Local Government Association

NHS England

Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1 PLAN DETAILS

(a) Summary of Plan

Local Authority	**London Borough of Merton**
Clinical Commissioning Groups	**Merton Clinical Commissioning Group**
Boundary Differences	**None significant**
Date agreed at Health and Well-Being Boardton:	**16 September 2014**
Date submitted:	**17 September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,428,000**
2015/16	**£12,198,000**
Total agreed value of pooled budget: 2014/15	**£7,848,000**
2015/16	**£12,198,000**

b) Authorisation and Sign-Off

Signed on behalf of the Clinical Commissioning Group	
By	Dr Howard Freeman
Position	Chairman of Merton CCG
Date	18 September 2014

Signed on behalf of the Council	
By	Simon Williams
Position	Director of Adult Social Services
Date	18 September 2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Caroline Cooper-Marbiah
Date	18 September 2014

(c) Related Documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Merton JSNA	http://www.merton.gov.uk/health-social-care/publichealth/jsna.htm
Merton JHWS	http://www.merton.gov.uk/democratic_services/w-agendas/w-fpreports/1222.pdf

2 VISION FOR HEALTH AND CARE SERVICES

(a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

1. Merton's Vision

The vision of Merton's Health and Wellbeing Board is to improve health and social care outcomes for the population of Merton by:

- Ensuring commissioned services are tailored to the needs of individual patients;
- Addressing the diverse health needs of Merton's population; and
- Reducing geographical, age and deprivation-related variation.

This vision is built around and evidenced by the Merton Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS), as set out below.

Ultimately our vision should deliver:
the right care, at the right time, in the right place with the right outcomes.

2. Merton's Objectives

Merton's Health and Wellbeing Board has agreed that the Better Care Fund Vision will be delivered through four principal objectives:

3. What informs the Vision?

The JSNA informs us that the population of Merton is young in comparison with the rest of England. Over 65 year-olds make up just under 12% of the population, which is projected to increase by 21% by 2021, although the numbers of 85 year-olds and over is set to rise by nearly 41%.

In 2011, 35% of the population were from BAME groups (Black, Asian and Minority Ethnic). The extent of ethnic diversity has increased markedly over the last 5-10 years with new emerging communities (particularly Polish, Urdu and Tamil) and is expected to rise over the next 10-20 years. The level of ethnic diversity across Merton is recognised to increase the complexity of delivering services in the following ways:

- Wider and diverse range of long-term conditions and complexity of need such as rates of smoking, obesity, ischemic heart disease and diabetes.
- Diverse needs with respect to accessing care and self-management resources, such as language and cultural barriers.
- Care that addresses cultural differences to care such as for mental health conditions including dementia.

Deprivation levels are low and residents have a higher life expectancy than the England average. For adults, levels of obesity, smoking and healthy eating are estimated to be better than the England average, although the estimated level of physical activity among adults is worse. There are however stark inequalities in health and lifestyle within Merton, for example, life expectancy for men living in the least deprived areas of the borough is almost nine years higher than for men living in the most deprived areas.

The difference for women is thirteen years. Circulatory disease and cancer are the top reasons for early death and, consequently, circulatory diseases (including stroke and cancer plus diabetes) are among the main causes of long-term illness and disability.

Since 2008, there has been an increase in unemployment with 7.8% of residents claiming out-of-work related benefits. This however does remain lower than London and England as a whole. In addition, where people live and the quality of their home has a substantial impact on their health, wellbeing and social outcomes, and there is a high level of housing needs amongst households in Merton.

In terms of geographical variation, Merton is broadly divided into two localities; East and West Merton, where there are significant variations in age, deprivation, care needs and subsequently life expectancy. In East Merton life expectancy is 9 years lower for males than in West Merton and for women, 13 years. In East Merton, the population is younger, but the needs of the population who are aged 50-65 years are rising. In West Merton, the population is more affluent but is ageing, with rising burden of long term conditions and complex needs. There is therefore a need to proactively identify or screen for and preventatively manage care needs and long term conditions as well as providing services to respond to crisis and exacerbations of conditions.

Merton's Health and Wellbeing Strategy has four broad objectives: giving every child a good start in life, enabling residents to live healthily, delivering services that offer choice and independence, and addressing the wider influencers of health such as housing and the environment. The Better Care Fund is especially concerned with the third of these areas but takes account of the whole strategy.

4. The South West London Five-Year Strategy

"People in south west London can access the right health services when and where they need them. Care is delivered by a suitably trained and experienced workforce, in the most appropriate setting with a positive experience for patients. Services are patient centred and integrated with social care, focus on health promotion and encourage people to take ownership of their health. Services are high quality but also affordable."

In June 2014, the six south west London CCGs submitted their 5 year strategy for health services across south west London. This strategy, which is the culmination of joint working since January 2014, seeks to address the rising demand for healthcare in south west London, and the quality and financial gaps that exist at present in its provision. The clinical input to the strategy was developed by seven clinical design groups (CDGs), with integrated care being both a CDG in its own right and a major component of the strategy as a whole. Patient feedback was sought as part of this process and used by the CDGs in developing the initiatives in the five-year strategy.

For integrated care services in particular, the vision across South West London is to develop services that:

- Help people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates.
- Help to keep people with one or multiple LTCs and complex needs stable.
- Allow people to get timely and high quality access to care when they are ill, delivered in the community where appropriate.

- Support people in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home.
- Provide people discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence.
- Support and provides education to both family and carers to ensure their health and well-being needs are met, and includes support to maintain finances and staying in work, where relevant.

Help people requiring end of their life care to be supported to receive their care and to die in their preferred place.

Social Care Strategy

A commissioning strategy was published in 2010 and is due for revision later in 2014. This is based on the Use of Resources framework used nationally and pioneered in Merton and a few other councils. There are six areas where the framework seeks to add value for customers and funders:

- Prevention: ensuring that everyone can use universal services for as long as possible and not be forced prematurely into segregated social care services.
- Recovery: offering everyone the chance to regain and maintain as much independence as possible following episodes of crisis, be it physical illness, mental illness or other crises such as homelessness
- Long term support: for those needing such support, offering it at home or ordinary community settings wherever possible, and maximising choice and control over the support received
- Process; ensuring processes used add value to the customer and minimising those which don't
- Partnership: ensuring that all agencies supporting residents work in partnership and that the customer experiences this support in an integrated manner
- Contribution: enabling and expecting everyone to make a contribution to their own or others' support

These values and principles underpin the work on integration as well as new duties such as the Care Act.

(b) What difference will this make to patient and service user outcomes?

5. The South West London Vision

For patients and service users, our aim by 2018/19 is to provide improved access to services that meet relevant quality standards, with a greater proportion of care provided by multi-disciplinary teams closer to individuals' home. We aim to expand and improve services provided outside hospital, up-skill the workforce, increase specialisation in the community and high quality care out of hospital whenever appropriate. Patients will benefit from services that are more proactive rather than reactive, and that will co-ordinate the efforts of multiple providers in seeking to improve the health and wellbeing of people across south west London.

Across south west London, we want people to experience an uninterrupted journey through services, ensure that patients' families and carers receive education and support, and improve connections to the voluntary sector. In addition, integrated services will make better provision for mental health care to enhance overall wellbeing, independence and 'social capital'.

The drive to achieve the London Quality Standards, and other relevant standards, will result in patients experiencing improved outcomes from healthcare services in south west London. The further separation of elective and non-elective surgery is expected to support a reduction in average lengths of stay and infection rates, and to lead to an improvement in outcomes.

A key driver for the 5 year strategy is to address the health inequalities that exist across south west London. Improvements to services will result in more consistent outcomes for patients, regardless of whom they are and where they live.

6. What will locality services look like in Merton in April 2015?

From a Merton perspective, the following table sets out the vision for services from April 2015 and how they will operate from the point of view of all interested parties and illustrates how the overall model of care within Merton will change to reflect the developing needs of the population. This table sets out how the practical implementation of the schemes will be felt on the ground and has been drawn up and agreed by all stakeholders through the Merton Model Development Group, Project Team and the Merton Integration Board.

Figure 1: How Merton Localities will operate from 1 April 2015

Ref	Stakeholder/Service	What will success look like?
2.1	Patients, Service Users and Carers	More coordinated care through key workers. Smoother discharge through single access pathway. More opportunity to be treated in the community and at home.
2.2	GPs and Primary Care	Leading monthly MDT meetings in every practice and working closely with key workers.
2.3	Key worker	Key worker role and responsibilities established and localities working to this model through health liaison workers and/or other professionals.
2.4	Social Work	The 'Proactive' teams working in three localities to a single pathway coordinated with healthcare teams. Single, agreed support planning process developed and operated across localities with teams working consistently to the agreed process and operating procedures. A single assessment process delivered at least through a 'trusted assessor' arrangement. Role of social care OTs and social care hospital discharge teams reviewed.
2.5	Community Health	Planned care functions delivered in three localities working to a single pathway in coordination with social work teams. Single, agreed support planning process developed and operated across localities with teams working consistently to the agreed process and operating procedures. A single assessment process delivered at least through a 'trusted assessor' arrangement.
2.6	Advanced practice-based MDT meetings	All localities using an agreed risk stratification tool and running monthly, practice-level MDT meetings that are fully constituted and defined. All MDTs operating to an increased level of efficiency and effectiveness.
2.7	MILES, reablement and step up beds	Processes for straightforward referral to reablement in place following restructuring of Merton Independent Living and Engagement Service (MILES) teams into three localities.

Figure 1: How Merton Localities will operate from 1 April 2015 (cont'd)

Ref	Stakeholder/Service	What will success look like?
2.8	Mental Health, incl. dementia and memory clinics	Formal links to MH services in place with MH workers potentially based within localities. Integrated pathways to dementia hubs and memory clinics.
2.9	Location	Teams are still not likely to be co-located but estates plans will be in place to deliver co-location in 2015/16.
2.10	End of Life	End of life services integrated into the locality pathways.
2.11	Process	Agreed, single access and assessment processes in operation. Key worker processes agreed and operational. Some degree of integration within processes to MH services. Trusted assessor agreements in place.
2.12	Acute Trusts	Fewer inappropriate admissions, as patients being managed by integrated teams in the community. Coordinated discharge function with single pathway of access to all locality services.
2.13	Voluntary Sector	Integrated into locality pathways and overall patient and service user processes.
2.14	Equipment	Local access to equipment, including swift prescribing and delivery to prevent unnecessary delays to discharges.
2.15	Management	Collectively managed resources identified.

7. An illustration: Mrs Jones' Story

Mrs Jones is an 83 year old retired schoolteacher who lives alone and has no relatives living locally. She has had COPD for the past 10 years and has increasing problems with breathlessness and mobility. Over the weekend she develops a cough and fever and then has a fall whilst feeding her cat.

She calls the London Ambulance Service who take her to St George's Accident and Emergency department where she is has a full geriatric assessment. This reveals that she has no fractures and access to her GP records helps the team identify that she is suffering from an exacerbation of COPD causing confusion and reduced mobility. This requires treatment with antibiotics and steroids and means she will be less able to look after herself for a period of time.

It is agreed that hospital admission is not needed; however Mrs Jones does not feel confident or safe to return home alone. The Rapid Response Team arranges for her to spend a couple of nights in a 'step-up' bed under the care of the locality based multi-disciplinary team.

She is introduced to the community nurse who will act as her key worker and together they agree a care plan. This includes support from the voluntary sector to ensure her home is warm when she returns and provide domestic support until she is well enough to do this herself. A clinical management plan, aimed to reduce exacerbations and identify any deterioration early, is developed with the help of her GP.

Once Mrs Jones is feeling better in her own home, the voluntary sector continues to support her by introducing her to an exercise class for older people, which helps her maintain her fitness and her mobility and where she makes some new friends.

(c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF-funded work contribute to this?

8. The five-year view

8.1 The Merton Perspective

Merton's five-year planning process is being developed in partnership with the SW London Commissioning Collaborative. These plans have been published in draft format and are currently open for consultation. The proposals in the SWL five-year plans are broadly summarised in the following paragraph.

8.2 The South-West London Perspective

The strategy as a whole will require fundamental changes to how services are delivered across south west London. Over the next five years, there will be an increasing shift in services from the acute to community services, with the development of more proactive services. Below are the anticipated changes by clinical area, as defined in the strategy by the seven clinical design groups:

- **Children's services** - Investment in community children's services during in advance of rolling-out integrated children's services and the Paediatric Assessment Unit model. The impact on acute capacity would then be assessed with a view to a future consolidation of acute children's services.
- **Integrated care** - Focus on the implementation of BCF plans during 2014/15 and 2015/16, with work in parallel to consider contracting, workforce and IT enablers for improving integration across south west London. Implementation of seven-day working in the community from 2016/17.
- **Maternity services** - All units to achieve 98-hours of consultant obstetric presence by the end of 2014/15, with full compliance achieved by 2018/19. Midwifery-related LQS to be achieved by the end of 2015/16.
- **Mental health** - Series of initiatives to develop capacity in community services, including developing a single point of access, increased access to IAPT and greater provision of home treatment, to be implemented between 2014/15 and 2016/17, with a view to reducing acute in-patient activity from 2017/18.
- **Planned care** - Creation of an implementation plan for a multi-speciality elective centre (MSEC), with Urology services deployed in an elective centre from 2016/17, one further specialty from 2017/18 and three more from 2018/19. Planning to include consideration of appropriate quality measures and approaches to contracting.
- **Primary care** - Fully networked model of primary care, in line with NHS England plans, to be achieved by 2016/17, with implementation plans for estates improvements and workforce transformation to commence in the same year. Greater emphasis to be placed on MDT working, prevention and supporting self-management.
- **Urgent and emergency care** - Implementation of seven-day working across urgency and emergency care services in SWL by 2015/16, supported by an ambulatory emergency care model. LQS to be achieved in all emergency departments by 2016/17. Further improvements in efficiency and effectiveness, including greater connectivity with other settings, to be pursued through implementation of new IT systems.

3 CASE FOR CHANGE

Please set out a clear, analytically-driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

9. Methodology

In setting out Merton's Case for Change, a four-step process was followed to ensure that the schemes ultimately being delivered by the integration process matched the needs of the target population. By taking this approach, the Health and Wellbeing Board can be assured that activity is focused on the target groups that will demonstrate the greatest benefits to patients, service users and the overall health and social care economy in Merton. The methodology was as follows:

9.1 Step 1: Clarifying the health and social care needs of the population.

Purpose: To ensure clarity about the opportunities to improve the health outcomes of patients and service users in Merton

Approach: Analysis of patients at risk of admission and the target population that will benefit from BCF schemes.

9.2 Step 2: Ensuring BCF Schemes will address the needs of the target population

Purpose: To review the schemes already identified within the original BCF Plan to ensure that they continued to meet the identified needs of the target population, including evaluation of MDTs, care-planning, care coordination and self-management schemes.

Approach: Check to ensure evidence-specific areas are reflected in plans and supported by established risk-stratification methodology. Amend or restructure these, as necessary.

9.3 Step 3: Aligning schemes with anticipated benefits and engagement of providers

Purpose: To identify where the greatest impact might be had on Merton's patient and service user population to demonstrate the impact that integration would have on the overall health economy.

Approach: Share analysis of the health and social care needs of the population with providers, identify any restructuring of schemes and agree the methodology to quantify the anticipated benefits of BCF with providers. This ensures that the schemes will be workable by all partners.

9.4 Step 4: Modelling the benefits

Purpose: To make sure that the agreed methodology is capable of demonstrating the desired benefits of a reduction in NELs of 3.5% (plus 2.2% forecast growth) in Merton.

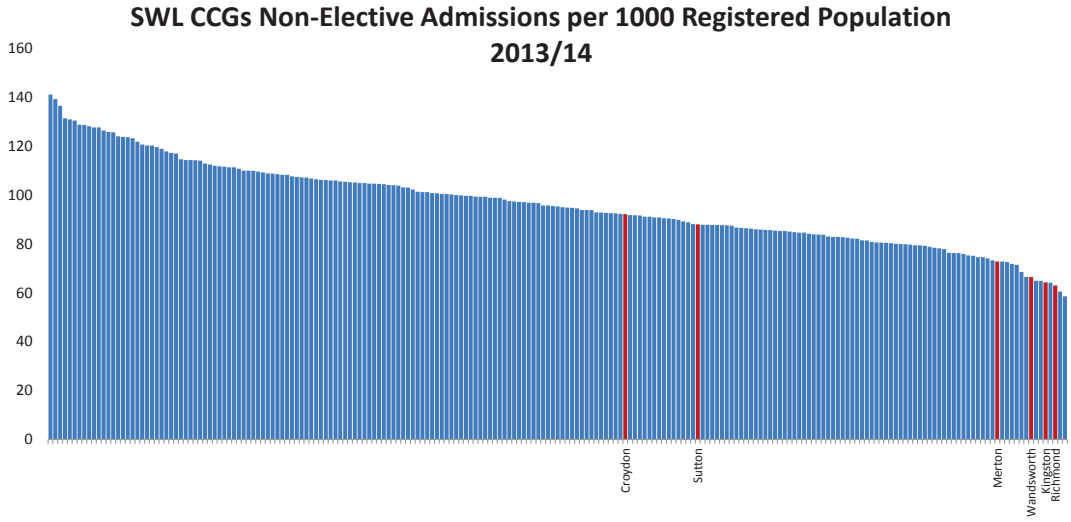
Approach: Demonstrate that the modelling is robust and capable of meeting the requirement for a reduction in NEL admission and triangulated with QIPP.

10. Step 1: Clarifying the health and social care needs of our population

10.1 The Starting Position

In assessing how integration can improve care delivery in Merton, it was first acknowledged that Merton already had a very low rate of NEL admissions.

Figure 2: Non-elective admissions per 1,000 registered population



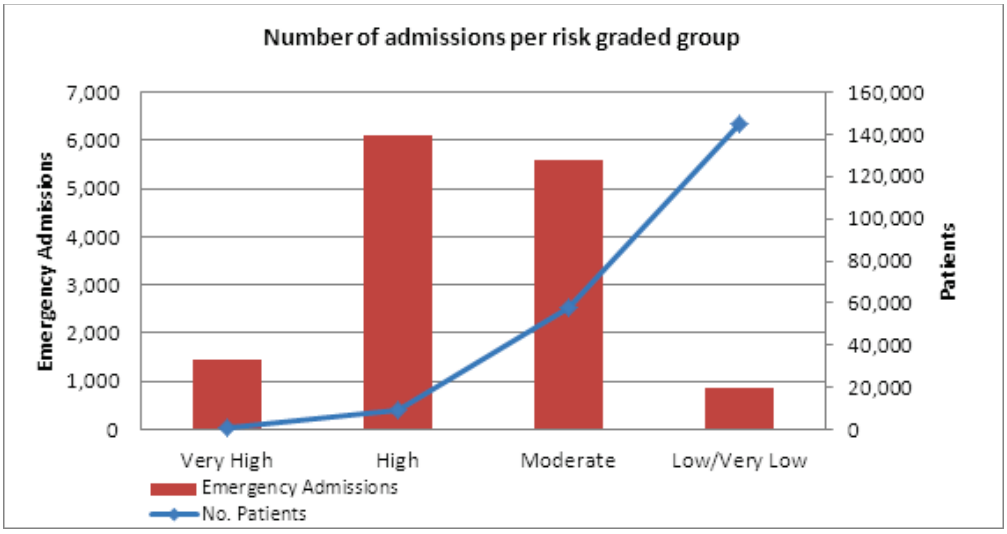
Consultation with the clinical community (both primary care and providers) supported the view that Merton CCG already managed patients well and, therefore, there was limited further opportunity to impact on non-elective admissions.

Nevertheless, as a consequence of the changed focus of the BCF Resubmission on reducing NEL admissions, a review of data around the overall patient population was undertaken in order to ensure that the existing BCF schemes are structured to address the needs of the population.

10.2. Analysis of population based on Risk stratification profiles

Using 'Sollis' Risk Stratification methodology across all 25 Merton practices in the three localities, it is evident that there are high admissions for the cohort of patients classified as 'Very High Risk' (VHR) and 'High Risk' (HR) of emergency admission in the next year.

Figure 3: Distribution of admission across risk profile groups



Analysis of the age groups and condition profiles was undertaken to gain an understanding of which groups of patients' admissions could potentially be prevented. This revealed that the number and combination of long term conditions had little impact on the rate of emergency admissions in the VHR and HR groups.

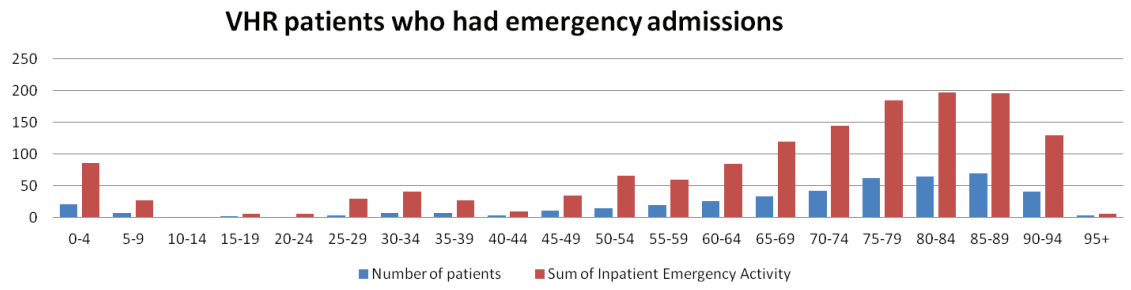
Figure 4: Rate of admissions compared to numbers of long term conditions.

Number of long term conditions	Number of patients	Number of emergency admissions	Rate of admissions
0	378	627	1.7
1	502	1068	2.1
2	447	764	1.7
3	556	955	1.7
4	596	1056	1.8
5+	1589	3081	1.9

10.3 Analysis of the Very High Risk (VHR) and High Risk (HR) Groups

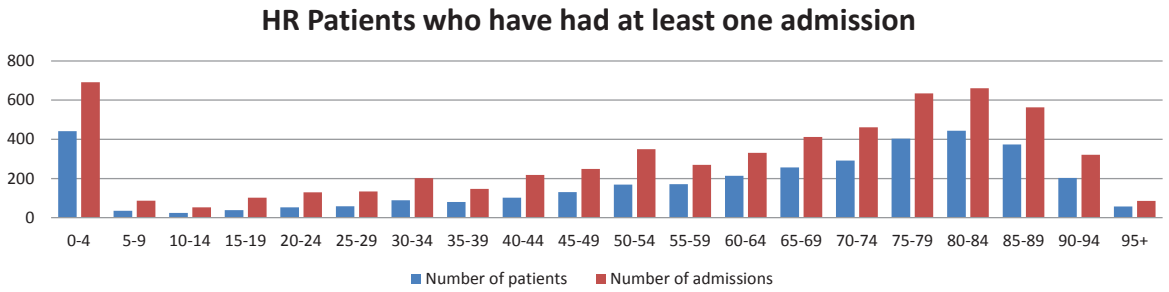
Analysing the VHR group, the majority had multiple long-term conditions and the trend for over 60s was very noticeable:

Figure 5: Analysis of Very High Risk patients.



By comparison with the VHR patients, the distribution of HR patients is more evenly spread across age ranges, although the expected increase at the over 65 age is still marked. Those people in the high risk group have a more varied long-term condition profile and the age profile of those that are admitted is widely distributed.

Figure 6: Distribution of High Risk patients with at least one admission.



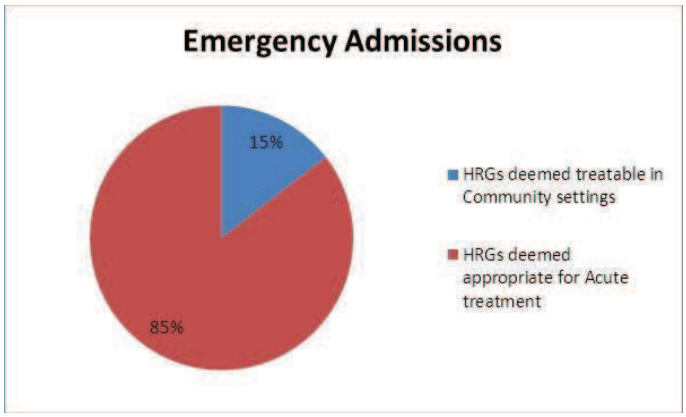
10.4 Analysis of Emergency admissions profile

The Sollis Risk Stratification tool used by Merton CCG does not currently show the reason for admission, nor the HRG under which patients were admitted. Therefore, we were not able to analyse the acuity or clinical needs of patients based on their risk profile. A full analysis of the data generated using the Sollis tool will be undertaken once the scheduled upgrade, due by the 30 September 2014, has been completed. We do not, however, anticipate this analysis to significantly impact the structure of our schemes, nor on the projected benefit derived from the schemes.

As an alternative to the Risk Stratification data, analysis of emergency admissions for Merton registered patients was conducted using Secondary Uses Services (SUS) data in order to gain an understanding of which types of emergency admissions could be impacted through BCF schemes.

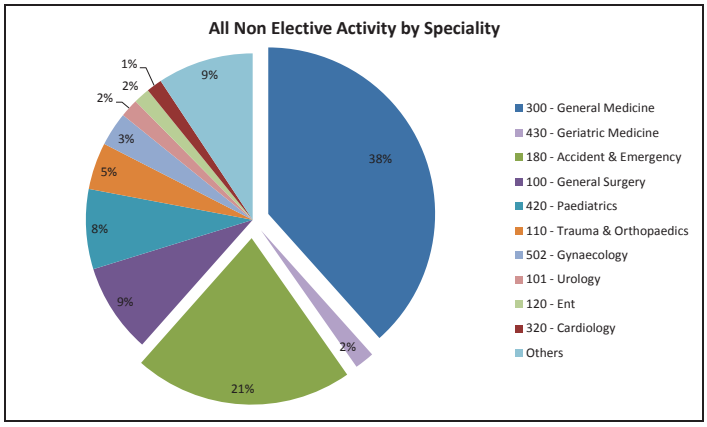
This analysis was done by GPs who identified a number of HRG (Healthcare Resource Group) codes which could be impacted by BCF. This list of HRG codes was deemed to potentially be preventable admissions as, due to the type of intervention, they were considered to be susceptible to treatment outside hospital if alternative responses were available in the community. (The full list and projected impact is shown in figure 12 in section 13.3)

Figure 7: Opportunity for preventing emergency admissions across all ages and all specialities



However, clinical consultation with GPs recommended that there was limited/no opportunity to impact emergency admissions for those patients that were admitted to specialities other than Emergency Medicine, Geriatric Medicine and General Medicine as, due to the nature of the speciality to which patients were admitted, they were highly likely to have required a secondary care intervention such as surgery.

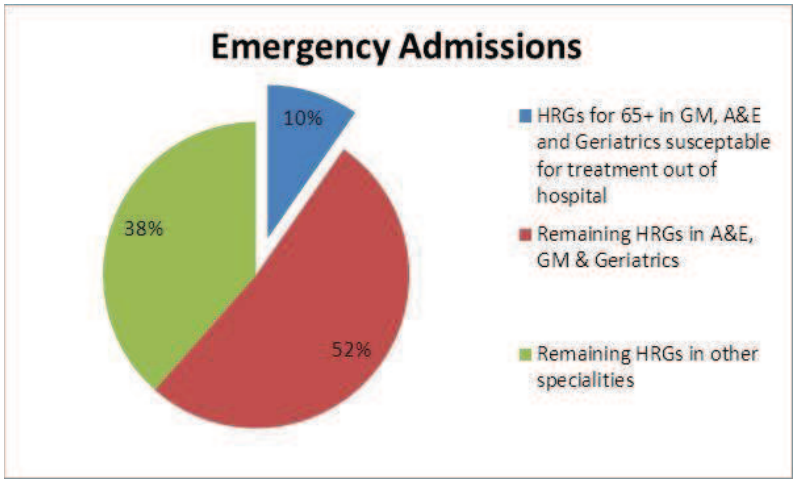
Figure 8: All non-elective activity by speciality



It was therefore concluded that the opportunity to impact emergency admissions was better represented by admissions for people over 65 admitted to the specialities of Accident and Emergency medicine, Geriatric Medicine and General Medicine.

This opportunity equates to 1289 potentially avoidable admissions.

Figure 9: Opportunity for preventing emergency admissions for 65+ in A&E medicine, GM and Geriatrics



11. Step 2: Ensuring BCF Schemes will address the needs of the target population

11.1 The ACG 'Sollis' Risk Stratification Tool used by Merton

All twenty-five GP practices in Merton undertake risk-stratification profiling to identify patients at high or very high risk of:

(a) Deterioration and subsequent escalation in the community (potential Acute spend).

(b) Patients who are frequent attenders in Acute services (existing Acute spend).

Merton uses the ACG SOLLIS system and practices have been trained in using this to identify the high risk cohort of the population.

11.2 Components for Success of BCF

A review of the components with the greatest evidence for success was undertaken to ensure that the BCF schemes had the greatest opportunity to deliver improvements for Merton patients and service users. The following components were all identified as being evidence-specific areas and are reflected in the Schemes within the Plan:

(a) Multi-Disciplinary Teams

MDTs are already operating in all 25 Merton practices on a monthly basis with a core team of GP, practice nurse, social worker and named clinician from Community Services. There has been specific investment from the BCF to support three Health Liaison Social Workers (one in each locality) to deliver meaningful, integrated support from a social work side to the MDT meetings. All relevant services, including mental health services, are involved in MDTs and the continuing successful outcomes from MDTs demonstrate that Merton's approach is robust. Practices have also all provided DDimer testing kits to rule out deep vein thrombosis at the GP surgery to avoid admission.

The project is also developing the role of the voluntary sector within MDTs, as it has been identified that non-clinical support for the target groups can often support people

to stay home for longer. Project ***Work Package 6.2*** has been set up specifically to assess and review the effectiveness of the MDTs operating across Merton and to spread best practice and support a consistent implementation.

(b) Case Management

As part of the initial steps towards integration in Merton in February 2013, it was agreed that there would be an alignment of services within LB Merton to a 'reactive' and a 'proactive' agenda, aligning and integrating social care and health care responses with urgent and planned care. Care plans are created for the patients identified as being at highest risk of NEL admission.

The delivery of this ambition is incorporated within the project as ***Work Package 2.3***, specifically delivering the initiatives that will support 'Proactive' responses. The full project structure can be seen in Section 4(c) of this document and full analysis of case management within Scheme 1.2 in Annexe 1.2.

(c) Care Co-ordination

Virtual case management forms the core activity of MDTs. A key worker, with an appropriate professional background is assigned and is ultimately responsible for co-ordinating the care of the individual and providing first-line support to the person and carer in terms of communication, initially assessing ongoing need, developing expectations of care and reflecting this in their care plan.

The key worker is also responsible for communicating progress or further need back to appropriate professionals, including clinicians who need to be connected in with ongoing actions, as well as to the wider MDT team.

Ideally, this takes place through a shared record system, using the NHS number as a unique primary identifier, and through the appropriate channels in relation to the level urgency (telephone, secure email, meetings etc.).

As part of the data sharing scheme, further investigation is taking place regarding the potential wider implementation of the 'Coordinate my Care' record system for these patients.

The successful establishment of the three locality teams in Merton with effect from July 2014 (Project ***Work Package 2.3.1***) ensures that the proactive management of patients and service users in the target groups can be even more effectively delivered and the opening of the Holistic Assessment and Rapid Investigation Service (HARI) from April 2015 (Project ***Work Package 2.1***) will support clinicians to keep their patients healthier in the community.

(d) Self-Management

It is a desired outcome for the MDT process to support patients and service users to live independently. A number of related project work packages address this need to support people in Merton to manage their own conditions, including:

- Project ***Work Package 2.3.2*** (Dementia): integration of dementia care services including Memory Clinics within localities.
- Project ***Work Package 2.3.3*** (End of Life): coordination of End of Life within locality teams, including jointly delivered EoL services.
- Project ***Work Package 2.3.4*** (AgeWell Prevention): delivery of integrated outcomes of LB Merton voluntary sector preventative support programme. Incorporated into the project as a result of alignment with the LB Merton Service Delivery Plan for Adult Social Care.

- Project ***Work Package 2.3.5*** (Expert Patient Programme), which delivers recurrent funding for a total of eight Expert Patient Programme (EPP) courses per annum, enabling 120 patients to benefit from the course each year.
- Project ***Work Package 2.3.6*** (Falls Prevention), incorporated into the project as a result of alignment with the CCG's two-year Operating Plan.
- Project ***Work Package 2.3.7*** (Podiatry Services), incorporated into the project as a result of alignment with the CCG's two-year Operating Plan.

All of the above schemes support the delivery of self-management schemes within the overall development of proactive services as part of the BCF Plan schemes.

12. Step 3: Aligning schemes with anticipated benefits and engagement of providers

12.1 Regrouping Schemes

In order to ensure that the schemes match the revised objectives and align with how the impact/benefits of the schemes have been quantified, it has been necessary to regroup some of the schemes from the original BCF Plan in April. In order to meet the focus of the schemes on 'Reactive' and 'Proactive' initiatives, the original community services schemes have been regrouped into two schemes based on the reactive and proactive models.

In the Part 2 template, the initiatives that make up the schemes have been regrouped and renamed accordingly in order to match the new structure.

Figure 10: Regrouping of schemes for BCF Plan Resubmission

Original Schemes from April 2014		Revised Schemes from September 2014		How will we measure the impact/benefit?
1	Community Beds and Rehabilitation	1.1	Reactive Schemes in the Community	Number of people being treated in the community rather than in Acute settings for selected groups of conditions when they require an urgent response.
2	Prevention of Admission Initiatives			
3	Integrated Locality Teams	1.2	Proactive Schemes in the Community	Number of people being Case managed and therefore not requiring an admission.
4	Seven-Day Working			
5	Protecting and Modernising Social Care	1.3	Protecting and Modernising Social Care	The number of people receiving social care services
6	Carers' Breaks	1.4	Carers' Breaks	Number of people receiving carers breaks
7	Investing into Integration Infrastructure	1.5	Investing into Integration Infrastructure	Effectiveness of case management

As with the objective of the schemes from April, the schemes continue to support Merton's commitment to meet the National Requirements (see also Section 7), as well as the need to restructure community services in the Borough in order to ensure that they are fit for purpose.

12.2 Stakeholder engagement

A focused review of risk stratification data, Acute activity data and the evidential basis and the principles of Merton's schemes culminated in a half-day workshop on 14 August 2014, which was attended by providers and commissioners. At this workshop, it was agreed by all that benefits relating to reduction in emergency admissions should be quantified under two broad headings and in line with the joint health and social care schemes already under way in Merton.

The impact of BCF schemes have therefore been modelled based on the projected impact of:

(i) Case Management – proactive care.

(ii) Prevention of admission – reactive care.

(iii) Protecting social care

13. Step 4: Modelling the Benefits

13.1 The combined purpose of the schemes

The Merton BCF schemes are designed to better manage people by:

(i) All services proactively planning responses to peoples anticipated health and social care needs.

(ii) Identifying people who are predicted to experience urgent deterioration in their health and provide access to urgent community response that prevent them being admitted to hospital to receive that care.

(iii) Protecting social care in order to prevent deterioration in people's health and independence causing a reliance on health care.

13.2 Benefits expected from Case Management - Proactive model

Risk Stratification data was reviewed to support the development of the 'reactive' model. This data provides an indication of the number of patients that should be proactively managed and forecasts an impact on emergency admissions for these patients.

A benefits/impact model was developed to forecast the impact on emergency admissions activity ascribable to case management by locality based MDT teams which operate in all of Merton's 25 GP practices. The impact on emergency admissions was forecast and validated with the support of Merton CCG's Clinical Director for Integration, Adults and Vulnerable People.

The methodology builds on 2014/15 QIPP plans. The 2015/16 QIPP/BCF forecasts that 10% of those identified through Risk Stratification as being at Very High Risk or High Risk of admission in the next year will have 1 admission prevented. This reduction was estimated based on:

1. Current benchmarked non-elective admissions performance for Merton.
2. Clinical review of evidence base regarding impact of Case Management, Risk Stratification, Care Co-ordination and Self-management.
3. Audit investigating the potential impact of case management on patients who had 3+ admissions in past 12 months.

The estimate was generated based on the schemes that are planned, the timing of implementation of the schemes and impact of previous QIPP schemes aimed at reducing emergency admissions.

Figure 12: Admissions avoidable through one reduction

Age Group	Number of patients	Number of admissions	Prevent one admission for 10% of those at Very High Risk or High Risk
18 - 74	1789	3543	178.9
75+	1721	2976	172.1
Total admissions prevented (reduce 1 admission for 10% of those at Very High and High Risk)			**351**

Whilst the BCF Case Management (proactive care schemes) are driven by the integration agenda, the One Merton Group is capitalising on primary care incentives that encourage member practices to use risk stratification to identify those patients at the highest risk of admission, as well as patients over 75. The locality MDT model has been developed and resourced to support GPs in proactively managing patients at highest risk of emergency admission.

13.3 Benefits expected from Prevention of Admission – Reactive Care

The following data was reviewed to support the development of the 'reactive' model:

- An initial analysis of 2013/14 emergency admissions to hospital at speciality level and HRG level.
- Identification of types of admissions that could reasonably be treated by planned 2014/15 QIPP schemes, notably by the implementation of the Community Prevention of Admission Team (CPAT) and the Holistic Assessment and Rapid Investigation (HARI) service, the implementation of which has been clinically lead by a Darzi Fellow and GPs.

The benefits model for reactive care is therefore based on the current QIPP (2014/15) modelling which provides a granular detail regarding the number and type of emergency admissions at HRG level that BCF reactive schemes aim to prevent. This is a currency that providers know, use and can monitor.

The impact of reactive response was quantified by Merton GPs advising what proportion of admissions to hospital for the identified list of HRGs could be prevented. This estimate forecasts the impact of planned community responses implemented through BCF schemes.

The reactive modelling and forecast impact is set out below:

Figure 13: Reactive modelling and forecast impact.

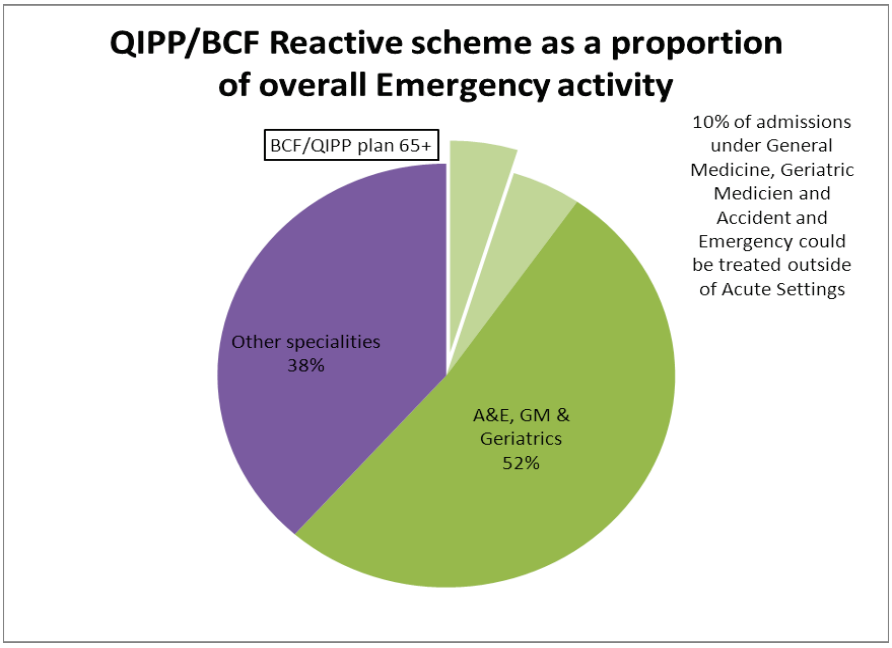
HRGs amenable to treatment outside Acute settings	Sum of Total Spell Count	Average of % reduction due to BCF Schemes (CPAT & HARI)	Sum of Reduction in spell count
AA25Z - Cerebral Degenerations or Miscellaneous Disorders of Nervous System	57	70%	40
AA27Z - Medical Care of Patients with Alzheimer's Disease	5	70%	4
AA31Z - Headache or Migraine	142	50%	71
BZ24C - Non-Surgical Ophthalmology with length of stay 1 day or less	4	50%	2
DZ11C - Lobar, Atypical or Viral Pneumonia without CC	26	50%	13

HRGs amenable to treatment outside Acute settings	Sum of Total Spell Count	Average of % reduction due to BCF Schemes (CPAT & HARI)	Sum of Reduction in spell count
DZ12B - Bronchiectasis without CC	1	50%	1
DZ15F - Asthma without CC without Intubation	27	60%	16
DZ19C - Other Respiratory Diagnoses without CC	34	50%	17
DZ21A - Chronic Obstructive Pulmonary Disease or Bronchitis with length of stay 1 day or less discharged hom	69	50%	35
DZ21A - Chronic Obstructive Pulmonary Disease or Bronchitis with length of stay 1 day or less discharged home	8	50%	4
DZ21K - Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation without CC	16	50%	8
DZ22C - Unspecified Acute Lower Respiratory Infection without CC	11	50%	6
DZ28Z - Pleurisy	26	50%	13
EB03I - Heart Failure or Shock without CC	100	40%	40
EB07I - Arrhythmia or Conduction Disorders without CC	106	40%	42
FZ37F - Inflammatory Bowel Disease with length of stay 1 day or less	2		0
FZ37J - Inflammatory Bowel Disease with length of stay 2 days or more without Major CC without Interventions	28	30%	8
FZ43B - Non-Malignant Stomach or Duodenum Disorders with length of stay 2 days or more without Major CC	23	30%	7
FZ43C - Non-Malignant Stomach or Duodenum Disorders with length of stay 1 day or less	9	30%	3
FZ44B - Malignant Stomach or Duodenum Disorders with length of stay 2 days or more without Major CC	20	30%	6
FZ45B - Non-Malignant Large Intestinal Disorders with length of stay 2 days or more without Major CC	15	30%	5
FZ45C - Non-Malignant Large Intestinal Disorders with length of stay 1 day or less	30	30%	9
FZ47B - Non-Malignant General Abdominal Disorders with length of stay 2 days or more without Major CC	72	30%	22
FZ47C - Non-Malignant General Abdominal Disorders with length of stay 1 day or less	22	30%	7
FZ49C - Disorders of Nutrition with length of stay 1 day or less	110	70%	77

HRGs amenable to treatment outside Acute settings	Sum of Total Spell Count	Average of % reduction due to BCF Schemes (CPAT & HARI)	Sum of Reduction in spell count
HA81C - Sprains, Strains, or Minor Open Wounds without CC	8	70%	6
JC27Z - Nursing Procedures & Dressings 1	49	70%	34
KB02F - Diabetes with Hyperglycaemic Disorders 69 years and under without CC	5	30%	2
KB03B - Diabetes with Lower Limb Complications without Major CC	7	30%	2
KC05C - Fluid and Electrolyte Disorders 70 years and over without CC	1	40%	0
LA04F - Kidney or Urinary Tract Infections with length of stay 2 days or more without CC	45	60%	27
LA04G - Kidney or Urinary Tract Infections with length of stay less 1 day or less	21	70%	15
LA09H - General Renal Disorders with length of stay 1 day or less	92	60%	55
LB16C - Lower Urinary Tract Findings without CC	2	60%	1
LB18Z - Attention to Suprapubic Bladder Catheter	8	70%	6
LB19B - Ureteric / Bladder Disorders 19 years and over without CC	1	70%	1
LB37B - Miscellaneous Urinary Tract Findings without CC	4	70%	3
LB38B - Unspecified Haematuria without Major CC	5	30%	2
PA14C - Lower Respiratory Tract Disorders without Acute Bronchiolitis with length of stay 1 day or more with	2	50%	1
PA14D - Lower Respiratory Tract Disorders without Acute Bronchiolitis with length of stay 1 day or more with	5	50%	3
PA14E - Lower Respiratory Tract Disorders without Acute Bronchiolitis with length of stay 0 days	8	50%	4
PA18B - Minor Infections without CC		70%	0
PA20B - Fever unspecified without CC	22	30%	7
PA21B - Infectious and Non-Infectious Gastroenteritis without CC	26	30%	8
PA26B - Other Gastrointestinal or Metabolic Disorders without CC	11	40%	4
PA65C - Upper Respiratory Tract Disorders with length of stay 1 day or more without CC	4	70%	3
Grand Total	**1289**	**49%**	**635**

The benefits expected due to 'Prevention of Admission – Reactive Care' equates to 635 reduced admissions in 2015/16. This reduction equates to 5% of overall Emergency activity based on 2012/13 activity data.

Figure 14: QIPP/BCF Reactive schemes as a proportion of overall emergency activity.



13.4 Benefits expected from reducing Excess Bed Days

Whilst Merton does not forecast to gain any further benefit by maintaining the current low rate of Delayed Discharges of Care, we do forecast to benefit from curbing the growth in excess bed days due to implementation of the In-Reach service in 2014. This benefit is quantified in the 2014/15 QIPP plans, which forecast stemming previous growth (1.95%) in excess bed days across the Acute hospitals for those over 65 admitted under the specialities of Geriatric medicine, General medicine and Accident

The 2015/16 QIPP/BCF forecasts maintaining this curtailed growth (1.95%) in excess bed days across the Acute hospitals for the same specialities and age group. This equates to 112 Excess Bed days prevented in 2015/16.

13.5 Benefits expected due to Protecting Social Care

Protecting and modernising social care is essential to ensure that people are appropriately supported and cared for in their community. Without the necessary support, people are more likely to require intervention from health services, be inappropriately admitted to institutional settings or be admitted to hospital. The Merton Protecting social care scheme enables Case Management and Prevention of admission schemes to derive benefits. Without protection of social care, emergency admissions are forecast to increase well above the current predicted growth rate of 2.2%. Without modernising social care permanent admissions to care homes would increase in line with the population for older people. The Protecting and modernising social care scheme will:

- Contribute to the planned reduction in emergency admissions to hospital
- Maintain current excellent performance in supporting discharge from hospital in a timely manner

The impact of protecting social care on emergency admissions has been considered and accounted for within the Pro-active and Reactive schemes. Additional quantified benefits in our plan relate to reducing the rate of permanent admissions to care homes for 2014/15 and 2015/16. The performance trend for the past 5 years shows that Merton achieved, on average, 100 permanent placements per year. Although during 2013/14 there was an unusual increase. Our plan is therefore based on the 2012/13 out-turn as it sets a more reliable, although ambitious, baseline for 2014/15 and 2015/16. Merton forecasts that due to BCF, the actual number of admissions will stay relatively constant at about 100 per year. When population growth is factored in, reducing the rate from 420.8 in 12/13, to 403 for 14/15 and 395 for 15/16 translates to a benefit of 5 prevented admissions during 14/15 and 6 admissions during 15/16.

13.6 Triangulation

The impact of BCF schemes and the CCG QIPP schemes have been triangulated to ensure the anticipated impact/savings are only accounted for once.

In 2014/15 these benefits related to the individual schemes have been accounted for through the CCG QIPP project structure.

It is anticipated that in 2015/16, the combined BCF schemes will be monitored under BCF project structure, however savings ascribed due to the impact on emergency admissions and excess bed days will continue to be accounted for through CCG QIPP plans.

In order to ensure the BCF and QIPP methodology aligns, QIPP and BCF project leads have moderated the forecast impact on activity on emergency admissions to ensure that double counting of anticipated benefits does not occur. The benefits model has then shared with our Acute providers and we have maintained a continuous dialogue with stakeholders to ensure validity of the model and to ensure providers are in agreement with assumptions regarding the predicted impact of schemes.

13.7 Merton BCF Model Summary

Figure 15, below, sets out the summary of the BCF modelling for Merton. Using the assumption that the 2014/15 QIPP Schemes will curtail growth of emergency admissions to 2.2% or below, Merton BCF/QIPP schemes are anticipated to deliver a 3.5% reduction in Emergency admissions in 2015/16 and therefore meet the requirements of the 3.5% reduction in non-elective admissions required to meet Merton's commitment to the Better Care Fund.

Figure 15: BCF Benefits Summary

Merton BCF Benefits Summary	Criteria	2014/15 Activity	2015/16 Activity	2014/15 Spell Cost	2015/16 Spell cost	2014/15 Benefits	2015/16 Benefits
Case Management (Proactive care)	Reduce 1 admission for 10% of VHR and HR patients	200	351	£2,209	£1,490	£441,800	£522,990
Prevention of Admission (Reactive care)	SGH, ESH, KH, CH	171	635	£938	£1,490	£160,398	£946,150
In-Reach (QIPP)	Excess Bed Days	112	112	£179	£179	£20,048	£20,048
Protecting Social Care	Reduction in permanent residential admissions	5	6	£32,240	£32,240	£161,200	£193,440
Protecting Social Care	Increased effectiveness of reablement	132	72	£2,138	£2,138	£282,175	£153,914
Protecting Social Care	Reduction in delayed transfers of care	0	0	£179	£179	£0	£0
Total Benefits		N/A	N/A	N/A	N/A	**£1,065,621**	**£1,836,542**
Total Reduction in Emergency admissions due to BCF	Aligned with 2014/15 QIPP	**371**	**986**	N/A	N/A		

13.8 Delivering the Change

In order to deliver the change, Primary Care Improvement is linked with the Merton Model component of the Better Care Fund to ensure that the most appropriate risk profiling methodology is implemented across Merton's 25 practice-based MDTs.

Best practice will be shared at locality meetings and a consistent model of risk stratification implemented across all Merton practices by 1 April 2015 to ensure that the benefits targets for the Better Care Fund are achieved.

13.9 Mitigating Risks within the Merton BCF Benefits Model

Although it is acknowledged that the approach of benefits modelling based on benefits derived from pro-active and reactive care risks double-counting prevented emergency admissions, this risk has been mitigated by:

- Quantifying the impact of proactive care based on the number of people, rather than the number of admissions, these people currently experience. It is anticipated that the types of admissions and the HRG classification of those being prevented are not the same as those that are being prevented due to reactive intervention.
- The impact of reactive care is quantified based on the 65+ cohort only and only admissions under the specialities of Geriatrics and General medicine.

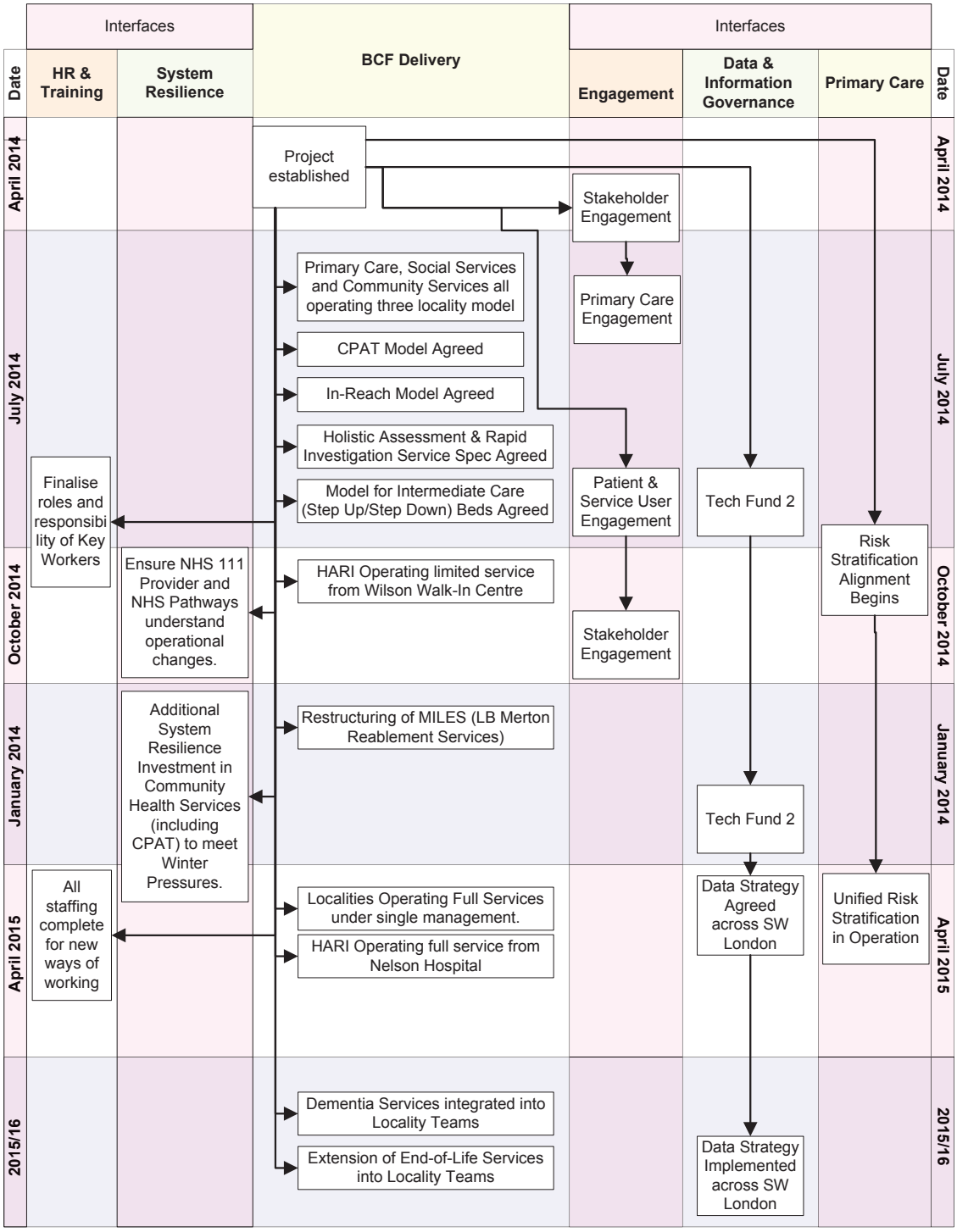
4 PLAN OF ACTION

(a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

14. Project delivery milestones

The project is following a fully-realised plan under Prince2 methodology. The following diagram illustrates the principal milestones in the delivery of the Plan.

Figure 16: Key Milestones of the Project Plan



(b) Please articulate the overarching governance arrangements for integrated care locally

15. Local governance arrangements

15.1 Working together in Merton

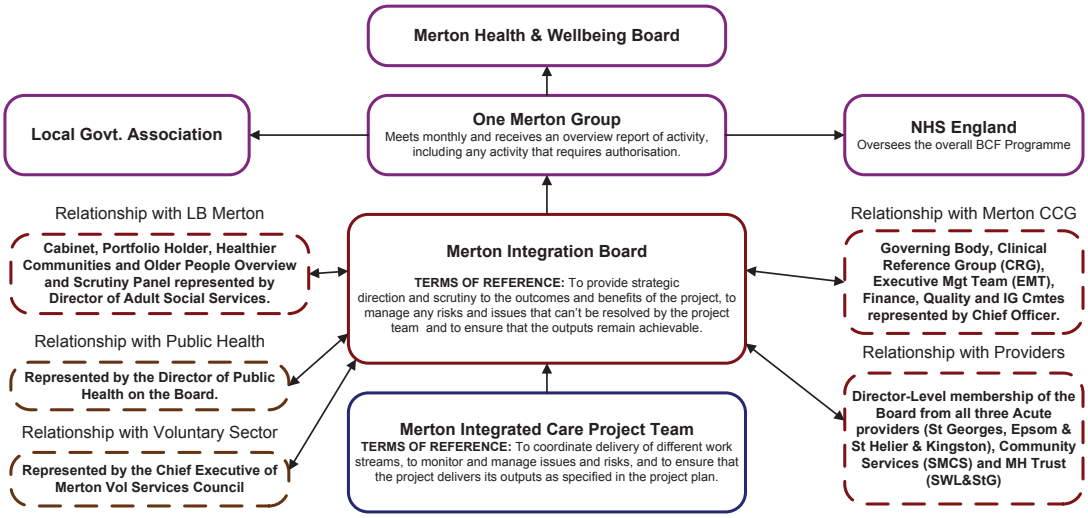
Merton has a history of integrated working between local health and social care, which has rapidly accelerated since February 2013 with the formation of the Merton Integrated Care Project Board, and the subsequent enactment of the *Health and Social Care Act 2012* in April 2013. Governance structures have therefore been developed and implemented that enable close working between health and social care locally. Some of these predate the announcement of the BCF.

15.2 Merton Health and Wellbeing Board

In common with other areas, the **Merton Health and Wellbeing Board** (HWB) has a statutory responsibility for ensuring that commissioning intentions of both Merton Council and Merton Clinical Commissioning Group are aligned, coherent, and meet the priorities set out in the **Joint Health and Wellbeing Strategy**. The Merton HWB has a statutory (mandatory minimum) membership, defined in the *Health and Social Care Act 2012*, that includes senior leaders from across health and social care services and meets on a bi-monthly basis.

Figure 17 sets out the over-arching governance arrangements for integration in Merton.

Figure 17: Overarching governance structure for Integrated care locally



15.3 The One Merton Group (OMG)

The **One Merton Group (OMG)** is an executive level joint group that reports to the Merton HWB. The OMG has a remit to provide strategic direction to integrated services locally. It brings together senior representatives from:

- Merton Council (Director of Community and Housing and Director of Children's and Families),
- Merton Clinical Commissioning Group (Chief Officer and Director of Commissioning and Planning), and
- Public Health (Director of Public Health).

The OMG meets monthly.

15.4 Merton Integration Board (MIB)

The **Merton Integration Board** has a remit to facilitate the practical aspects of integrated working locally and reports to the OMG. It brings together stakeholders to co-design local integrated services; this includes providing direction to, and coordinating the output of the Project Team and the six workstream subgroups:

- Finance and Performance
- The Merton Model
- IT and Data
- Workforce Strategy
- Engagement
- Integrated Quality Commissioning

The Merton Integrated Care Project Board membership includes representatives from Merton Council, Merton CCG, the community services provider (Sutton and Merton Community Services), local acute and mental health providers and a voluntary sector representative. The Merton Integration Board meets on a monthly basis and the full membership of this is set out in Figure 17 below in order to demonstrate that the Board represents the stakeholders at an appropriate level.

Figure 18: Representation on the Merton Integration Board

Organisation	Representative
Epsom & St Helier Hospital	Head of Clinical Programmes
Voluntary Sector	Chief Executive, Merton Voluntary Service Council
Kingston Hospital	Director of Organisational Development
LB Merton	Director of Community and Housing
Merton CCG	Chief Officer Director of Commissioning and Planning
Public Health Merton	Director of Public Health
Royal Marsden (SMCS)	Divisional Director, SMCS Assistant Chief Nurse
St George's Hospital	Divisional Chair for Community Services Director of Strategy
St George's MH Trust	Service Director

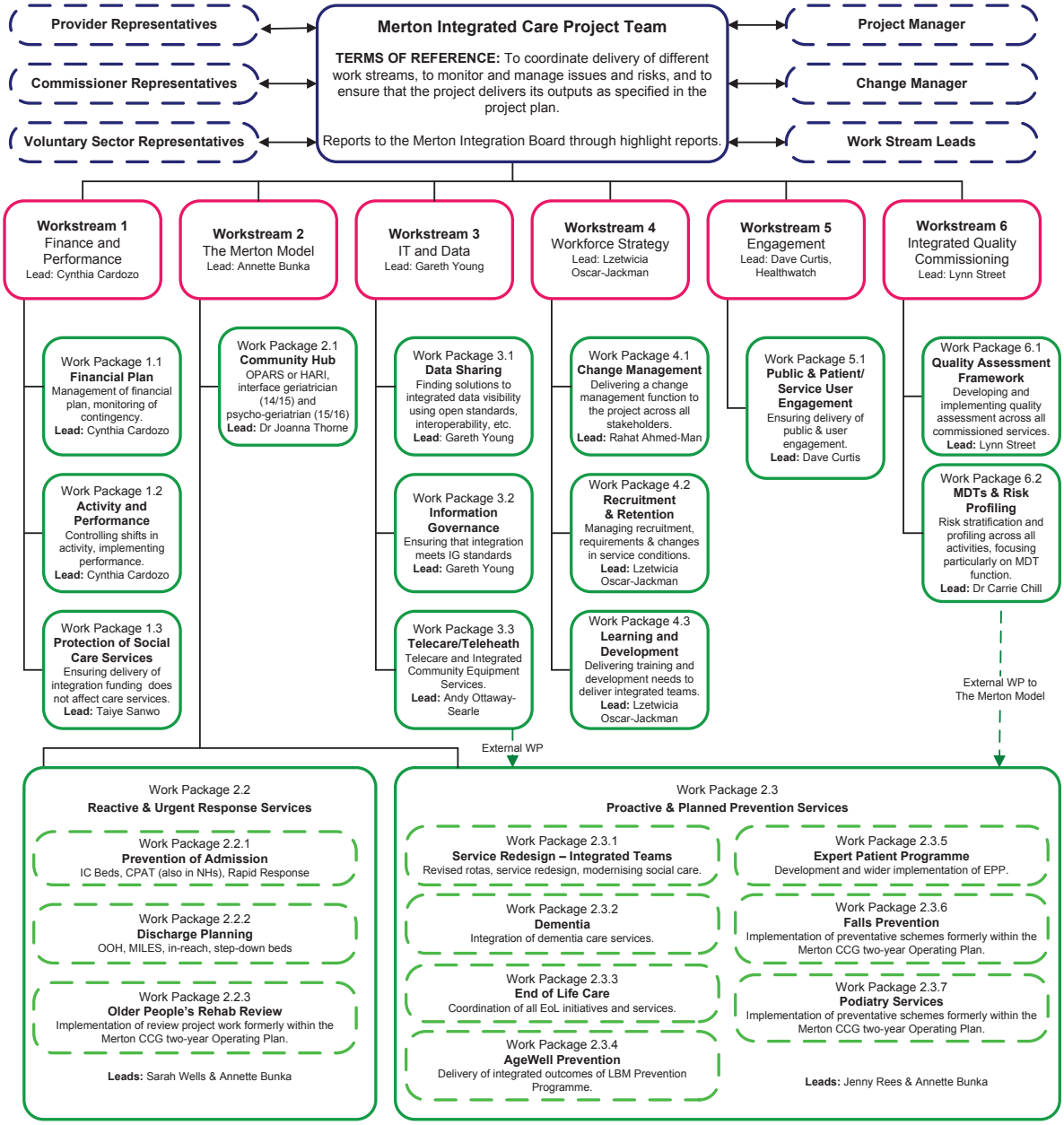
(c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track.

16 Project delivery structure

The delivery of the Better Care Fund Plan is managed through the 'Merton Integrated Care Project Team', which meets every fortnight, alternating with a meeting of the 'Merton Model Development Group', which is the largest and most complex of the work streams.

The Project Team manages the continuing delivery of outputs as well as risks and issues and is chaired by the Project Manager. Any risks and issues that cannot be resolved by the project team are escalated to the Merton Integration Board.

Figure 19: Project and Work Package Structure



(d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annexe 1) for each of these schemes.

16 List of BCF Schemes (September 2014)

It should be noted that delivery of the components of these schemes commenced in April 2014, as part of the original BCF Project Delivery. Due to the need to refocus the BCF as part of the resubmission, these schemes have been regrouped to meet the structure set out in Part 2 of the Plan and consequently comprise components that are not planned are already wholly or partly delivered.

Figure 20: List of BCF Schemes (September 2014)

Revised Schemes from September 2014		Brief Description of Scheme	Annexe Ref	Page
1	Proactive schemes to support reduction in non-elective admissions through community services.	The scheme comprises a number of components that aim to reduce the number of admissions to hospital that could reasonably be treated by alternative community services/responses. The components are focused on a seven day a week and 24/7 model of delivery where appropriate, embedding out-of-hours capacity and appropriately skilled 'night' staff to ensure a reactive approach to care in the community Escalating care needs or crises are identified and responded to swiftly by dedicated multi-professional teams with increased capacity for rehabilitation and reablement.	1.1	52
2	Reactive schemes to support reduction in non-elective admissions through community services.	This scheme comprises a number of components using risk stratification to provide primary and community providers with an indication of the number of patients that can be proactively managed and therefore forecasts an impact on admissions for these patients. A risk stratification model was developed to examine the impact on emergency admissions activity forecast and validated with the support of Merton CCG's Clinical Director for Integration, Adults and Vulnerable People. This is quantified on the basis of number of people being managed with a key worker through integrated MDTs, which operate in all of Merton's 25 GP practices.	1.2	56

Figure 20: List of BCF Schemes (September 2014)(cont'd)

Revised Schemes from September 2014		Brief Description of Scheme	Annexe Ref	Page
3	Protecting and Modernising Social Care	Protecting social care is essential to ensure that people are appropriately supported and cared for in their community. Without the necessary support, people are more likely to require intervention from health services and the more likely they are to be admitted to hospital. The Merton Protecting social care scheme enables Case Management and Prevention of admission schemes to derive benefits. Without protection of social care, emergency admissions are forecast to increase well above the predicted growth rate of 2.2%.	1.3	59
4	Carers' Breaks	This scheme will increase the capacity of the Night Nursing Service, providing additional skilled support which is available to carers between the hours of 7pm and 7am in order to prevent unnecessary emergency admissions. This will primarily be through remote advice provided from a hub, extended to mobile / visit support in appropriate cases. The scheme is integrated with Merton Social Services.	1.4	61
5	Investing into Integration Infrastructure (Enabler)	To create an environment where data and records can be shared between appropriate professionals to prevent patients and service users having to repeat their stories multiple times and to provide a more efficient and effective process for data exchange. This scheme provides funding towards a multi-agency project to develop information sharing across health and social care across south west London, commissioned from South London Commissioning Support Unit. Organisations must put processes and systems in place to ensure that NHS number 'completeness' is maintained at or above 97.5% as the primary identifier in communications. It includes funding to facilitate the use of the Coordinate My Care system as a platform to hold common care plans developed by the integrated locality teams, ahead of larger-scale information sharing progress.	1.5	63

5 RISKS AND CONTINGENCY

(a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

17 Extract of Risk Register

NOTE: to make the template more useable, column headings 2, 3 and 4 have been replaced by abbreviations. The full headings are as follows:	
Lkhd	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*
Impt	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* **(***And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*
Ovrl	**Overall risk factor** *(likelihood multiplied by potential impact)*

There is a risk that:	Lkhd	Impt	Ovrl	Mitigating Actions
NELs cannot be reduced by at least 3.5% because the plan is not realistic.	2	4	8	As set out in Section 3, a full and robust analysis based on the best available evidence has been drawn up in order to reach a conclusion that the 3.5% target is achievable. If the local health and social care economy is unable to meet the target, the P4P money will continue to support Merton residents with healthcare services, as per the guidance.
NEL reductions do not have a material impact on the overall care economy for reasons such as low-value HRGs being targeted.	1	4	4	During the analysis of available evidence to prepare the Case for Change, appropriate HRGs were selected and the impact of reduction of these is set out in Figure 1 of Section 3 demonstrating £622,234 in 2014/15 and £1,039,571 in 2015/16.
Incorrect base data is used to assess the level of NEL reduction resulting in errors and incorrect assumptions.	1	4	4	The base data has been checked and verified so errors and incorrect assumptions are unlikely.
The NEL reduction target is not considered ambitious enough by NHS England or the reason for the level of ambition is not considered satisfactory.	2	3	6	Merton has set out a case to meet the NHS England challenge of a 3.5% reduction in NELs alongside a projected 2.2% growth in demand. Merton is already a high-performing locality in respect of NELs and the target is both realistic and achievable.

There is a risk that:	Lkhd	Impt	Ovrl	Mitigating Actions
Schemes are not financially evidence-based or modelled for full benefits realisation.	2	4	8	A full and robust analysis based on the best available financial evidence has been drawn up in order to reach a conclusion that the benefits are achievable. Owner: Board.
Schemes are not implemented due to lack of project management.	1	4	4	A full project management environment has been in place throughout the project in order to ensure that the schemes will be delivered according to the plan. Owner: Board.
The National Conditions will not be met from the project's outputs.	1	4	4	The project is set up to address the requirements of the National Conditions. Owner: Board.
The BCF fails to deliver forecast shifts to activity in 2015/16.	1	4	4	Robust project management including a separate work stream focused solely on Finance and Performance. CCG has worked extensively with acute providers to ensure that there are robustly modelled plans. Providers have assured CCG QIPP plans. Owner: Board
Shifting of resources towards community providers destabilises one (or more) acute providers due to the cumulative impact of multiple BCF plans across the area.	5	2	10	Impact will be monitored through SWL Collaborative Commissioning and overall 5 year strategic plan. Owner: HWB.
Introduction of Care Bill results in a significant increase in the cost of provision of care from 2016 onwards and impacts on current planning	3	2	6	Local system will keep impact and costs under review. DH has promised that under New Burdens deal that all new duties will be fully funded so primary mitigation is to hold government to this promise. Secondary mitigation to tailor services to resources. Owner: HWB.
Complexity of measuring success of individual initiatives leading to an impact on the pay by performance element of the BCF	3	1	3	Each scheme is being measured to an aggregate level to ensure appropriate savings can be attributed to each scheme. Owner: Board.
Failure to deliver data sharing project between health and social care undermines integrated service delivery	4	3	12	Separate work stream solely focused on this work stream with commitment from all partner organisations for this to happen. Nevertheless, the complexity of the local system and the fact that Merton is not a principal commissioner of any Acute services means there remains a risk that this will not be delivered meaningfully in a reasonable timescale. The SWLCC is currently commissioning work on this. Owner: Board.

There is a risk that:	Lkhd	Impt	Ovrl	Mitigating Actions
Tension arises between partners on the definition of 'protection for social services with a health impact'	1	4	4	Local definition of protection of social services. Regular meetings of senior teams in CCG and council, led and attended by CCG Chief Officer and council Director of Community and Housing. All schemes in plan fully debated and understood. Transparency over financial plans on both sides including savings. Shared performance metrics so impact of schemes and performance of whole system can be monitored. Owner: Board.
Existing programmes, such as QIPP and social care efficiency programmes, lead to 'double-counting' of savings	1	4	4	All schemes have been reviewed to ensure that the data sets used triangulate with each scheme to ensure that there is no double counting. The finance and performance group will also monitor these schemes on a monthly basis. Additional scrutiny will take place by an external agency on QIPP/BCF assurance. Owner: Board.
Increasing demand on services (through demographic factors such as an ageing population as well as increased service expectation) means that targets cannot be met	2	4	8	All schemes have been reviewed to ensure that the data sets that are being used to triangulate with each scheme to ensure that there is no double counting. The finance and performance group also monitors these schemes on a monthly basis where all providers are present. Owner: Board.
Health and social care working practice may not change as rapidly as required by QIPP/BCF plans	2	3	6	There is a separate workforce and culture work stream as part of this project and will address this issue - including training and development. Owner: Board.
PPI Engagement will not be meaningful if the project is not clear what it wants to engage on.	1	3	3	Healthwatch Merton and MCVS are fully involved with the project at Board and project team level and will supporting the project to deliver meaningful and relevant PPI. The project team is clear about what will benefit most from meaningful engagement. Owner: Board.
The project can't develop a meaningful, integrated Quality Assessment Framework for services being delivered due to different priorities and reporting structures.	1	4	4	There is an entire work stream dedicated to this requirement. A series of meetings has taken place to develop a meaningful joint quality monitoring regime. Owner: Board.

There is a risk that:	Lkhd	Impt	Ovrl	Mitigating Actions
Telehealth desired outcomes can't be delivered because meaningful evidence can't be demonstrated to clinicians to ensure there is take-up.	2	2	4	A work package is dedicated to this. Project Manager is taking a full interest in developing a business case and a pilot programme will be run to demonstrate benefits to Merton GPs in localities.

(b) **Contingency plan and risk sharing**

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place (i) between commissioners across health and social care and (ii) between providers and commissioners.

18 Agreement on risk-sharing: between Commissioners

While the introduction of the BCF presents a considerable opportunity to facilitate greater integration between health and social care services, it also creates greater interdependencies between organisations with different statutory obligations. These obligations are set out in the Health and Social Care Act 2012 for Merton CCG, and for Merton Local Authority by the Care Act 2014.

In recognition of these obligations, and the level of investment that is to be made both as individual organisations and from a joint pool, risk-management and risk-sharing agreements are being developed collaboratively. For the purposes of risk sharing, it has been agreed that, in the case of non-performance, the financial risk of £894k will be shared on an equitable basis. Given that Merton CCG and LA have agreed all the investments in advance, if the target reduction is not achieved, Merton CCG and LA will jointly review the investments schemes to agree which schemes should either be modified or terminated, such that the funding is released to pay the providers.

This is currently being formalised with a contractual agreement for risk sharing between Merton Local Authority and Merton CCG.

19 Agreement on risk-sharing: between Commissioners and Providers

It is unlikely that there will be a risk to Acute Providers, given that any non-elective activity above the 2008-09 threshold (or adjusted) is paid at 30% as per PbR and the consensus from Providers is that they make a loss on non-elective activity above the threshold. Acute Providers will continue to be paid as per contractual agreement on activity performance. There is also currently a capacity issue at our main Provider (St George's) and therefore any reduction in admissions would help release beds for specialist activity.

Potential risks could sit with our Community and Mental Health Providers where, investments will be given to schemes that deliver the reduction in emergency admissions. These schemes will have agreed KPIs and penalty clauses where targets are not met.

System-wide risks of the integration agenda will be reviewed among all partners. Where the impact of deliverables risks any one of the partners being at financial risk, the parties will work together through the Merton Integration Board to mitigate that risk.

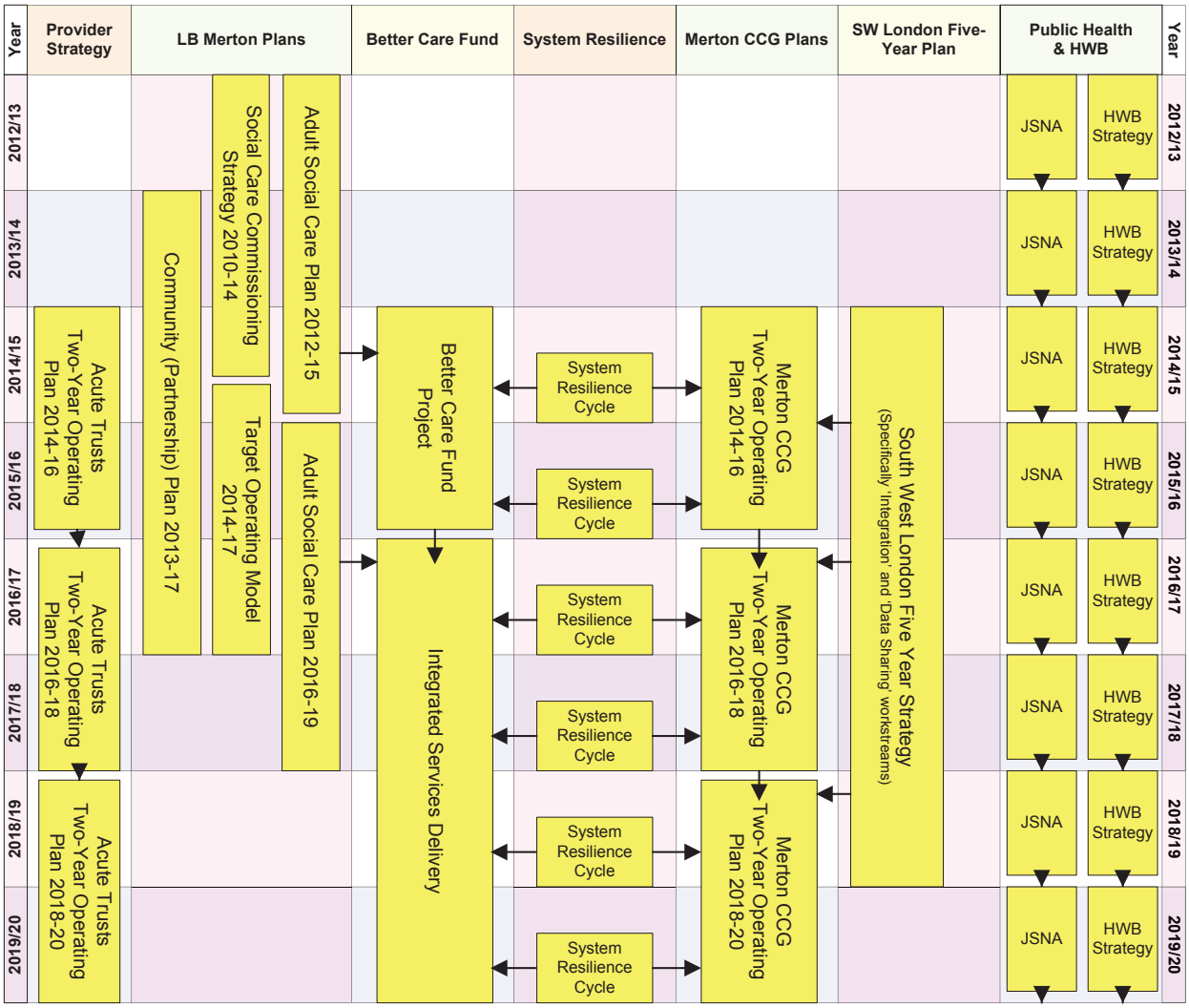
6 ALIGNMENT

(a) Please describe how these plans align with other initiatives related to care and support underway in your area

20 Alignment with other plans

Broadly, the long-term vision for integrated health and social care services for Merton will align with the other Merton strategies illustrated below.

Figure 21: Illustration of interdependencies between strategies



(b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

21 Alignment with two-year and five year operating plans

The BCF provides a framework for these successful, joint initiatives to become appropriate, integrated services with a suitable funding structure and outcomes to support them and the Merton partners welcome this initiative to improve service delivery for patients and service users in the Borough.

For Merton CCG, the Better Care Fund Plan and the implementation of the service changes and schemes, forms the core of a wider two-year operational plan linking with our key delivery areas as well as the vision and strategy for south west London as outlined in our five-year strategic plan.

As outlined in Merton CCG's two-year operational plan our key delivery areas which align with our BCF plan include:

1. Older and Vulnerable Adults
2. Mental Health
3. Keeping Healthy and Well
4. Early Detection and Management
5. Urgent Care
6. Children and Maternity

Merton CCG is committed to focusing efforts on a wider transformational service redesign that will deliver a financially sustainable health system over two years and has recognised that a sustainable health system can only be achieved in partnership across our health and social care economy.

The two-year Operational Plan also reflects the need to develop integrated services and an associated programme is also being initiated to ensure that the Plan's objectives are delivered within a formal framework.

The BCF (as the Merton Integration Plan) also aligns with the LB Merton Service Plan for Adult Social Services and Figure 18 demonstrates how the three strategies are interrelated. Figure 19 subsequently explains how the natural synergies between the 'Merton Model' work stream within the BCF Project (where the delivery of the schemes sit) and the 'Older and Vulnerable Adults' work stream of the two-year operating plan were combined to ensure a coordinated delivery of outputs across both strategies.

Figure 22: Interdependencies between BCF, CCG Two-Year Operating Plan and LB Merton Service Plan

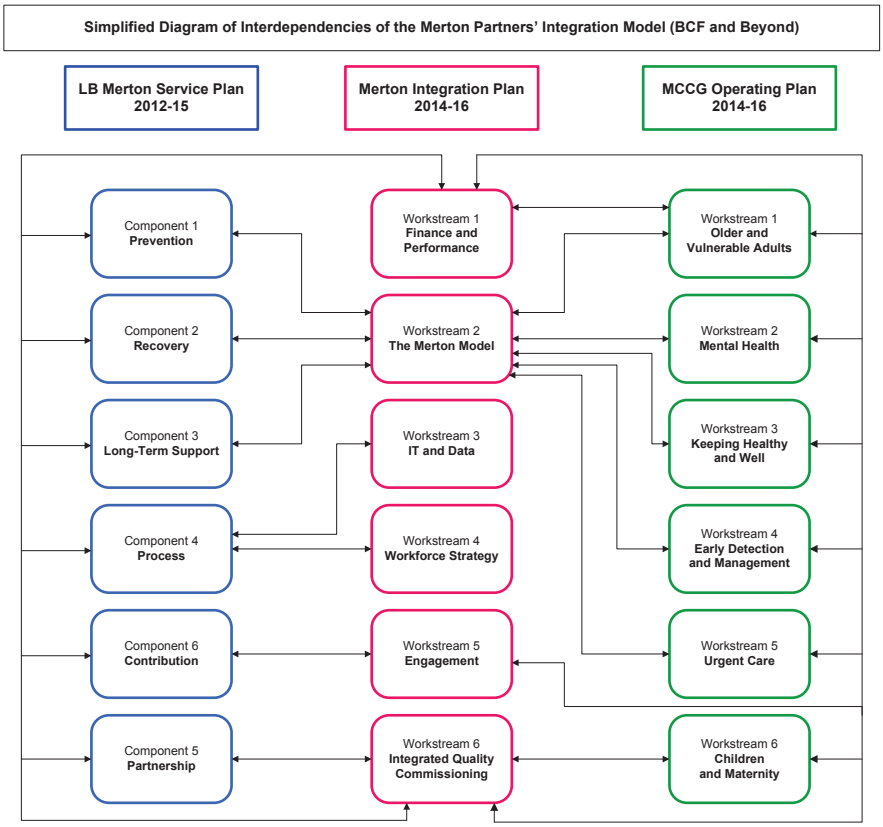
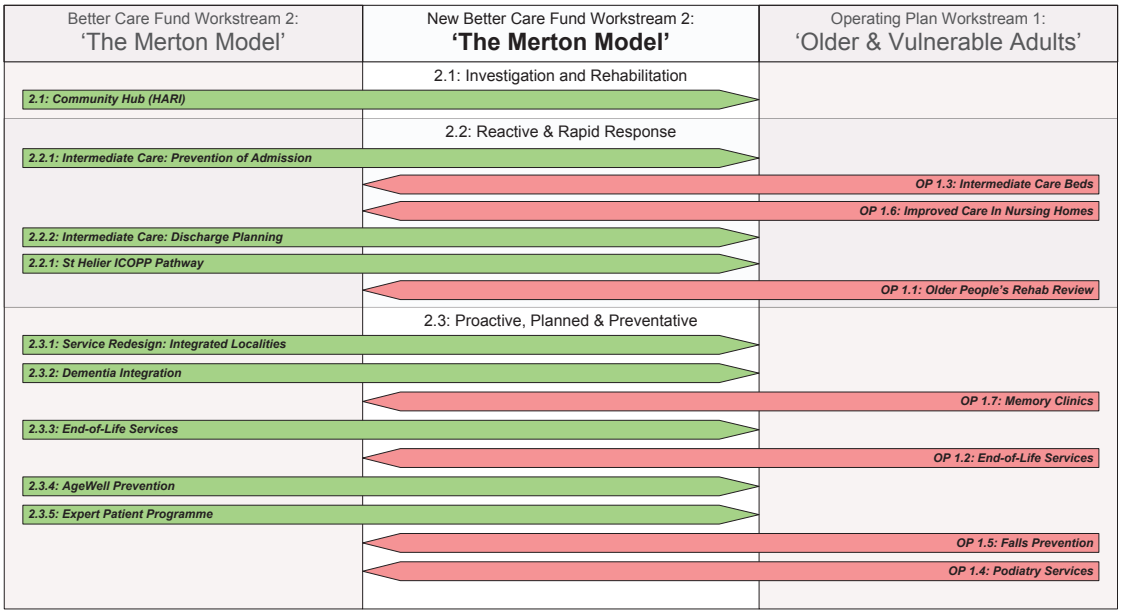


Figure 23: Combining work streams across the BCF Plan and the Two-Year Operating Plan



(c) Please describe how your BCF plans align with your plans for primary care co-commissioning.

22 Co-commissiong

CCGs in SWL submitted a joint expression of interest for primary care co-commissioning in June of this year. CCG leads, alongside their local authority counterparts recognise that the lack of aligned incentives between commissioning acute, community and social care services with primary care, presents risks to the successful implementation of BCF plans. Stakeholders, including patients and the public, who have engaged on a SWL level, have stressed the importance of improved access to good quality primary care. Co-commissioning primary care is therefore an important element of the BCF.

Since submitting the primary care co-commissioning EOI, CCGs have come together to form the SWL Transforming Primary Care Delivery Group. This includes the NHSE London LAT. This group has overall responsibility to lead the implementation of the Transforming Primary Care strategic plan for SWL. In addition, CCGs are working with NHSE to develop further plans for primary care co-commissioning, currently reviewing which functions are developed locally and under joint commissioning arrangements.

SWL CCGs have identified the following specific benefits of co-commissioning primary care:

- Local knowledge and intelligence of need and patterns of services in general practice, including already commissioned LES contracts to allow more effective commissioning at the local level
- Better coordination and alignment of already commissioned CCG services with general practice services
- Greater achievement of objectives and plans for transforming primary care in SWL through the 5-year strategic plan and the opportunity to affect change at 'scale and pace'
- Better alignment of current CCG primary care schemes with overall commissioning intentions for primary care. This includes, reducing variation in quality of primary care through implementation of the primary care service specifications (formerly primary care standards), closer monitoring and better relationships with primary care providers and alignment of already CCG commissioned initiatives with core contracting

- Contract design based on local population needs and intelligence, with greater involvement in contract monitoring and management
- Increased scale and pace of enabling factors to transform primary care including estates and workforce

All of these benefits will contribute to the success of the implementation of the BCF and integrated care plans. In particular, better implementation and outcomes for integrated multidisciplinary teams and blurring organisational boundaries where appropriate.

Commissioners in SWL are interested to assume responsibility for joint commissioning of primary care in order to align commissioning and incentives so that:

- There is appropriate support and suitable incentives to build multidisciplinary working with the right level and processes for accountability, improving the care of people with LTCs and complex needs
- Models of general practice provided and improved access to primary care services focus on the needs of the local population, in line with the HWB strategy and social care (as well as the health) needs of the population
- Primary care capacity and changes in service provision and skill mix to support this, align with local plans for expanding community services
- Primary, community and social care providers work together to reduce health and social care inequalities

Commissioning intentions for primary care are aligned with those for acute and community provision.

7 NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections

(a) Protecting Social Care Services

(i) Please outline your agreed local definition of protecting adult social care services (not spending)

Merton's definition of Protecting Adult Social Care Services is as follows:

"Enables social care to continue to operate in a way that ensures that the whole system works effectively, and that core social care services are not undermined. This will be done through the integration agenda, sharing a pooled budget, reconfiguring services and rearranging the workforce."

(ii) Please explain how local schemes and spending plans will support the commitment to protect social care.

Merton is committed to mitigate the impact of savings that the council has to find in the following ways:

- Funding for core services which are essential to the whole system, at the same time modernising them.
- Working together to find efficiencies that also benefit social care.
- Continued joint investment in prevention.

The framework for this the efficiency and investment framework was developed and piloted in Merton and is now used nationally.

The following specific activities will facilitate the protection of social care services:

- The scheme on prevention, Ageing Well, is one protection element. By adding £80k of funding in 2015/16, the BCF will protect the Ageing Well programme, for which the Council is planning to reduce funding in future years. Outcomes for the programme will be agreed between the BCF partners
- The council will ensure 24 hour access to Domiciliary Care Packages. The council will meet the demand from health sources, offering timely and prompt service in the community as an alternative to hospital admission and on discharge
- LB Merton is planning to achieve efficiency measures where the effect upon capacity of hours delivered will be minimal. The additional funding from BCF will help protect the service and also includes funding for night sits, and the extra demand for visits resulting from successful avoidance of hospital admission
- The New Duties scheme is as per the national guidance whereby the amount is proportional to the nationally announced figure. It is expected to be spent mainly on staff to undertake the additional assessments required
- Expanding the council's capacity to arrange care packages during the weekend (8am-5pm) and in the weekday evenings adding a care package from (5pm-8pm). This scheme is also expected to include greater responsiveness from the MASCOT Telecare service

- The 7-day working proposal is to expand the hours of the community rehabilitation team, which works with people in intermediate care beds in specific nursing homes, and also in people's homes. This will mean that both the health and social care elements of the reactive stream will move to 7 days. This provides the basis for integrating these two services (and others in the reactive stream) on an even footing

Merton has agreed with host commissioners that it will be involved in contract review meetings and local communications between partner providers to ensure there is a continued focus on Merton despite the fact that it is not a host commissioner for acute trusts

(iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.).

The agreed figure for protecting and modernising social care within the BCF is £3,577,000. This includes funding for care packages, funding for Merton Independent Living and Reablement Service (MILES), and funding for implementation of the Care Act.

(iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met.

The Care Act brings new duties and pressures into the health and social care system, in particular:

- assessing people who fund their own care.
- assessing carers who have new rights for assessments and services.
- implementing national eligibility criteria.
- ensuing that safeguarding arrangements reflect the new statutory basis and the new definition of those for whom we have a duty to safeguard.
- implementing the new threshold of £118k below which the council must make some financial contribution.
- taking the overview of the market and having contingency plans for provider failure.
- applying the over arching principles a of Wellbeing and Prevention in how support is commissioned and delivered.

Our intention is to ensure that these issues are embedded in our arrangements for integration. For example, our shared assessment processes in proactive case management will need to have regard to national criteria, assessments of carers should look at their needs across health and social care, and support to providers already comes from the CCG as well as the council. Our shared governance and project structures ensure that planning can take place in the right places.

(v) Please specify the level of resource that will be dedicated to carer-specific support.

Merton has allocated £551,000 for carer support during 2015/16.

(vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?
The London Borough of Merton faces a challenging financial environment. It has an agreed Medium Term Financial Strategy which has already delivered significant savings but has more to find through to 2018 to ensure financial balance. Whilst the political administration has promised to protect support for vulnerable people, in reality, adult social care has to deliver further significant savings. The part of the BCF for protecting and modernising social care will help to ensure that services vital for the whole system will be maintained and that these services will play a full part in achieving whole system objectives such as reducing non elective submissions.

(b) Seven Day Services to Support Discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Strategic Commitment

Merton already performs in the upper quartile for NEL admissions; therefore to improve performance further, there must be a step-change in the way that services are provided. There is a shared commitment between LB Merton and Merton CCG to reorganise and expand existing services to operate for seven days of the week, and an appreciation of the interdependencies between health and social care services in achieving these aims.

Locally Agreed Plans

Achieving truly integrated seven day services is core to Merton's plans for future services. The approach will see the development of complementary services in health and social care, integrated to provide patients and service users a seamless service as the BCF is fully implemented. To meet this objective, a specific pillar of the BCF will focus on transitioning services to seven-day working; meaning admissions to an acute setting can initially be avoided and discharge is not delayed merely because it is a weekend. Fundamentally the service model will change contractual arrangements with community and social providers will need to change and the ways the community and indeed the primary care workforce will change.

Although Merton currently has a low level of delayed transfers of care, moving to a seven-day model of working offers the opportunity of significant advances in this respect. The seven day working model of care is expected to be fully operational by the end of 2014/15, and the period of implementation will be used to understand emerging levels of integration between services and drive improvements where required. Underpinning the changes is the move to three integrated MDTs organised into geographic localities. Through the BCF, Merton is making considerable investments to support the development of these locality teams, and they will become the vehicle that delivers seamless, integrated and consistent care for seven days.

The role of the Merton Integration Board is to provide practical support for the local integration of services. Through this representation and reporting, the key points in the Joint Health and Wellbeing Strategy can be met in a practical sense. Our operational subgroup, enabled by the finance and performance, quality and workforce and culture subgroups, will be responsible for further planning, mobilising and delivering our plans for seven-day services. In addition, the integrated care project board, and the executive teams will assess our progress to deliver this, directly against our performance on the national metrics.

Social Care Plans

LB Merton is proposing that social care services undergo a full restructuring to ensure that 'the right staff with the right skills are available in the right place at the right time'. This change will allow for additional capacity to arrange care packages in the evening and on weekends, preventing the historical delays associated with discharging from acute settings Friday through to Sunday. Reorganisation will enable additional social care staff to be based at St Helier and St George's, while services such as intensive home care and night sits will facilitate timely discharges and receiving individuals with social care needs back into the community over seven-days.

Through making services available for greater periods of the week, social care related additional bed days in hospital can be reduced. In order to aid integration, teams will be structured into three localities, mirroring the organisation of health services.

Health Plans

Merton CCG already commissions some services that operate for seven days, such as community nursing (provided by SMCS). Along with this service being expanded, two new seven-day services will be commissioned: community rehabilitation and intermediate beds located within nursing homes. The later service will be offered to patients with a high potential to return to their home after a short spell of intermediate care to rehabilitate intensively to an acceptable level of functioning in the home environment.

The aim of these services is that acute trusts will experience no difference when discharging patients no matter what day of the week it is. Services such as intensive rehabilitation in people's homes and additional rehabilitation in intermediate settings will facilitate timely discharge from the acute setting. Expanding community nursing keeps people in their homes for longer, avoiding potential emergency admissions where there is no other alternative.

(c) Data Sharing

(i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services.

NHS commissioned services are using the NHS number as the primary identifier for correspondence. Primary care, through contract changes effective from 1 April 2014, also uses the NHS number to communicate with other services.

Local Authorities do not currently use the NHS Number as the primary identifier for correspondence across all health and care services but have plans in place to do so. Although our current social care database is not capable of allowing both the Carefirst number and NHS number to be used in conjunction as primary identifiers LBM has recently tendered for their social care system and are in the process on implementing Framework-i. This system will use the NHS number as primary identifier and will be live on a phased basis between June and September 2015. A complimentary training process for IG will accompany this change.

In the meantime, we have been through a comprehensive data matching process within our current system, CareFirst, and currently have 83.1% compliance for NHS numbers in Adult Social Care as at September 2014.

The NHS number has also been added as a field on the Initial Contact forms designed to accommodate the new Adult Social Care Collections (Zero Based Review – ZBR) and we will work through the remaining data over the coming months with an ambition to be fully compliant when we launch the new system.

Once this is in place we have an ongoing process for keeping the NHS numbers up to date they will run regular reports that will identify missing NHS numbers. These reports will be circulated to the relevant managers for action as part of our regular data quality monthly reporting. They will also consider developing an NHS number for completeness performance indicator

Alongside the technical work needed to get the NHS number uploaded into our Social Care System we have also designed a programme of work designed to support information sharing based around this information.

This will include:

- Using the NHS number as the basis for information sharing prior to an Multi-Disciplinary Team meeting to allow practitioners who have a legitimate relationship with a service user to prepare accordingly.
- Working with our newly formed locality teams to see how information can be shared better within those teams. Any information sharing in these settings will be based around the NHS number and legitimate relationships between the practitioners and patients and service users.
- Development of Information Sharing Agreements and Fair Processing Notices where these are relevant
- Specific training for staff looking at information governance but with a focus on helping staff understand their responsibility re: using the NHS number to facilitate information sharing and how to do that within the legal framework.

(ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)).

Our Commitment to APIs and Open Standards

The following organisations are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)):

- Merton Council
- Merton Clinical Commissioning Group
- Sutton and Merton Community Services (part of The Royal Marsden NHS Foundation Trust)
- St George's Healthcare NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust.

LBM and Merton CCG recognise that interoperability between different systems is essential to delivering integrated health and social care systems and the partners are committed to pursuing an information architecture that is built on open application programming interfaces (APIs). An initial list of systems holding relevant data has been compiled by the SLCSU working on behalf of the SW London CCGs and Boroughs. This work will form the basis of some further work by the SW London CCGs Commissioning Collaborative proposing a solution across South West London.

Merton will support and contribute to this process.

NHS Mail is widely used across our partnered NHS organisations, supported by N3 Connectivity, for the secure transmission of patient confidential data, and LB Merton have implemented third party email gateway security solutions: Proofpoint, GC Mail and CJSM, the latter two of which are specifically compatible with NHS Mail.

(iii)	**Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.**

The following organisations are committed to ensuring that the appropriate Information Governance Controls will be in place.

- Merton Council
- Merton Clinical Commissioning Group
- Sutton and Merton Community Services (part of The Royal Marsden NHS Foundation Trust)
- St George's Healthcare NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust

We are committed to ensuring that appropriate IG controls will be in place. We are committed to obtaining and maintaining a minimum of level two on all IG Toolkit requirements. We are committed to upholding the values of Caldicott 2, and to fulfilling our duty to share.

- The confidentiality of service user information will be respected
- The duty to share will be met in order to ensure that members of the care team have access the data that is necessary for the delivery of safe and effective care
- Information that is shared for indirect care purposes should be anonymised.
- The rights of service users to object to their data being shared will be respected

We have designed our organisational structure in such a way to give sufficient precedence and priority to information governance, through the IT and data sharing group.

This IT and data sharing group has developed a programme of work based around the following key themes:

- Information Sharing Agreements
- MDT meetings
- Co-ordinate My Care Pilot
- NHS Numbers
- Commissioning and Contracts
- Training
- Consent
- System Access
- Paper records
- Communication

Taken together we believe these themes will deliver improved data sharing amongst health and social care professionals which will, in turn contribute to better outcomes for service users.

(d) Joint assessment and accountable lead professional for high risk populations

(i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them.

The following four component activities with the central professional; the key worker, who acts as the accountable lead professional, is the mainstay of the principle of our out-of-hospital strategy, the expansion of our community-based service model and development of inter-relationships between community services, social care services and primary care.

Figure 24: The key activities and central professional underpinning integrated working

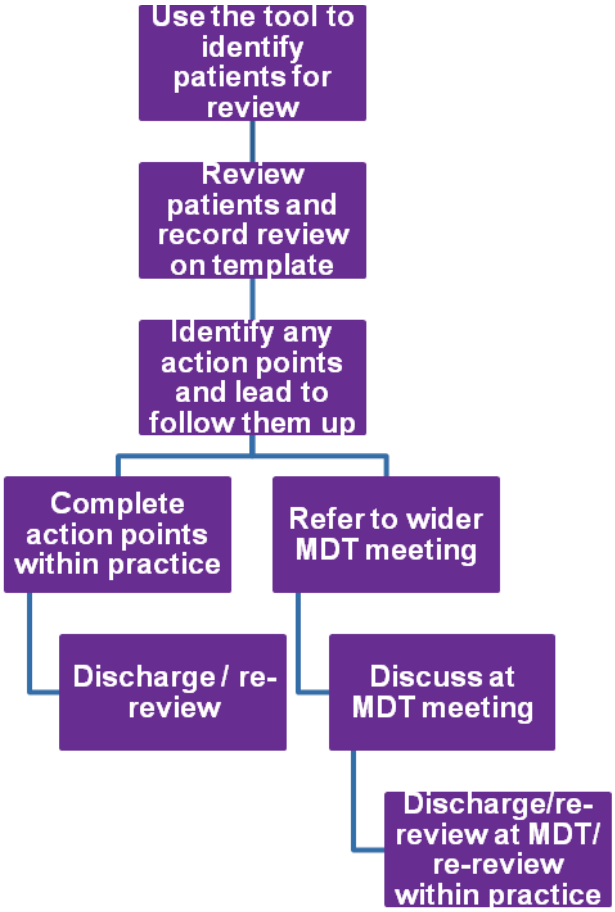
As stated comprehensively in Section 3, all 25 GP practices in Merton are already undertaking risk-stratification profiling using the Sollis tool to proactively identify patients at high risk of deterioration and subsequent escalation in the community or who are frequent attenders in acute services.

Currently, 3510 adults registered with Merton GPs are at Very High and High risk of admission. During 2013/14, these adults had 6519 emergency admissions to hospital.

(ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population.

GP practices and GP leads in Merton are using the risk stratification profiling as per the following flow chart, linking in with multi-disciplinary teams:

Figure 25: GP Risk Stratification, as used in Merton



Virtual case management forms the core activity of multi-disciplinary meetings where primary care and community clinicians, alongside social care professionals review ways in which to deliver care to patients, and jointly agree action plans.

A **key worker**, with an appropriate professional background is assigned and is ultimately responsible for co-ordinating the care of the individual and providing first-line support to the person and carer in terms of communication, initially assessing ongoing need, developing expectations of care and reflecting this in their care plan.

The key worker is also responsible for communicating progress or further need back to appropriate professionals, including clinicians who need to be connected in with ongoing actions, as well as to the wider MDT team. Ideally this will ultimately take place through a shared record system, using the NHS number as a unique primary identifier, and through the appropriate channels in relation to the level urgency (telephone, email, meetings etc.). The latter data sharing component of this way of working is expected to take longer to achieve.

(iii)	**Please state what proportion of individuals at high risk already have a joint care plan in place.**
	Merton does not currently have access to this information. However, we have conducted an audit of Very High and High Risk patients at one practice and this audit demonstrated that 100% of those patients who had 3 or more admissions in the past year had care plans in place. Merton CCG is currently planning implementation of software that will enable this information to be provided. The expected timescale for implementation is November 2014.

8 ENGAGEMENT

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections

(a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future.

As part of the process of designing a new approach to integrated care in Merton, we have held a number of events which have included consulting and engaging staff, clinicians, the voluntary sector, service users and carers. Users and carers have been involved from the early stages in the design of our integration project, and an evolved learning approach is one our guiding principles which underpins the way we design integrated care. The following activities took place or are taking place to engage patients, service users and the public in the development and design of integrated services:

August 2013: 'What would brilliant look like?'

This event was attended by 50 service users and carers as well as the voluntary sector to identify what would define a brilliant integrated care system in Merton. Feedback and suggestions from this event were captured and this input has been used to develop the local model.

October 2013: Engage Merton

We ran an event called 'Engage Merton' in partnership with Healthwatch Merton. More than 60 patients, members of the public, service users, carers, clinicians and other stakeholders were involved in discussions about the Commissioning Intentions for 2014-2015 and the Engagement Strategy and Implementation Plan for 2013-2015. The findings from the event enabled us to set priorities, form Commissioning Plans and develop an Engagement Strategy.

The event identified 'seldom heard' groups including, housing associations, individuals from the traveller community, members of the public without internet access, amongst many others, and developed ideas for engaging with these groups going forward. Feedback also provided us with greater insight into how the voluntary sector can support the integration agenda in Merton. This can be seen in Appendix 1.

November 2013: Integrated Care Model Simulation

We ran a simulation of the process, involving service users and carers, GPs, social workers, clinicians as well as managers from acute hospitals, community and mental health providers. During the simulation a group of service users and carers acted as advisors to each of the professionals who were playing the role of a 'key worker.'

They were also part of a group participating as voluntary and community groups. This event helped to test the 'Merton model', acted as a learning event for professional development, and gained knowledge from the perspectives of all the people who were involved.

April 2014: 'Introducing the Better Care Fund Integration'

A catered, half-day stakeholder event was held in April 2014, attended by more than 30 organisational stakeholders (commissioners, providers, voluntary sector, etc.). The event introduced the submission, as agreed by the Health and Wellbeing Board, and initiated the Merton-wide stakeholder management plan, as part of the overall project framework.

September 2014: 'Joining Health and Social Care' – Your Experiences

A full-day event facilitated by Healthwatch Merton at which 40 service users, patients, carers and members of the public were asked about their experiences and opinions of six areas of integration focus: dementia, carers, end-of-life care, crisis, discharge from hospital and keeping well at home. The format of small groups and facilitators rotating around the tables delivered excellent results and these are currently being reviewed in order to shape the continued development of integrated services in Merton.

(b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

(i) NHS Foundation Trusts and NHS Trusts

Merton CCG and LB Merton have been progressive in their approach to engaging and involving service providers in how services should be developed and redesigned to meet the integration agenda and meet the rising demand for health and social care. Given that Merton does not host an acute provider and shares a community provider with Sutton, a complex multi-stakeholder environment results creating even more weight to ensuring that health and social care providers are involved in parallel with designing services.

Whilst commissioners in Merton will provide the momentum, strategy and framework for service-level change, Merton CCG and LB Merton are acutely aware that service providers bring good insight into frontline issues and solutions. In addition it is recognised that workforce planning and step-changes in multi-professional working across health and social care organisational boundaries, can only be overcome through a carefully managed and continuing engagement between commissioners and providers.

We therefore hosted two engagement events on 16 July 2014 and 21 July 2014, which was attended by Directors from our Acute and Community providers to present our BCF schemes and changes we were planning. We hosted a further event on the 14th of August to engage our main acute providers (St. Georges Healthcare NHS Trust and Epsom and St. Helier University Hospitals NHS Trust) with the methodology we used to quantify the impact of our schemes of Acute emergency activity.

We have maintained a constant dialogue with identified leads at our main Acute providers and they have agreed to our forecasts relating to impact on emergency admissions.

As part of the 2013/14 contracting process, we shared our projected impact on emergency admissions at HRG level with St. Georges NHS Trust and Epsom and St. Helier University Hospitals NHS Trust. This will be repeated as part of the 2015/16 contracting process; however, as part of the BCF resubmission our providers have been part of the process of forecasting the predicted impact.

(ii) Primary Care Providers

GPs have been kept informed about progress with the BCF Plan through regular communications and through the GP Practice Leads Forum.

(iii) Social Care and Providers from the Voluntary and Community Sector

The voluntary and community sector, including providers, are represented at all levels in the integration and BCF governance structures, including the Merton Integration Board, Project Team, Merton Model Development Group and in developing work packages, as appropriate.

(c) Implications for Acute Providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The introduction of the BCF is likely to have far reaching implications in terms of the way that health and social care is provided in the future. Many of the resultant changes are likely to be felt most intensely by acute providers. Recognising this Merton, through bodies such as the Merton Integration Board, has engaged with providers to ensure that there is a shared awareness of the likely changes.

When the changes to integrated care are fully implemented, the whole-system effects are expected to provide benefits to acute providers in the area. A reduction in the numbers of emergency attendances and admissions will relieve pressure on trusts' A&E departments, better enabling them to meet the 4-hour A&E target and also reduce the amount of activity that is funded at the marginal rate (currently 30% of tariff).

The Merton HWBB projected reduction of non-elective FFCE activity on our acute providers is shown in the table below. This takes into account projected 2.2% growth and will enable Merton HWBB to deliver an overall 3.5% reduction on non-elective FFCEs.

Figure 26: Forecast impact of Merton BCF schemes on our main acute providers

Total forecast impact on Acute provider NEL FFCEs 2015/16 in general and acute due to Merton BCF Schemes					
	St George's NHS Trust	**Epsom & St Helier NHS Trust**	**Kingston NHS FT Trust**	**Croydon NHS Trust**	**Merton HWBB reduction of NEL FFCEs**
Proactive Schemes	223	102	13	13	351
Reactive Schemes	404	184	23	24	635
Total Impact	**627**	**285**	**35**	**38**	**986**

These calculations have been shared with providers as part of the BCF submission process and will be used as part of the 2015/16 contracting process to reflect planned QIPP savings.

Current forecasts to quantify the benefits of reduction of non-elective FFCEs for the BCF submission have applied the national average tariff for non-elective admissions of £1490. However, further work is required to validate this forecast, as our Acute providers have identified that currently, a significant amount of this activity occurs under the short stay general medicine tariff of c£380 per admission. We will continue to work with our providers to estimate the financial value of the reduced activity, and these calculations will be used in the 2015/16 contract.

Figure 27: Financial impact of Merton BCF schemes on our main acute providers

Total financial impact on Acute provider NEL FFCEs 2015/16 in general and acute due to Merton BCF Schemes					
	St George's NHS Trust	**Epsom & St Helier NHS Trust**	**Kingston NHS FT Trust**	**Croydon NHS Trust**	**Merton HWBB reduction of NEL FFCEs**
National tariff for FFCEs	£1,490	£1,490	£1,490	£1,490	£1,490
Prevention of forecast 2.2% growth	242	110	14	15	381
3.5% reduction	385	176	22	23	605
Total Financial Impact	**£933,824**	**£426,422**	**£52,753**	**£55,992**	**£1,468,991**

As many of the schemes included within the BCF are interdependent between Merton CCG and LB MERTON, a risk-sharing agreement has been reached. This will ensure that both partners are able to take greatest advantage from the fund, and that in the case of non-performance one organisation would not be disproportionately disadvantaged, as well as taking joint responsibility for the whole health and social care economy.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

Scheme ref no.
Merton 1.1
Scheme name
Reactive Community Schemes to Prevent Admission
What is the strategic objective of this scheme?
The strategic objective of this scheme is to put in place a number of coordinated initiatives to support the prevention of admission teams in Merton to meet the objective of keeping people out of Acute hospitals and treating them in the community. The scheme comprises a number of coordinated components that have the objectives of • Further reducing the number of delayed transfers of care. • Reducing non-elective emergency admissions. • Evidencing the effectiveness of reablement. • Reducing admissions to residential and nursing care. • Improving the overall patient and service user experience.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The impact of reactive response is quantified on the basis of the number of admissions to hospital that could reasonably be treated by alternative community services/responses implemented under BCF. Analysis and modelling is based on Acute HRG codes. This is based on the current QIPP modelling that provides a granular detail regarding the number and type of emergency admissions at HRG level that BCF reactive schemes aim to prevent. This is a currency that providers know, use and can monitor. In summary, the reactive modelling is set out below: • The 2014/15 QIPP forecasts a 49% reduction on admission to St George's Hospital, Epsom & St Helier Hospital, Kingston Hospital and to Croydon Hospital with one of the 10% of HRGs deemed to be treatable in the community due to implementation of community response services such as the CPAT or HARI services. • The 2015/16 QIPP/BCF benefits from the full year effect of these schemes as implementation is forecast to be completed by 2014/15 year end. The service model is able to reduce the likelihood of avoidable emergency admission in times of deterioration or crises by ensuring that appropriate and responsive care and support is available in the community, including access to specialist care In addition, the service model is able to reduce service users' length of stay in acute services, encouraging a smooth discharge with appropriate support in the community to deliver high quality care, promote rehabilitation and reablement, preventing readmission into acute services or subsequent admission into care homes.

Services are particularly focused on a 7 day a week and 24/7 model of delivery where appropriate, and therefore embeds out-of-hours capacity and appropriately skilled 'night' staff to ensure a reactive approach to care in the community, relieving the pressure on emergency departments. In particular, seamless communication and interactions with local urgent care services, NHS 111 and primary care will be delivered. This will also include the rapid deployment of social care provision in the community where required

Escalating care needs or crises are identified and responded to swiftly by dedicated multi-professional teams with sufficient capacity to enable people to stay at home unless acute specialist care or intermediate or respite care is required. These community teams work closely with acute care colleagues to avoid emergency and unplanned care admissions

The capacity of rehabilitation and reablement services, professionals and skill will be increased in the community, to ensure that needs addressing independence and functionality are addressed, preventing admission to hospital, ensuring discharge from hospital is timely or preventing premature permanent admission to care homes

Rehabiltation and reablement capacity is supported by intensive short-stay intermediate care (non-home based) to reduce likelihood of admission to hospital or promote earlier discharge from hospital. This service will be kept to an essential minimum (continuing to promote home-based care where appropriate) and referral criteria will be strictly controlled by service leads to ensure that only people with a potential to return to independence are managed through this service. This is to prevent 'bed-blocking'

Greater specialist support to be delivered in the community in collaboration with primary care, by enhancing relationships and communication between acute care professionals, primary care and community-based professionals. This includes responsive and timely specialist advice and support given to primary care professionals to prevent admissions and promote discharge from hospital, and the ability for GPs to 'fast-track' diagnostics (including community-based diagnostics) and clinical review for 'at risk' individuals

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Service:	Delivered by:	Commissioned by:
Community Prevention of Admission Team (CPAT): nursing team across the whole of Merton – supplemented by System Resilience funding over the winter.	Sutton & Merton Cmty Services (CH Provider)	Merton CCG
Holistic Assessment and Rapid Investigation Service (HARI): rapid access (24 hour) to clinical and medical investigations in a community hospital setting.	TBC (contract awarded)	Merton CCG
Merton Independent Living and Enablement Service (MILES): short-term reablement service delivered by in-house reablement team. Currently being reviewed.	LB Merton	LB Merton
Community Intermediate Care Beds: step-up and step down facilities to be used for rapid response to emergency and crisis situations.	Various nursing home providers.	Merton CCG

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The basis for this work largely comes from the well referenced national documents that have set out research to manage emergency admissions. These are primarily:

- The National Audit Office, Emergency admissions to hospital; managing the demand (October 2013): http://www.nao.org.uk/wp-content/uploads/2013
- The Kings Fund, Emergency hospital admissions for ambulatory care sensitive conditions; identifying the potential for reductions (April 2012): http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf
- The Kings Fund, Avoiding hospital admissions, what does the research evidence say? (December 2010): http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010_0.pdf

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Through the Merton BCF programme structure, the Finance and Performance Group monitors the strategic programme indicators (non-elective FFCEs and the HWBB indicators) as well as operational indicators such as service activity and effectiveness.

The group also commissions ad-hoc audits to evaluate specific areas of service delivery in order to gain an understanding of the correlation between operational indicators and strategic indicators in order to evaluate the impact of individual schemes.

What are the key success factors for implementation of this scheme?

- Out of Hours Brokerage Officers to source and set up care packages.
- Occupational Therapists to implement reablement programmes and techniques and/or provide equipment, minor adaptations and Telecare prior to service packages and /or admissions to residential/nursing or hospital beds.
- Out of hours admin support to update the data base on a real time basis.

- Additional carers to provide short term intensive home care and night sits.
- Mobile Response Officer to provide back up and immediate installation of telecare monitoring system.
- Carers and users feedback.
- Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care.
- Implementation of 7 day working in social care.

Scheme ref no.
Merton 1.2
Scheme name
Proactive Community Schemes to Prevent Admission
What is the strategic objective of this scheme?
For the proactive model, risk stratification provides primary and community providers with an indication of the number of patients that should be proactively managed and therefore forecasts an impact on admissions for these patients. This model provides the BCF project team with an indication of the required scale of community case management by MDT teams. A risk stratification model was developed to examine the impact on emergency admissions activity forecast and validated with the support of Merton CCG's Clinical Director for Integration, Adults and Vulnerable People. This is quantified on the basis of number of people being managed through integrated MDTs, which operate in all of Merton's 25 GP practices. In summary, the proactive modelling is based on the following: • The 2014/15 QIPP forecasts a 49% reduction on Ambulatory Sensitive Conditions. • The 2015/16 QIPP/BCF forecasts that 10% of Very High Risk and High Risk patient will benefit from a reduction of one admission due to Case Management
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• A service model where coordination of the journey and experience of people (service users) identifies those who are vulnerable or could benefit from care, and which focuses on prevention, self-management, education and training, increase in quality of living and life expectancy promoting overall wellbeing. • A service model where skilled workers coordinate ongoing proactive care in their multi-professional locality teams, each 'facing' acute care trusts in neighbouring localities (West Merton – St. George's Hospital, Raynes Park – Kingston Hospital and East Merton – St. Helier's Hospital). Each locality team will work with their locality network of GP practices, with access to specialist support in the community as required. Multi-professional teams are 'blended' to provide appropriate disciplines, skill mix, leadership and accountability to provide a proactive approach to care. • Risk stratification and case management activities across multi-disciplinary teams will deliver proactive care, identifying and managing individuals at risk of deterioration, admission to acute care services or care homes, supporting care which addresses the needs of the 'whole person'. • Each identified person will have a strong relationship with their GP or key worker who is able to lead as their care-coordinator, helping them to receive timely and consistent support and care from a multi-professional and multi-organisational team.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Service:	Delivered by:	Commissioned by:
Holistic Assessment and Rapid Investigation Service (HARI): rapid access (24 hour) to clinical and medical investigations in a community hospital setting.	TBC (contract awarded)	Merton CCG
Merton Independent Living and Enablement Service (MILES): short-term reablement service delivered by in-house reablement team. Currently being reviewed.	LB Merton	LB Merton

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The basis for this work largely comes from the well referenced national documents that have set out research to manage emergency admissions. These are primarily:

- The National Audit Office, Emergency admissions to hospital; managing the demand (October 2013): http://www.nao.org.uk/wp-content/uploads/2013
- The Kings Fund, Emergency hospital admissions for ambulatory care sensitive conditions; identifying the potential for reductions (April 2012): http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf
- The Kings Fund, Avoiding hospital admissions, what does the research evidence say? (December 2010): http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010_0.pdf

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- **Clinical** – patients and service users will not be admitted to an inpatient hospital ward unless medically necessary, enabling customers to have their needs met in the least intrusive manner, and as close to their familiar home environment as possible.
- **Operational** – joint working between health and social care staff with enhanced hours presence will enable a more productive response to customers, who will be given the right care and support at the most effective time. The project will reduce

the spikes in activity caused currently by Monday to Friday working.

- Discharges from acute settings happen across seven days of the week, based on medical suitability for discharge and not the availability of packages of care in the community.
- Rehabilitation and reablement packages are agreed ahead of discharge and begin as soon as the person is within the community setting, regardless of the day of the week that this falls upon – overall the length of stay in the acute setting is reduced and outcomes are improved.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Through the Merton BCF programme structure, the Finance and Performance Group monitors the strategic programme indicators (non-elective FFCEs and the HWBB indicators) as well as operational indicators such as service activity and effectiveness.

The group also commissions ad-hoc audits to evaluate specific areas of service delivery in order to gain an understanding of the correlation between operational indicators and strategic indicators in order to evaluate the impact of individual schemes.

What are the key success factors for implementation of this scheme?

- Out of Hours Brokerage Officers to source and set up care packages.
- Occupational Therapists to implement reablement programmes and techniques and/or provide equipment, minor adaptations and Telecare prior to service packages and /or admissions to residential/nursing or hospital beds.
- Out of hours admin support to update the data base on a real time basis.
- Additional carers to provide short term intensive home care and night sits.
- Mobile Response Officer to provide back up and immediate installation of telecare monitoring system.
- Carers and users feedback.
- Implementation of three geographical localities and integrated MDT working to provide ‘wrap-around’ care.
- Implementation of 7 day working in social care.

Scheme ref no.
Merton 1.3
Scheme name
Protecting and Modernising Social Care
What is the strategic objective of this scheme?
To ensure that social care services are not compromised by a reduction in direct funding for social care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Protecting social care is essential to ensure that people are appropriately supported and cared for in their community. Without the necessary support, people are more likely to require intervention from health services and the more likely they are to be admitted to hospital. The Merton Protecting social care scheme enables Case Management and Prevention of admission schemes to derive benefits. Without protection of social care, emergency admissions are forecast to increase well above the predicted growth rate of 2.2%.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
N/A
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
N/A
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Through the Merton BCF programme structure, the Finance and Performance Group monitors the strategic programme indicators (non-elective FFCEs and the HWBB indicators) as well as operational indicators such as service activity and effectiveness. The group also commissions ad-hoc audits to evaluate specific areas of service delivery in order to gain an understanding of the correlation between operational indicators and strategic indicators in order to evaluate the impact of individual schemes.
What are the key success factors for implementation of this scheme?
Continued ability of Merton Adult Social Care to fund its agreed programme.

Scheme ref no.
Merton 1.4
Scheme name
Carers' Breaks
What is the strategic objective of this scheme?
To support carers to continue to keep service users and patients in their own homes and to reduce avoidable admissions to care homes.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme will increase the capacity of the Night Nursing Service, providing additional skilled support which is available to carers between the hours of 7pm and 7am in order to prevent unnecessary emergency admissions. This will primarily be through remote advice provided from a hub, extended to mobile / visit support in appropriate cases. The scheme is integrated with Merton Social Services.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Additional support commissioned by Merton CCG from Community Healthcare provider.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Evidence of impact of short breaks: http://lx.iriss.org.uk/category/short-break-research-area/evidence-impact-short-breaks-respite-care Evidence for the Impact of Short Breaks on Carer Well-Being https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/221938/DCSF-RR222.pdf
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Through the Merton BCF programme structure, the Finance and Performance Group monitors the strategic programme indicators (non-elective FFCEs and the HWBB indicators) as well as operational indicators such as service activity and effectiveness. The group also commissions ad-hoc audits to evaluate specific areas of service delivery in order to gain an understanding of the correlation between operational indicators and strategic indicators in order to evaluate the impact of individual schemes.
What are the key success factors for implementation of this scheme?
Reduction in NEL admission ascribable to carer breakdown. Patient and service user satisfaction.

Scheme ref no.
Merton 1.5
Scheme name
Investing into Integration Infrastructure (Enabler)
What is the strategic objective of this scheme?
To create an environment where data and records can be shared between appropriate professionals to prevent patients and service users having to repeat their stories multiple times and to provide a more efficient and effective process for data exchange.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme provides funding towards a multi-agency project to develop information sharing across health and social care across south west London, commissioned from South London Commissioning Support Unit. Organisations must put processes and systems in place to ensure that NHS number 'completeness' is maintained at or above 97.5% as the primary identifier in communications. It includes funding to facilitate the use of the Coordinate My Care system as a platform to hold common care plans developed by the integrated locality teams, ahead of larger-scale information sharing progress.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Development of a delivery chain for this is being coordinated with the South West London Commissioning Collaborative and, as such a delivery chain has not yet been agreed. Solutions will be developed among all commissioners.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Development of the evidence base is being coordinated with the South West London Commissioning Collaborative and, as such, evidence will be reviewed among all commissioners.

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Progress monitored through Merton Integration Board.
What are the key success factors for implementation of this scheme?
• NHS Number becomes the primary method of data sharing for customers/patients between teams within the three integrated MDT localities. • Meeting or exceeding of the targets set out as part of the *Better Care Fund* for NHS Number completeness. • Seamless data sharing within integrated locality teams and between health and social care partners.

ANNEXE 2 – Provider commentary

For further detail on how to use this Annexe to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Merton
Name of Provider organisation	St George's Healthcare NHS Trust
Name of Provider CEO	Miles Scott
Signature (electronic or typed)	Signature on embedded PDF: St George's Sign Off (PDF).pdf

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	16,882
	2014/15 Plan	17,294
	2015/16 Plan	16,517
	14/15 Change compared to 13/14 outturn	+412
	15/16 Change compared to planned 14/15 outturn	-777
	How many non-elective admissions is the BCF planned to prevent in 14-15?	371
	How many non-elective admissions is the BCF planned to prevent in 15-16?	977

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The planned non-elective admissions reduction of 1,348 (data as above) has been discussed with St. George's Healthcare NHS Trust. Our view is that this is ambitious in comparison to the plans of neighbouring CCGs. Merton already has a population admission rate in the lowest quartile nationally, and there have been changes to the threshold for local emergency admissions over the last 3 years which may make an ambitious target for reduction difficult to deliver. We support this ambition but are concerned that this does present a risk to delivery. Merton CCG has been clear that the mechanism for delivery of the planned reduction in non-elective admissions is entirely through out of hospital

		services.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes.

ANNEXE 2 – Provider commentary

For further detail on how to use this Annexe to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Merton
Name of Provider organisation	Epsom and St Helier University Hospitals NHS Trust
Name of Provider CEO	Chrisha Alagaratnam
Signature (electronic or typed)	Signature on embedded PDF: EStH Sign Off (PDF).pdf

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	16,882
	2014/15 Plan	17,294
	2015/16 Plan	16,517
	14/15 Change compared to 13/14 outturn	+412
	15/16 Change compared to planned 14/15 outturn	-777
	How many non-elective admissions is the BCF planned to prevent in 14-15?	371
	How many non-elective admissions is the BCF planned to prevent in 15-16?	977

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	N/A
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust fully supports the principles of the Better Care Fund and the schemes developed by partner agencies in Merton, led by Merton CCG and the London Borough of Merton to implement integrated

		care for the local population. Merton has worked collaboratively with the Acute Trust and other partners to establish clear objectives and agreed metrics across the schemes. There is a programme management approach to monitor the impact at point of delivery in the community settings and we are working with the leads to establish how best to correlate these with acute emergency activity data. We would encourage a focus on data quality and data capture across the schemes, enhanced by clinical audit and user experience feedback. The Trust is reassured by the detail of the benefits modelling and evaluation. We will build on this work to develop a monitoring framework that contributes to understanding the schemes that demonstrate the greatest impact. Merton has calculated the target reduction in non-elective admissions at 5.7% which includes a growth of 2.2%. We would like to note that we have seen a 5% growth in year of attendances at St Helier A&E, including the urgent care centre. Further consideration may need to be given to the changing landscape with the closure of some London A&E departments and the potential impact on other A&E departments. Contractually, the acute contract will remain as it is under PbR and any discussions regarding risk share and / or performance rewards will be from the default PbR position.

ANNEXE 2 – Provider commentary

For further detail on how to use this Annexe to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Merton
Name of Provider organisation	SW London and St Georges Mental Health NHS Trust
Name of Provider CEO	David Bradley
Signature (electronic or typed)	David Bradley

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	16,882
	2014/15 Plan	17,294
	2015/16 Plan	16,517
	14/15 Change compared to 13/14 outturn	+412
	15/16 Change compared to planned 14/15 outturn	-777
	How many non-elective admissions is the BCF planned to prevent in 14-15?	371
	How many non-elective admissions is the BCF planned to prevent in 15-16?	977

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes

The following pages are not part of the formal narrative submission but, for ease, set out a conveniently printable facsimile of the data contained within the 'Part Two' template: 'Technical Submission'.

The official, formal documentation should always be considered as the 'master' version and the following data is provided for convenience only.

TAB: PAYMENT FOR PERFORMANCE

1. Reduction in non elective activity	
	Numbers
Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	17,117
Change in Non Elective Activity	-600
% Change in Non Elective Activity	-3.5%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds	
	Figures in £
Financial Value of Non Elective Saving/ Performance Fund	894,000
Combined total of Performance and Ringfenced Funds	3,252,601
Ringfenced Fund	2,358,601
Value of NHS Commissioned Services	5,746,000
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P				
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	4,216	8,457	12,676	17,117
Cumulative Change in Non Elective Activity	-126	-253	-421	-600
Cumulative % Change in Non Elective Activity	-0.7%	-1.5%	-2.5%	-3.5%
Financial Value of Non Elective Saving/ Performance Fund (£)	187,740	189,230	250,320	266,710

TAB 1: HWB FUNDING SOURCES

Source	Gross Contribution (£000)	
	2014/15	**2015/16**
Local Authority Social Services		
Merton	3,428	944
Total Local Authority Contribution	**3,428**	**944**
CCG Minimum Contribution		
NHS Merton CCG		11,254
Total Minimum CCG Contribution	**-**	**11,254**
Additional CCG Contribution		
NHS Merton CCG	**4,420**	
Total Additional CCG Contribution	**4,420**	**-**
Total Contribution	**7,848**	**12,198**

TAB 2: SUMMARY OF HWB SCHEMES

Summary of Total BCF Expenditure (figures in £000)				
	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care	
	2014/15	**2015/16**	**2014/15**	**2015/16**
Acute	-	-		
Mental Health	-	-		
Community Health	3,231	3,813		
Continuing Care	-	-		
Primary Care	-	-		
Social Care	3,183	6,452	1,877	3,577
Other	1,434	1,933		
Total	**7,848**	**12,198**		**3,577**

Summary of Commissioned Out-of-Hospital Services Spend from MINIMUM BCF Pool		
	From 3. HWB Expenditure Plan	
		2015/16
Mental Health		
Community Health		3,813
Continuing Care		
Primary Care		
Social Care		
Other		1,933
Total		**5,746**

Summary of Benefits			
	From 4. HWB Benefits		**From 5. HWB P4P Metric**
	2014/15 vs outturn	**2015/16 vs outturn**	**2015/16**
Reduction in permanent residential admissions	(322)	(193)	
Increased effectiveness of reablement	(282)	(154)	
Reduction in delayed transfers of care	(0)	(0)	
Reduction in non-elective (general + acute only)	(442)	(1,441)	894
Other	(20)	(20)	
Total	**(1,066)**	**(1,808)**	**894**

- Merton has accounted for the benefit of preventing the 2.2% forecast growth in non-elective admissions in addition to the benefit of the 3.5% planned reduction of non-elective admissions

TAB 3: HWB EXPENDITURE PLAN

Scheme Name	Area of Spend	Please specify if Other	Commissioner	Provider	Source of Funding	2014/15 (£000)	2015/16 (£000)
Case Management - Proactive Care: Incontinence	Social Care		Local Authority	Charity/ Voluntary Sector	CCG Minimum Contribution	20	20
Case Management - Proactive care: Health Liason officers (x 3)	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	150	150
Case Management - Proactive Care: Telecare	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	400	400
Case Management - Proactive Care: Seven day working	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	240	500
Case Management - Proactive Care: Agewell	Social Care		Local Authority	Charity/ Voluntary Sector	CCG Minimum Contribution	-	80
Prevention of Admission - Reactive care: Equipment	Social Care		Local Authority	Private Sector	CCG Minimum Contribution	200	200
Prevention of Admission - Reactive care: Miles Reablement	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	900	1,400
Prevention of Admission - Reactive care: Miles Reablement	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	100	100
Case Management - Proactive Care: Medication management	Social Care		Local Authority	Private Sector	CCG Minimum Contribution	20	20
Protecting Social Care: Domiciliary Packages	Social Care		Local Authority	Private Sector	CCG Minimum Contribution	800	2,000
Prevention of Admission - Reactive Care: Equipment	Social Care		Local Authority	Private Sector	CCG Minimum Contribution	57	57
Protecting social care: Developing personal and health care budgets	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	-	400
Investing into infrastructure: Data Sharing	Social Care		Local Authority	CCG	CCG Minimum Contribution	28	42
Protecting Social Care: Non-recurrent change fund	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	15	15

TAB 3: HWB EXPENDITURE PLAN

Scheme Name	Area of Spend	Please specify if Other	Commissioner	Provider	Source of Funding	2014/15 (£000)	2015/16 (£000)
Case Management - Proactive Care: Project costs	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	30	30
Case Management - Proactive Care: Project costs	Social Care	MCCG Project Costs	Local Authority	Local Authority	CCG Minimum Contribution	223	94
Case Management - proactive care: Integrated locality teams	Other	Community/ Mental Health/ Voluntary	CCG	NHS Community Provider	CCG Minimum Contribution	607	960
Prevention of admission - reactive care: 7 Day working	Other	Community/ Mental Health/ Voluntary	CCG	NHS Community Provider	CCG Minimum Contribution	110	240
Prevention of admission - reactive care: CPAT	Community Health		CCG	NHS Community Provider	CCG Minimum Contribution	943	1,106
Prevention of admission - reactive care: Community Beds and rehabilitation	Community Health		CCG	NHS Community Provider	CCG Minimum Contribution	2,288	2,707
Investing into infrastructure: Data Sharing	Other	Community/ Primary Care/ Social Care/ Voluntary	CCG	NHS Community Provider	CCG Minimum Contribution	166	182
Protecting Social Care; Carers breaks	Other	Voluntary	CCG	Charity/ Voluntary Sector	CCG Minimum Contribution	551	551
Protecting Social Care: Disabled Facilities Grant	Social Care		Local Authority	Local Authority	Local Authority Social Services	-	944
Total						**7,848**	**12,198**

TAB 4: HWB FINANCIAL BENEFITS PLAN

2014/15								
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		Case management - proactive care	NHS Commissioner	(200)	2,209	(441,800)	10% Reduction of Ambulatory Care Sensitive Admissions	Monitoring of SUS data for Avoidable Ambulatory Care Sensitive conditions
Reduction in permanent residential admissions		Prevention of admission- Reactive care	NHS Commissioner	(171)	938	(160,398)	Impact at HRG level modelled which demonstrated a 49% reduction on conditions that are amenable to treatment outside Acute Settings	Monitoring a set of HRG codes classified as conditions that are amenable to treatment outside Acute Settings
Other	Excess bed days	Prevention of admission- Reactive care	NHS Commissioner	(112)	179	(20,048)	Preventing growth in the number of excess bed days	Monitoring Excess bed days activity across our four major Acute Trusts
Reduction in permanent residential admissions		Protecting Social Care	Local Authority	(5)	32,240	(161,200)	Preventing growth in the number of permanent residential admissions	Monitoring number of new permanent residential admissions and average length of residential admissions
Increased effectiveness of reablement		Protecting Social Care	Local Authority	(132)	2,137	(282,084)	Combined benefit of increasing the number of people offered reablement and the effectiveness of reablement. i.e quantified the value of reablement based on the cost of alternative care	Monthly monitoring of number of people offered Reablement and annual audit of effectiveness of reablement
Reduction in delayed transfers of care		Protecting Social Care	Local Authority	(1)	179	(179)	Preventing growth in the rate of DTOC	Monthly monitoring of number of DTOCs

TAB 4: HWB FINANCIAL BENEFITS PLAN

2015/16								
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		Case management - proactive care	NHS Commissioner	(351)	1,409	(494,559)	%of VHR and HR patients amenable to Case Management	Monitoring admissions data of Very High Risk and High Risk individuals via the Risk Stratification tool
Reduction in non-elective (general + acute only)		Prevention of admission- Reactive care	NHS Commissioner	(635)	1,490	(946,150)	%of admissions for conditions that are amenable to case management	Monitoring a set of HRG codes classified as conditions that are amenable to treatment outside Acute Settings
Other	Excess bed days	In-Reach	NHS Commissioner	(112)	179	(20,048)	Preventing growth in the number of excess bed days	Monitoring Excess bed days activity across our four major Acute Trusts
Reduction in permanent residential admissions		Protecting Social Care	Local Authority	(6)	32,240	(193,440)	Preventing growth in the number of permanent residential admissions	Monitoring number of new permanent residential admissions and average length of residential admissions
Increased effectiveness of reablement		Protecting Social Care	Local Authority	(72)	2,137	(153,864)	Combined benefit of increasing the number of people offered reablement and the effectiveness of reablement. i.e quantified the value of reablement based on the cost of alternative care	Monthly monitoring of number of people offered Reablement and annual audit of effectiveness of reablement
Reduction in delayed transfers of care		Protecting Social Care	Local Authority	(1)	179	(179)	Preventing growth in the rate of DTOC	Monthly monitoring of number of DTOCs

TAB 5: HWB PAY FOR PERFORMANCE (P4P) METRIC

Non - Elective admissions (general and acute)										
Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	2,031	2,043	2,032	2,139	1,945	1,956	1,926	2,026	1,919
	Numerator	4,216	4,241	4,219	4,441	4,090	4,114	4,051	4,262	4,090
	Denominator	207,588	207,588	207,588	207,588	210,322	210,322	210,322	210,322	213,187
				P4P annual change in admissions			*-600*			
				P4P annual change in admissions (%)			***-3.5%***	Average cost of a NEL		
						P4P annual saving	*£894,000*		**£1,490**	

TAB 5: HWB PAY FOR PERFORMANCE (P4P) METRIC

Non-Elective Admissions Mapped against CCGs										
Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Merton	% Merton resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Croydon CCG	9,042	8,244	8,410	8,376	0.5%	0.8%	43	39	40	40
NHS Kingston CCG	3,223	3,158	3,180	3,106	3.6%	3.0%	116	114	114	112
NHS Lambeth CCG	7,181	6,970	7,432	7,128	0.8%	1.3%	58	56	60	57
NHS Merton CCG	3,962	3,965	3,935	4,170	87.8%	82.0%	3,477	3,480	3,454	3,660
NHS Sutton CCG	4,266	3,807	3,860	4,140	3.4%	2.8%	145	129	131	141
NHS Wandsworth CCG	5,999	6,722	6,688	6,859	6.3%	10.1%	377	423	421	431
Total						**100%**	**4,216**	**4,241**	**4,219**	**4,441**

Residential Admissions				
Metric		**Baseline (2013/14)**	**Planned 14/15**	**Planned 15/16**
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**517.6**	**403.2**	**395.3**
	Numerator	125	100	100
	Denominator	23,765	24,800	25,299
		Annual change in admissions	*-25*	*0*
		Annual change in admissions %	*-20.0%*	*0.0%*

Reablement				
Metric		**Baseline (2013/14)**	**Planned 14/15**	**Planned 15/16**
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual rate*	**83.3**	**85.7**	**85.7**
	Numerator	45	60	78
	Denominator	55	70	91
		Annual change in proportion	*2.4*	*0.0*
		Annual change in proportion %	*2.9%*	*0.0%*

Delayed transfers of care													
Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 populatio n (aged 18+).	*Quarterly rate*	**288.2**	**264.1**	**247.1**	**161.5**	**287.8**	**263.7**	**247.0**	**161.4**	**287.4**	**263.5**	**246.4**	**161.3**
	Numerator	456	418	391	261	465	426	399	264	470	431	403	267
	Denominator	158,248	158,248	158,248	161,566	161,566	161,566	161,566	163,542	163,542	163,542	163,542	165,579
						Annual change in admissions			***28***		*Annual change in admissions*		***17***
						Annual change in admissions %			***1.8%***		*Annual change in admissions %*		***1.1%***

Patient – Service User Experience Metric				
Metric		**Baseline 2013-14**	**Planned 14/15 (if available)**	**Planned 15/16**
1A (ASCOF) Social care-related quality of life Enhancing quality of life for people with care and support needs.	*Metric Value*	18.8	18.8	18.8
	Numerator	36,307	36,307	36,307
	Denominator	1,932	1,932	1,932
Improvement indicated by:	Increase			

Local Metric				
Metric		**Baseline 2013-14**	**Planned 14/15 (if available)**	**Planned 15/16**
BCF 2: 2B(2) -Proportion of older people (65 and over) who were offered a Reablement or Intermediate Care Service during the period October to December	*Metric Value*	0.9	2.0	2.5
	Numerator	30	70	91
	Denominator	3,345	3,480	3,620
Improvement indicated by:	Increase			

== ENDS ==

This page is intentionally left blank