all new information is accessible.
- Reviewing how volunteers can support carers through volunteering schemes such as befriending and side by side project.
- Reviewing and promoting the use of Carers Discretionary Grants for carers of adults (£200pa, or more in cases of financial hardship) linked as an outcome of a carers assessment.

As well as funding an extensive range of services that support people in their own homes, the BCF supports this work through a variety of schemes including support for the Alzheimer's Society and the Dementia Hub in Merton to support those with Dementia and their carers, funding to support Carers Support Merton, through funding night sitting services from Marie Curie and by contributing to the Ageing Well Programme which invests in and supports Merton's local voluntary and community

infrastructure, bringing together preventative services that provide information, advice and support in the community to strengthen Merton resident's physical, social, emotional, and economic resilience and works to address inequalities within our borough.

Disabled Facilities Grant

The Disabled Facilities Grant is a key enabler to support people to remain in their own home and supports our Home First discharge model. Adaptations are supported in line with the borough policy and commissioned through a Home Improvement Agency. That contract is in the process of being recommissioned and alongside that process we will be working to further improve how we can work collaboratively as a system to help ensure that the right adaptation solutions are implemented in a timely fashion to support individuals. Our aim is to implement a wide-ranging service, providing information, advice, and support for people seeking assistance with disabled adaptations solutions. This will include providing information and advice on home improvements, energy efficiency and support to apply for grants and other funding.

We utilise the flexibilities to support other activity that helps people return and remain at home. In particular we use DFG funds to support Age UK Merton to provide a Hoarding Service. The service goes beyond deep cleans and making fit for return services, to provide a longer intervention to address the hoarding behaviour rather than just the immediate issues.

In Merton the Director of Community and Housing oversees Social Services and Housing and this enables closer alignment of goals and close working between social care and housing, including the DFG in both the development of plans and in every day working e.g. in supporting discharges. The Assistant Director for Commissioning in the Department has oversight of the HIA commissioning process and is the strategic lead for BCF.

LBM is a non-stock owning authority and therefore works with a range of social and private landlords to meet housing needs. We work closely with social landlords through a range of partnership structures to ensure that necessary property adaptations can be delivered in a timely way to facilitate discharge. Engagement with private landlords is managed on a case-by-case basis, reflecting the nature of the market. The Director of Adult Social Care (DASS) also has strategic and managerial responsibility for the Council's housing needs function and this helps ensure a joined up strategic approach to the use of the DFG.'

Equality and Health Inequalities

Work to reduce inequalities is a thread throughout the BCF Plan. We are working with the voluntary and community sector to support older people to re-engage with and access community resources for their health and wellbeing post Covid.

Continuing the Community Response Hub, alongside social prescribing and case management through the Integrated Locality Teams, we aim to ensure we have the services in place to deliver services to match people's needs to deliver person centred care. The JSNA is the core dataset that feeds our understanding but has been supplemented this year by other sources such as the Council's 'Your Merton' consultation, South London Listens and specifically commissioned feedback from ethnic minority and LD communities.

We know people in East Merton have worse health and shorter lives and existing health and social care inequalities have been amplified by COVID-19, so a range of services commissioned through BCF funding support those in most need in this area and where required across the borough. There are increasing number of people with complex needs and co-morbidities where programmes such as Integrated Locality Teams provide bespoke personalised proactive support to enable people to remain in the community where possible.

The model supporting home first principles enables more people to retain their independence and services aim to provide a personalised approach to support the individual's needs and help them access other services to support them.

Work is being undertaken at Merton place and within PCNs to utilise information through population health management to help focus our resources on those with greatest need and who may not currently access services and along the priority of those with frailty, look at how we can support CORE 20 plus 5 initiatives.

Areas of specific note include:

- The Community Response Hub which initially started in response to the COVID 19 pandemic but identified an ongoing need for independent advice and support.
- Living Well Service run by Age UK to improve physical and mental wellbeing
- Funding the voluntary sector to reduce factors that increase the likelihood of presentation to health or social care, including an enhanced lunch club offer, improving heating and insulation, supporting access to benefits and helping with small grants for energy, food and clothing.
- Reducing isolation especially amongst older men through our music workshops- Tuned In (A single has just been produced called Uptown Lockdown)
- Contribution to Social Prescribing, which has a particular focus on those areas and individuals where there is social complexity
- Funding to educate and empower individuals to manage their health and well being including Expert Patient Programmes
- Falls and other prevention initiatives including 'Merton Moves' and 'Happy and Active in Merton' linking with libraries around digital inclusion

Work to Reduce Inequalities through the Disabled Facilities Grant (DFG) includes:

- Hospital to home assistance and assistance with preventing admission or re-admission to hospital, e.g. blitz cleans, moving furniture and basic equipment e.g. bed/bedding.
- Relocation Assistance and Emergency Adaptations
- Dementia Friendly Aids and Adaptations Grant
- Helping Hand Service for Low Level Hazards
- Help with Energy Efficiency.

Daily discharge discussions and escalations meetings enable support best designed to minimise any unnecessary time in hospital and aim to maximise the independence of the individual.