Committee: Health and Wellbeing Board

Date:

Agenda item: Better Care Fund Plan (BCF) for 23-25

Wards: Merton

Subject:

Lead officer: Mark Creelman/John Morgan

Lead member: Councillor Peter McCabe

Forward Plan reference number:

Contact officer: Annette Bunka- Assistant Head of Transformation -Integrated Care (Merton)- SWL ICS/ Phil Howell - Interim Assistant Director of Commissioning- Adult Social Care, Integrated Care and Public Health-LBM

Recommendations:

A. ***To approve the submission of the attached Better Care Fund Plan for 23-25, that includes a narrative and a Better Care Fund 2023-25 Planning Template to NHS England by the deadline of 28th June 2023.***

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. Owned by the Health and Wellbeing Board (HWB), the Better Care Fund is a joint plan for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006). There is an annual requirement to submit a Better Care Fund Plan, this year a two year plan has been requested. The Plan is made up of a narrative document along with a planning template that details schemes and services to be funded; financial allocations against each scheme / service; and planned performance against a number of key performance indicators. The submission this year as in last year also requires completion of a demand and capacity template for intermediate care, included in the pack. A slide deck summarising the key elements of the returns is included in the papers.

2 BACKGROUND

2.1. Introduced in 2015, the Better Care Fund Programme is one of the government's national vehicles for driving health and social care integration. It established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:

- minimum allocation from NHS
- disabled facilities grant – local authority grant
- social care funding (improved BCF) – local authority grant
- Adult Social Care Discharge Fund (introduced in November 2022, with an allocation for both local authority and ICB)

3 DETAILS

3.1. Please refer to the presentation slides for an overview and the detailed BCF reports.

4 ALTERNATIVE OPTIONS

4.1. Not applicable as an NHSE requirement

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The BCF aligns with the Merton Health and Care Together Programme and engagement has taken place regarding this. Details are included in the narrative report. Where any significant changes are under consideration, an engagement process would be included as part of this. Discussion has started across Merton and Wandsworth regarding the use of care home beds for bedded rehabilitation, which are funded from the BCF. Further work will take place and a separate process is being set up for this which is outside of the scope of these papers.

6 TIMETABLE

2023-2025

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. The core Better Care Fund allocation (the minimum NHS contribution) has been uplifted by 5.66%. This uplift has been used to cover increases in staffing costs and other initiatives detailed in the slide pack and template. Whilst this is a 2 year plan, the financial figures included for 24/25 are a proxy and will be updated once budgets have been confirmed.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. The Better Care Fund is underpinned by an agreement made pursuant to section 75 of the NHS Act (2006). The agreement for 2022/23 is in the process of being sealed, and the agreement for 2023/25 is in progress.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The work being undertaken through the Better Care Fund to reduce health inequalities is described within the narrative, in particular from page 20 onwards and also summarised in the slide pack.

10 CRIME AND DISORDER IMPLICATIONS

10.1. Not applicable

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. Were the plan not to be submitted, or the submitted plan not to be agreed by the DHSC there is a risk that allocated funding for the core (NHS minimum contribution) element could be clawed back. This risk is deemed to be extremely low in terms of likelihood.

12 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix A: Summary Slide Deck

Appendix B: Better Care Fund Narrative

Appendix C: Better Care Fund 2023/25 Planning Template

13 BACKGROUND PAPERS

13.1. 2023 to 2025 Better Care Fund policy framework - GOV.UK (www.gov.uk)

Merton
South West London Integrated Care System

Merton Better Care Fund

Plan for 23-25
Merton Health and Wellbeing Board
27.06.23
Phil Howell and Annette Bunka

What is the Better Care Fund?

- National policy framework
- Local single pooled budget to incentivise the NHS and local government to work more closely
- Placing well-being as the focus of health and care services
- A mechanism for joint health, housing and social care planning and commissioning
- Brings together ring-fenced budgets from Integrated Care Boards (ICBs) and local government including some specific funding

BCF Funding 23/25

BCF funding contributions	2022/23 (£)	2023/24 (£)	2024/25(£) *Proxy
Minimum NHS contribution	15,057,573	15,909,832	16,810,328
Improved Better Care Fund (iBCF)	5,009,679	5,009,679	5,009,679
Disabled Facilities Grant (DFG)	1,452,224	1,452,224	1,452,224
Total	**21,519,476**	**22,371,735**	**23,272,231**
Adult Social Care Disharge Fund			
Merton LA	623,258	702,349	1,165,900
SWLICB -Merton Place	850,780	850,780	1,412,295
Overall Total	**22,993,514**	**23,924,864**	**25,850,426**

BCF – National Objectives and Conditions

Merton South West London Integrated Care System

The **national objectives for the BCF** remain the same as 2022-23 and are to:

- i. Enable people to stay well, safe and independent at home for longer.
- ii. Provide the right care in the right place at the right time.

National conditions (that all plans must meet- these have been updated for 23-25)

- A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
- Plans to set out how the services the area commissions will support people to remain independent for longer and, where possible, support them to remain in their own home.
- Plans to set out how services the area commissions will support people to receive the right care in the right place at the right time.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution to the BCF.

Metrics for 23-24

Metric 23/24	Proposed Ambition
Reduction in Ambulatory Care Sensitive Conditions Admitted to Hospital	Modest reduction from 22/23 actuals, to reflect increase in the use of virtual ward from community referrals and increased use of Rapid Repsonse.
Reduction in Falls admissions (New)	Modest reduction to reflect an increase in initiatives particularly in care homes but also in developing a closer working relationship with falls prevention partners.
Discharge to usual place of residence	In line with 22/23 actuals, as hospital pressures continue.
Residential Admissions -Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	The estimated rates for 22/23 indicate this target would not met, so a modest decrease compared to estimated outturn has been put forward for 23/24, as more complex and frailer patients are being discharged.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Increase in this percentage proposed to reflect an improving trend.

Also included in the submission is a detailed demand and capacity analysis for intermediate care, the completion (not content) is a requirement of the submission.

BCF – Local Plans and Priorities

Merton South West London Integrated Care System

The key priorities for integration within 2023/25 BCF Plan mirror the Merton Health and Care Together Programme and build on previous BCF Plans:

- Continued development of **proactive care**, multi-agency working across health and social care to support the vulnerable in their own homes – **Integrated Locality Teams**, closer working with voluntary sector to build capacity and provide support for unpaid carers
- Improved flow from hospital to the community and **integrated intermediate care** (building on home first, virtual wards, recruitment drives in reablement and to support social care maintenance.)
- **Rapid response services** and **enhanced support to care homes**
- Work to **reduce inequalities** (including Community Response Hub, Living Well Services run by Age UK)
- **Disabled Facilities Grant** to support these initiatives.

As part of this plan, linking to the reprovision of community services, there is a chance to look at opportunities for more joint working and closer integration, with a focus on the services that have the greatest impact.

Appendix 1 provides further details of where the funding is spent.

Use of BCF Uplift

Merton South West London Integrated Care System

One of the BCF conditions is that the NHS need to maintain the uplift to Social Care of 5.66% for 23/24 and 24/25.

Alongside cost of living uplifts for some of the existing schemes, the proposals for areas for investment which will be developed further during 23/24 are:

Proposals	2023/24	2024/25* proxy funding
Increase in community equipment budget to meet demand	£110,000	£173,360
Dementia support for hospital admission avoidance, through developing the befriending, respite etc offer.	£37,614	£80,000
Carers services and prevention	£20,000	£50,000
Data reporting and information analysis - It is evident there is a lot more data processing, return completion etc for BCF and ASC discharge fund and this requires capacity.	£40,000	£50,000
Integration transformation support	£30,000	£70,000

ASC –Discharge Fund

Merton South West London Integrated Care System

The funding is focused on achieving the maximum reduction in delayed discharges, with a focus on *a 'home first' approach and discharge to assess (D2A),* with the proposals for investment below. These will be subject to development/review in 23/24.

Schemes	23/24	24/25*Proxy funding
Rapid response/quick start reablement	£218,000	£361,880
Additional social work staffing to support discharge and to in reach into the Transfer of Care (TOC) team	£476,000	£790,160
Carer liaison in hospital to support discharges	£167,000	£277,220
Age UK help at home service	£177,000	£293,820
Handy person & Telecare	£141,000	£173,982
Dementia and nursing beds and 1:1 support in care homes	£310,321	£515,133
Additional community equipment	£100,000	£166,000
Total	**£1,589,321**	**£2,578,195**

Section 75 Agreement

Merton South West London Integrated Care System

- Agreement between local authorities and NHS bodies and can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner/s.
- Pooled budgets combine funds from Local Authority and Integrated Care Board (ICBs) to enable them to fund integrated services.
- Since the introduction of the Better Care Fund in 2015, NHS and local authorities have been required to operate a pooled budget via a section 75 agreement
- Agreements will cover the following areas:-
    - Duration
    - Risk Share
    - Dispute Resolution
    - Governance

Appendix A

Integrated Locality Teams and Proactive Care

Merton South West London Integrated Care System

Multi-disciplinary working across health and social care across Merton responsible providing integrated, person-centred, proactive care for complex patients at high risk of admission, those with severe frailty and those who are in the last year of life.

The BCF contributes to:

- The locality based community teams, made up of nurses (including case managers, care navigators, dementia specialist nurses, end of life care nursing)
- 6 health liaison social workers
- Voluntary sector services, including Dementia Hub, Carers Support, falls and other prevention initiatives
- Telecare through MASCOT
- Living Well Service run by Age UK to improve physical and mental wellbeing
- Community Response Hub which initially started in response to the COVID 19 pandemic, but identified an ongoing need for independent advice and support
- New in 23/24- Further support for Dementia and Carers

Improving Flow from Hospital to Community, Integrated Intermediate Care & Rapid Response

Merton South West London Integrated Care System

Single Point of Access (SPA) in place for Discharge to Assess and for Intermediate Care to support people home from hospital sooner. Daily discharge discussions and escalation meetings to support patients to be as independent as possible.

The BCF contributes to:

- Reablement services (with increases in provision to support evenings, weekends and admission avoidance)
- Home and bed based rehabilitation
- Integrated domiciliary packages of care, including temporary funding for 12/24 hr care if needed
- Rapid Response (which has recently expanded through funding from Ageing Well monies) offering rapid two hour response to prevent admission to hospital and work to provide a single seamless service if social care required
- In reach nurses at St George's to help with admission avoidance and complex discharges
- Community Equipment (ICES)
- 7 day working

Work to Reduce Inequalities

Merton South West London Integrated Care System

- Community Response Hub providing 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 was produced called Uptown Lockdown)
- Contribution to Social Prescribing, which has a particular focus on those areas and individuals where there is social complexity.
- Falls and other prevention initiatives including 'Merton Moves' and 'Get up and Go' Project which is a programme of physical activity available to residents and patients in East Merton and Morden PCN areas to address mild frailty, with a focus on strength and balance activities.

Through the Disabled Facilities Grant (DFG):

- 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

Better Care Fund 2023 - 2025

Narrative Plan

London Borough of Merton

Version control	
No	5
Date	15 June 2023

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 2023/25. The submission also includes as it did last year, 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 supported by Merton Health and Care Together Committee Meeting, the Merton place committee. It 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- the GP Federation, Merton Connected – Merton's Voluntary Sector Committee and representation from Primary Care Networks.

The Better Care Fund Plan is built on the refresh of Merton's Health and Care Plan and the draft South West London Joint Forward Plan, both of which have been developed with significant community engagement, with workshops 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 from a wide variety of resources. More recent engagement has taken place in the development of the Joint Forward Plan to supplement this.

In Merton, the Departments have recently changed from Community and Housing overseeing social services and housing to Adult Social Care, Integrated Care and Public Health. This reflects the importance of integration and prevention within Merton's goals, whilst still making use of the historical alignment with housing, and the work of 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.

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

How Have Stakeholders Been Involved?

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. These organization come together to form 'Merton Health and Care Together'. The pandemic brought us even closer together and accelerated system learning and now as a team to lead Merton in the South West London Integrated Care System (ICS).

Through the Merton Health and Care Together, providers and commissioners in Merton work together to identify and lead transformational change across the system to improve health and social care outcomes for the people of Merton.

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) was 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 the emerging South West London Joint Forward Plan, local Emergency Care Delivery Boards, Transformation Boards and the programmes of work underneath these to support the delivery of the aims and objectives of the Better Care Fund.

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 presented at specific meetings including at the Officers Meeting of the SWL Integrated Care Board (Merton and Wandsworth place), the Management Team at the London Borough of Merton and Merton and Wandsworth Hospital & Community Transformation Programme Board. The governance approval process is for the plan to be presented and supported at Merton Health and Care Together Committee, Merton's place based committee and final sign off at The Health and Wellbeing Board on Tuesday 28th June 2023.

Merton Health and Care Together Committee comprises a wide range of partners including SWL ICB, London Borough of Merton, 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- the GP Federation, Merton Connected – Merton's Voluntary Sector Committee and representation from Primary Care Networks. The governance for the ICB is currently being reviewed, currently the meetings where the BCF Plan has been discussed and detailed above, all report into the Place Based Committee.

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. This is also where there is oversight of the incorporation of the BCF into the Section 75 agreement.

In Merton, the Departments have recently changed from Community and Housing overseeing social services and housing to Adult Social Care, Integrated Care and Public Health. This reflects the importance of integration and prevention within Merton's goals, whilst still making use of the historical alignment with housing, and the work of 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.

In developing and implementing the plans for 2023-25, Merton Health and Care Partnership and the Hospital and Community Transformation Board are increasingly important developing the BCF plan and ensuring these plans are implemented and ensuring the involvement of key stakeholders from across all local organisations.

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. This has resulted in a system under pressure and a number of workforce challenges, particularly the ability to recruit and retain staff.

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. Improvements have already been made with the Transfer of Care (TOC) team at St Georges. This has included further recruitment which has resulted in 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.

A successful Hospital at Home/Virtual ward pilot programme has been established across Merton and Wandsworth 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. We view this 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 expanded the pilot programme increasing service to take up to 80 beds and accepting referrals from both hospital and the community. By March 2023 the service had seen 493 patients across the service, providing a seven-day service delivered by a multidisciplinary team which includes Consultant GPs, ANPs, Nurses, and Pharmacists. Early evaluations of the service indicate that there have been approximately 3000 bed days saved based on comparison data around average length of stay in the local hospital. In January 2023, the central remote monitoring service started which looks at optimising patients through the use of a technology enabled service.

We continue to review and develop our local service model alongside those in other areas of South West London, and are developing innovation pilots to look at how the service can interface with our acute trust as well as the remote monitoring hub.

The Health and Care Plan sets out how Merton is 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.

Through our Ageing Well Programme we continue to work to develop integrated services that provide proactive and preventative care, provide urgent response and intermediate services when required to support admission avoidance and support more effective discharges as well as support the delivery of high quality services for those with frailty, dementia and end of life, striving to keep people independent either in their own home or within a care setting.

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.

Work has started on a redesign of the intermediate care services which should enable a more integrated and cost- effective model. Analysis from our existing services show that more patients could be given rehabilitation and support in their own homes rather than in bed-based rehabilitation facilities. Pilots have started in Wandsworth with St George’s enhancing the therapy offer at our hospital based rehabilitation beds in order to enable people to return home sooner which we hope to learn from in Merton.

A review of community services is also being undertaken in Merton, with a particular focus on the current provision delivered through our community contract with Central London Community Healthcare NHS Trust that is jointly commissioned by the ICB and London Borough of Merton. This will run alongside the discussions regarding the Better Care Fund development for 24/25 but are unlikely to be fully enacted until 25/26.

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.

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 have taken place, where we are reviewing how we can best make use of population management techniques to provide support to those who most need it, but who may not easily access care.

We continue to support unpaid carers in Merton, and as well as the ongoing implementation of the Carers Strategy, we have two further schemes being

developed in 23/24 to provide advice and support for carers and those with dementia, including expansion of befriending and respite support.

The DFG funding and the BCF overall to support the reduction of inequalities, developing pilots through use of Population Health Management and through Innovation and Inequalities Funding.

Further details are contained in the document below.

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, including extensive recruitment programmes oversees and training modules to ‘grow our own’ workforce.

National Condition 1: 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 age well priorities within Merton's Health and Care Plan focus on frailty, on supporting older people to access community resources as well as improving access to and information on integrated services.

As part of the South West London Joint Forward Plan, the focus is to:

- Prevent ill health and support people to self-care
- Reduce health inequalities
- Keep people well and out of hospital
- Provide the best care wherever patients are accessing our services
- Use technology to improve care
- Manage our money
- Make South West London a great place to work
- Deliver the NHS' requirements of the Integrated Care Partnership Strategy.

Across South West London, it has been agreed that a review of each of the BCFs be undertaken. This process has started and will be an opportunity to look at closer integration and further areas for joint working, with a focus on services that have the greatest impact. This will feed into broader discussions regarding integration across services within the ICS.

A review of community services is also being undertaken in Merton, with a particular focus on the current provision delivered through our community contract with Central London Community Healthcare NHS Trust that is jointly commissioned by the ICB and London Borough of Merton.

Leaders across health and social care in Merton hold a shared vision of a more locally focused, person-centred model of care rooted in prevention, health improvement, self-care and earlier interventions for the residents of Merton, so the reprovision of community services is an opportunity for Merton to address this and enable further integration across physical and mental health and social care. It presents the opportunity, through collaboration, to address long standing inequalities and incorporate the wider determinants of health and wellbeing as well as an opportunity to engage the wider community; creating the conditions for voluntary sector and other partners to play key role in health and social care delivery fully utilising Merton's community assets, developing and delivering a model that reflects the key priorities of community care both nationally and locally.

Through our Ageing Well Programme we continue to work to develop integrated services that provide proactive and preventative care, provide urgent response and

intermediate services when required to support admission avoidance and support more effective discharges as well as support the delivery of high quality services for those with frailty, dementia and end of life, striving to keep people independent either in their own home or within a care setting.

Key areas include proactive care 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, including those who make up the locality-based community teams (e.g. district nurses, case managers, care navigators, dementia specialist nurses, end of life care nursing);
- Health Liaison Social Workers aligned to PCNs;
- Age UK living well co-ordinators and Alzheimer's Society co-ordinators linked to PCNs as well as other voluntary sector services to support independence;
- Telecare through MASCOT
- 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.
- 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.

Alongside the broader development of community services, we will be building on our Integrated Locality Teams to develop Neighbourhood Teams in line with the Fuller Report, increase use of the Universal Care Plan (UCPs) as a key tool to support cross agency information sharing and through Population Health Management, target particular interventions of those of greatest need. Discussions have started and Merton feels it is in a good place with the relationships and teams already established. We have been piloting innovative ways to enhance our Integrated Locality Teams through PCN led initiatives. These include PCN led MDTs as opposed to practice-based MDTs which are the current model. These will be reviewed to enable learning to be spread across the borough. More work is being undertaken to increase the development and use of UCPs to support people's wishes and share appropriate information to support them to receive the right care.

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.

Single Point of Access (SPA) in place for Discharge to Assess and for Intermediate Care to support people home from hospital sooner. Daily discharge discussions and escalation meetings to support patients to be as independent as possible.

The aim is to continue to build on this in 23/25 and maintain the flow within the challenges of increased pressures and workforce challenges.

The BCF contributes to:

- Funding Intermediate Care, both home and bed-based provision, working on home first models through increases in rehabilitation and reablement (linked to discharge to assess) to enable faster discharges from hospital
- Increased capacity over 7 days
- Integrated domiciliary packages of care, including temporary funding for 12/24 hr care if needed
- Meeting the increases in demand for community equipment
- Daily discharge discussions and escalation meetings to support patients to be as independent as possible with in reach nurses to support complex discharges.

Work has started on a redesign of the intermediate care services which should enable a more integrated and cost- effective model. Pilots have started in Wandsworth which we hope to learn from in Merton.

The subsequent sections describe in more detail the specific workstreams in place to provide proactive and preventative care, enabling more people to stay well, safe and independent at home for longer and where support is needed, receive the right care, in the right place, at the right time, whether they are in their own home or a care home. It also includes the work developing population health management to support the reduction of health inequalities and how the BCF is used to fund these areas.

Implementing the BCF Policy Objectives

National Condition 2: Enabling people to stay well, safe and independent at home for longer

The Health and Care Plan sets out how Merton is 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.

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 by

providing a range of initiatives to support people in the community and where possible, in their usual place of residence. These include:

- Support for people to access community resources so people get the support they need in the community, e.g., through the continuation of the Community Response Hub funded through the BCF. This connects people who may be struggling financially, or are feeling lonely, isolated or worried about their mental health as well as those trying to stay independent at home or get more active by putting them in touch with support to help them in the community. The Hub supported over 2000 people in 22/23 with support ranging from signposting to referrals for services and further support. Finances, debt and food support form a large part of the initial enquiries.
- Work with the voluntary and community sector partners to expand personalised care approaches, reflected in the prospectus of community partners funding, now called Civic Pride, supported via BCF. This supports the voluntary and community sector programme, aiming to bring together wider funding opportunities to ensure that support is available for all Merton residents. It aims to:
    - invest in and support Merton's local voluntary and community infrastructure.
    - nurture a strong sense of community and reduce inequalities
    - bring together preventative services that provide information, advice and support in the community to strengthen Merton resident's physical, social, emotional, and economic resilience
- This also includes support towards asset-based approaches including social prescribing and Expert Patient Programmes (EPP) as well as support for carers. EPP is a free course for adults living with a long-term health condition or caring for someone with a long term condition with the aim of improving their health and wellbeing by developing and learning new skills.
- 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 (ILTs) that provide holistic and personalised support to those most of risk and by providing proactive care 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 in their own home and help them to remain independent. The BCF supports the funding of these multi agency teams, including health liaison social workers, case managers and community nursing, co-ordinators and the voluntary sector to provide support in the community to these vulnerable patients. These teams form the building blocks of the work being undertaken to develop neighbourhood teams in line with the Fuller Report recommendations. Development work has included developing an online resource detailing the roles and responsibilities of each of the partners in the ILTs that is accessible across all organisations to

support new members of staff who join to help them understand the role of the respective partners and having a joint resource help them develop as a team.

Population Health Management

The ICS is a data driven system that tackles inequalities, improves population outcomes and drives up productivity, supporting social and economic development, with Merton very much in the centre of this work.

Part of this includes an aligned approach to improving population health and use the increasingly rich data available to target those in our communities with the greatest need, to focus more on prevention and population health improvement, using a Population Health Management (PHM) approach. PHM is a methodology, to help frontline teams and system planners understand current health and care needs and predict what residents will need in the future. It involves analysing data and using that intelligence to identify population cohorts (or segments) to allocate resources to those with the greatest need and where interventions will add most value.

Working as a system, our health and care services are working together to design new proactive models of care which will improve health and wellbeing today as well as in the future. This means we can tailor better care and support for individuals, co-produce and design more joined-up and personalised care with our communities (patient segments or identified cohorts) and make better use of public resources for example the development of integrated multi-disciplinary neighbourhood teams (Fuller Stocktake).

In SWL we have Health Insights available as our data/analytics platform, which has been built using Microsoft Power BI and this presents data from various sources using interactive dashboards. We also have a SWL BI/Analytics team who can provide more sophisticated data and analytics functions, as well as create new bespoke dashboards to support our work programmes.

In SWL we have been building our PHM capability. In 2021 we took part in PHM Development Programme which enabled us to set up population health management pilots to look at the data and information together to give us valuable insights in a digested format, which helped us to identify nearly 7,000 people, in either primary care networks (PCNs) or in our places across SWL and together create and design interventions that helped to improve agreed outcomes. During 2022, we engaged with our partners from across South West London to listen and identify examples of good practice, valuable resources, and appetite to use PHM, capturing the variety of development needs. This included ICS partners from PCNs, local authority and borough partners, NHS acute and community services and provider collaboratives and mental health trusts. This stocktake enabled us to set out the steps we need to

take together to create the capability and capacity to use our collective resources more effectively, to add most value to our population and tackle inequity.

As part of this we have worked with our health and care partners to develop and publish the South West London Population Health Management PHM Roadmap, which outlines the steps, recommendations and interdependencies for PHM in SWL.

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 have taken place, where we are reviewing how we can best make use of population management techniques to provide support to those who most need it, but who may not easily access care.

To enable more people to maintain their independence for longer, 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 are looking at ways 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, including updating of information to support people to Age Well 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.

Supporting Unpaid Carers in Merton

BCF funding supports an extensive range of services that support people in their caring roles. 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 Civic Pride Grants 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.

The Merton Carer Strategy 2021-2026 was approved by Merton's Health and Wellbeing Board in 2020. Under the Merton Carers Implementation Board, four multi-agency subgroups were established using four themes:

- *Identification, Recognition, and Contribution*
- *Health, and Wellbeing of Carers*
- *Realise and release potential*
- *A life alongside caring*

During 22/23 the work of these subgroups was reviewed and success celebrated. Following this, the Board recognised the need to realign some of the priorities to avoid duplication and to maximise effective use of resources. Task and finish groups have been developed to take forward key workstreams in the coming year.

Priorities include:

- updating the information on the London Borough of Merton website and other key local websites such as GP practices
- developing the Young Carers Implementation Plan following consultation with the Head of Family Support & Safeguarding and the Head of School Improvement and young carers themselves.
- Establishing an NHS Commitment to Carers Programme working group aligned with tasks in the Commitment to Carers Programme and GP Quality Markers to take forward key actions for health partners, including work to improve outcomes for patients and carers at hospital discharge
- Mapping the Carers of Adults Pathway and develop a standard operating procedure to help carers and staff to navigate the system, recognising the need for a focus on transition.

Intermediate Care Support in the Community.

The demand and capacity analysis for Intermediate care is included within the planning template for the second year. Learning from last year's submission has been helpful in drawing up the analysis for 23/24, even though some of the format has changed.

The key area where capacity was greater than demand was within the 2-hour Urgent Care Response Team, in spite of significant promotional work to increase referrals into the team. The promotional work continues into 23/24, but from the experience of last year, we have predicted there will still be less demand than there is capacity for this. Where this is the case, the team continue to support other less urgent response calls.

We have predicted an increase in capacity for rehabilitation at home as we start to implement new models of care in 23/24, moving away from bed based support and providing more home based support where possible.

Whilst the current modelling shows that demand is likely to outstrip capacity in some areas over the winter months, the BCF funding will be used flexibly in order to meet increases in demand.

Impact of schemes on metrics

A number of the schemes funded by the BCF to enable people to stay well, safe and independent at home for longer are described above in National Condition 1. In terms of the BCF metrics, reducing unplanned admissions for chronic ambulatory care sensitive conditions and reducing emergency admissions following a fall, there are a range of schemes supporting these aims including proactive care through Integrated Locality Teams and preventative services, providing personalised care and support in people's own homes.

Alongside the broader development of community services, we will be building on our Integrated Locality Teams to develop Neighbourhood Teams in line with the Fuller Report, increase use of the Universal Care Plan as a key tool to support cross agency information sharing and through Population Health Management, target particular interventions of those of greatest need. We have been piloting innovative ways to enhance our Integrated Locality Teams through PCN led initiatives. These will be reviewed to enable learning to be spread across the borough.

The BCF currently funds a number of prevention projects, two of which are aimed active ageing, reducing frailty and reducing risk of falls for Merton residents/patients. These include 'Merton Moves', which is a small scale but innovative coaching programme with Wimbledon Guild that provides older people with six weeks of support to engage in a new physical activity. Locally research previously commissioned highlighted a number of barriers older people may face to get involved in physical activity including incorrect perceptions from others or thinking exercise wasn't for them. This has been mirrored in case studies by Merton Moves that highlight older people's reticence to join mainstream classes and lack of confidence from some to join activities following Covid 19 lockdowns. The project supports/gives confidence and provides practical solutions to older people to join an activity, gives taster sessions at reduced costs and sessions across the borough including Mitcham and Morden. 105 people were supported and signed up to the Merton Moves pledge between March 22 to end of March 2023. The second project is called 'Get up and Go' Project. This is a programme of physical activity available to residents and patients in East Merton and Morden PCN areas to address mild frailty, with a focus on strength and balance activities. The programme has included physical activity classes, a small grant programme to community organisations and 'train the trainer' element. There are currently 9 classes running in Mitcham and 7 classes in Morden. Classes have been developed in collaboration with the community and voluntary sector and range from dance to seated pilates to boccia and new age kurling.

Two further schemes are being developed in 23/24 to provide advice and support for carers and those with dementia, including expansion of befriending and respite support.

Providing the right care, in the right place at the right time, in relation to supporting safe and timely discharge.

Supporting timely discharges is a key element of the BCF and a key priority for Merton. A local workshop with key strategic partners was held in 22/23 with the aim of improving proactive discharge planning across Merton and Wandsworth, and pathways to bring together a programme of work that will review existing pathways and look at opportunities to support integration across partner organisations where appropriate and reviewing our position locally against the High Impact Change Model.

Progress in implementing the High Impact Change Model for managing transfers of care

Merton has a Discharge Transformation programme, working alongside Wandsworth, which includes a review of the progress in achieving the High Impact Change Model.

A discharge task & finish group has been set up, which reports to the Hospital & Community Transformation Board. The group will have a greater focus on reviewing the progress against achieving the best practice discharge standards, set by NHS England, for acute, community and mental health areas. This will help to inform where there are areas for improvement, which are reflected in the High Impact Change Model.

Change 1: Early Discharge planning

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

- Case management releasing time for discharge case coordinators to focus on people discharged earlier in their journey.
- Early notification process being implemented (Social Work allocation, Key safes, amenities)
- Daily meetings with system partners moved to the afternoon for people on pathway 1 to prepare for next day discharge.

Change 2: Demand & Capacity

Demand and capacity monitoring is now shared across system partners using a modified RAG system to better understand system pressures and respond quickly through mutual aid with system partners. Home first and MDT working is in place with plans under development to review the current bed-based rehabilitation and increase to a more home-based approach to care delivery.

Change 3: Multidisciplinary working

Multi-disciplinary/multi-agency discharge teams, including the voluntary and community health and care sector; MDT teams through Hospital at Home/Virtual Ward and Integrated Locality Teams, MDTs support proactive care in people's own homes.

Change 4: Home First / Discharge-to-Assess.

Home first/discharge to assess – Enabling an established referral process via single-point of access, improving community support options in therapy and social care options. There are daily communications with the D2A team and TOC hub to better understand people's needs and to identify any information gaps. It is envisaged that even closer working is necessary to integrate these functions further.

Change 5: Flexible working patterns

Flexible working remains a priority for the system and the number of weekend discharges is improving but remains gaps in implementation across system partners.

Change 6: Trusted Assessment

Trusted assessment processes are to be revisited as part of the discharge task and finish group work with frontline staff across the system. As part of this group, housing partners will consider how to improve their links with discharge processes earlier in the process.

Change 7: Engagement and choice

Engagement and choice are key to any development. For example: with earlier discharge planning with people and their family commencing earlier in a hospital stay this would allow more time to consider their available choices. In terms of other engagement regarding service changes, this will be undertaken through the community and hospital transformation programme, as a public and patient engagement process is already in place to support the programme.

Change 8: Improved discharge to care homes.

Improving discharges back to care homes is in process through the full implementation of Enhanced Health in Care Homes initiatives including:

- A positive end-of-year review of the Enhanced Health in Care Homes Framework status, reflecting substantial progress in achieving the standards for older peoples care homes.
- Building relationships across the system and the Care Home Support Team.
- Improved use of Red bag and e Red bag.
- Use of NHS mail, and all care homes having one identified GP lead.
- Rolling out remote monitoring in care homes supported by training and set up in each home.

Change 9: Housing and related services

Detailed within ‘Disabled Facilities Grant (DFG) and wider services section.

A number of initiatives have emerged from this work which has included setting up a discharge sub-group with aims to:

- To review and refine the discharge pathways that they are jointly developed, with shared definitions and understanding of how they work, with clarity and how they apply to each cohort of patient.
- To agree a joined up and integrated care model for rehab, recovery and reablement, to refine how we best work together, not just in Merton and Wandsworth but across neighbouring boroughs too, based on embedding home first principles and working to discharge people to their usual place of residence where possible.
- Improved processes, interprofessional relationships & approaches in line with the high impact change model, and using themes from ‘Make a difference alerts’ and escalation calls to look for opportunities to address the issues within the transformation work.
- Identify actions to improve and streamline discharge performance and operational data
- Review and incorporate shared learning/best practice from other boroughs in our approach.

To support the next stage of this work a discharge summit is due to take place in June to consolidate the work that has taken place so far and work through the next priorities with a wide range of partners.

Work has also taken place across SW London to review discharge processes. The key outputs of this review include the development of A SWL Hospital Discharge Transformation Plan and a SWL Discharge Data Quality and Capture Improvement Plan, which will be used to help develop local plans and strategies.

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 forms 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.

We continue to work through and improve on our 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. This includes more innovative ways to highlight the 2 hour Urgent Care response services, use of the care home support team to reduce unnecessary emergency admissions from care homes and increase in the use of the Universal care Plans across the system. There have been recent improvements in the number of plans developed and those being viewed by London Ambulance Service and we will work with partners to continue these increases.

A significant transformation piece well underway across Merton and Wandsworth review intermediate care and look at the opportunities for providing more home-based support. This, along with the other developments including Virtual ward, I report into the Merton and Wandsworth Hospital and Community Transformation Programme Board which currently oversees the delivery of the wider transformation schemes, with Merton Health and Care Partnership overseeing those specific to Merton.

The additional discharge funding is being used for:

- Rapid response/quick start reablement
- Additional social work staffing to support discharge and to in reach into the Transfer of Care (TOC) team
- Carer liaison in hospital to support discharges
- Age UK help at home service
- Handy person & Telecare
- Dementia and nursing beds and 1:1 support in care homes
- Additional community equipment.

Intermediate Care in Supporting Discharges into the Community.

The demand and capacity analysis for Intermediate care is included within the planning template for the second year. Learning from last year's submission has been helpful in drawing up the analysis for 23/24, even though some of the format has changed.

We have predicted an increase in capacity for rehabilitation at home over the winter months as we start to implement new models of care in 23/24, moving away from bed based support and providing more home based support where possible.

Whilst the current modelling shows that demand is likely to outstrip capacity in some areas over the winter months, the BCF funding will be used flexibly in order to meet increases in demand.

In order to support the pressures of hospital flow, SWL re introduced the bed bureau over the winter of 22/23. It is not clear whether this will be deployed again for future winters.

A pilot funded via innovation funds is currently taking place to support patients out of hospital sooner. This will be evaluated in 23/24 to help inform the direction of travel and approach.

Discharge to Usual Place of Residence

This is detailed in 'Providing the right care, in the right place at the right time, in relation to supporting safe and timely discharge' section above.

With more complex and frailer patients presenting, the level of complexity on discharge has meant that an increased number of patients have required admission to residential care. The stretch target proposed for 22/23 was not achieved but we expect to broadly maintain the current position, by the further work being undertaken to support home first.

Supporting Unpaid Carers in Merton

BCF funding supports an extensive range of services that support people in their caring roles. 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 Civic Pride Grants 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. Details of the strategy work are included in section on national condition 2.

Priorities for 23/25 include:

- updating the information on the London Borough of Merton website and other key local websites such as GP practices
- developing the Young Carers Implementation Plan following consultation with the Head of Family Support & Safeguarding and the Head of School Improvement and young carers themselves.
- Establishing an NHS Commitment to Carers Programme working group aligned with tasks in the Commitment to Carers Programme and GP Quality Markers to take forward key actions for health partners, including work to improve outcomes for patients and carers at hospital discharge

- Mapping the Carers of Adults Pathway and develop a standard operating procedure to help carers and staff to navigate the system, recognising the need for a focus on transition.

Two further schemes are being developed in 23/24 to provide advice and support for carers and those with dementia, including expansion of befriending and respite support.

Work is also taking place to change how people can access services including:

- Pilot a Health on the High Street hub approach.
- Pilot an Ethnicity and Mental Health Improvement Project (EMHIP) hub in Merton.
- Empower the voluntary and community sector to re-engage older people with services as the community hub develops.
- Develop more options for people to personalise their care.
- Build on learning from the vaccination programme to reach all communities and promote all primary care services e.g. pharmacy, optometry.
- Develop new roles and approaches e.g. have mental health workers in each primary care network, working alongside health and wellbeing coaches.
- Better connect professionals across community multi-disciplinary teams.
- Continue the approach, taken during the pandemic, to work with communities and service users to understand voice and lived experience and co-create key messages and inform future plans.

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. Merton's Housing Assistance Policy sets out the flexibilities in the use of the DFG e.g. to enable support at a lower level of spend.

In Merton, the Departments have recently changed from Community and Housing overseeing social services and housing to Adult Social Care, Integrated Care and Public Health. This reflects the importance of integration and prevention within Merton' goals, whilst still making use of the historical alignment with housing, and the work of 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.

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.

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.

The feedback from the consultations concluded we need to listen to communities and people in Merton in their own spaces and environments to understand their health and wellbeing needs and invest in and empower them. What people have told us is that cultural sensitivity needs to be considered in all work we plan and deliver, and communities need to be part of this. Mental health and emotional wellbeing are vitally important across Start Well, Live Well and Age Well, and we must also consider the impact of Covid-19 on mental health. Prevention and early intervention are key, together with the social determinants of good health and wellbeing, eg employment, housing, finance and social networks. Improved information and communication about local services available is needed across the whole health, care and voluntary sector and efforts to raise awareness about how to access support. We must consider living and working environments, and how developing Merton as a healthy place can improve health and wellbeing. Regenerating high streets and making best use of green spaces is key. Across all our plans we aim to:

- Reduce health inequalities and embed equity.
- Use a population health management approach to drive change.
- Focus on sustainability and making Merton a healthy place.

- Engage with service users, patients and communities so all work is developed with and by people in Merton.

The section ‘ Implementation BCF Policy Objectives’ describes further details on how we will achieve this.

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. The analysis to date has been undertaken across South West London which has identified much of what we already know: people in East Merton have worse health and shorter lives and existing health and social care inequalities have been amplified by COVID-19. A range of services commissioned through BCF funding support those in most need in this area and where required across the borough, which are summarised below. 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. 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.

Further work using the CORE 20 plus 5 data will be undertaken at a local level to build on the work already being undertaken and we will build on learning from the vaccination programme to reach all communities and promote key services and ways to access support.

The population health management work also being undertaken (described in the National condition 2 section) also supports the reduction in inequalities.

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