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Merton Council

Health and Wellbeing Board

Date: **20 September 2022**

Time: **6.15 pm**

Venue: **Council chamber - Merton Civic Centre, London Road, Morden SM4 5DX**

Merton Civic Centre, London Road, Morden, Surrey SM4 5DX

1	Apologies for absence	
2	Declarations of pecuniary interest	
3	Minutes of the previous meeting	1 - 6
4	Understanding Health Inequalities and prevention *Presentation to be provided at the meeting*	
5	Combatting Substance Misuse	7 - 14
6	Children and Young People's Voice *Presentation to be provided at the meeting*	
7	NHS and Social Care	
7a	Kings Fund report on inequalities Recommendations and response *Presentation to be provided at the meeting*	
7b	Model of Primary Care Overview and update on Rowan's, East Merton Hub, Extended Access *Presentation to be provided at the meeting*	
7c	Better Care Fund Plan for 2022-23 funding action tackling health inequalities.	15 - 42

This is a public meeting – members of the public are very welcome to attend.

Requests to speak will be considered by the Chair. If you would like to speak, please contact by midday on the day before the meeting.

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Health and Wellbeing Board Membership

Merton Councillors

- Peter McCabe (Chair)
- Brenda Fraser
- Jenifer Gould

Council Officers (non-voting)

- Director of Community and Housing
- Director of Children, Schools and Families
- Director of Environment and Regeneration
- Director of Public Health

Statutory representatives

- Four representatives of Merton Clinical Commissioning Group
- Chair of Healthwatch

Non statutory representatives

- One representative of Merton Voluntary Services Council
- One representative of the Community Engagement Network

Voting

3 (1 vote per councillor)
4 Merton Clinical Commissioning Group (1 vote per CCG member)
1 vote Chair of Healthwatch
1 vote Merton Voluntary Services Council
1 vote Community Engagement Network

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HEALTH AND WELLBEING BOARD
21 JUNE 2022

(6.15 pm - 8.45 pm)

PRESENT	Councillors Councillor Peter McCabe (in the Chair), Creelman, Councillor Brenda Fraser, Dr Vasa Gnanapragam, Councillor Jenifer Gould, Dr Sekeram, Simon Shimmens and Dr Dagmar Zeuner
ALSO PRESENT	Heather Begg, Dr Yannish Naik, Clarissa Larsen (Health and Wellbeing Board Partnership), Amy Dumitrescu (Democracy Services Manager), Bola Roberts (Democratic Services Officer)
ATTENDING REMOTELY	Simon Shimmers (Chief Executive Merton Voluntary Service), , Dr Mohan Sekeram, Sarah Goad (Age UK Merton) Tracey Weight (Merton and Wandsworth CCG), Sally Burns (Parent and Carer), Dr Karen Worthington, Annette Bunka (SWL CCG), Gemma Dawson (SWL CCG)

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for Absence were received from Jane McSherry (Director Children Schools and Families) Dr Aditi Shah.

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

There were no declarations of interest.

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

RESOLVED: That the minutes of the meeting held on 22 March 2022 were agreed as a correct record.

4 LIVING WITH COVID (Agenda Item 5)

The Director of Public Health gave an overview of living with COVID.

Instead of an acute response, COVID is currently being treated as other respiratory infections. She advised that the Board has an ongoing role in the oversight of COVID preparedness: supporting with ongoing vaccination, looking after those with Long COVID and ensuring the vulnerable have good access to therapies. If a more serious variant emerged, the acute response would be led nationally by the UK Health Security Agency. She reminded the Board of its Community Subgroup which kept an active dialogue with the community through the pandemic and is ready to stand up, if needed, in future. In terms of legacy, Infection Prevention Control is now better embedded in care homes and adult social care settings and active engagement is ongoing with Community Champions and the voluntary sector

5 CARERS STRATEGY (Agenda Item 4)

Heather Begg (Commissioning Officer, Adult Social Care) Sally Burns (Parent and Carer) and Tracy Weight (CEO Carer Support) presented a summary of Merton Carer's Strategy.

The slides from his presentation are attached to the minutes.

Sally Burns said she had been involved in the Strategy since 2019 and last spoken at the HWBB in 2020. She emphasised the impact of caring on both physical and mental health. She explained that COVID had exacerbated loneliness with less support services available and delays to health treatments. It is important that we make progress, both for carers and to avoid even more future demand. A joint approach is needed and, she felt that, whilst there is effort on all sides, lack of resources is impacting progress, for example, delivery of Carers' Cards.

The Chief Executive of Carer Support said the Carers Strategy is one of the best co-produced pieces of work she has been involved with. The current focus is on young carers who have been disproportionately affected by COVID and they are working with schools and GP practices on identification. Also working with parent carers looking at pathway to assessment to help get support in place and avoid crisis point. This work is due to be completed in August.

The Locality Director Merton and Wandsworth welcomed the Carers Strategy and congratulated partners. It was good to see GP identification included and suggested an area to consider is discharge from hospital, referencing the Healthwatch survey.

The Director of Public Health asked partners see how resources could be identified to help mobilise action. It was agreed that the Interim Director of Community and Housing will meet with the Director of Children, Schools and Families and the Locality Director for Merton and Wandsworth to review resources. The Chair asked that they report back on this as he recognises the value of carers and wishes to support them.

RESOLVED:

A. That the Board acknowledge the progress of Merton's Carers Strategy 2021-2026
B. That The Board review the priority outcomes and determine whether there are other priorities to be included for year 2
C. That The Board commit the necessary resources to supporting the work to deliver the priority outcomes for carers
D. That The Board seek the views of more carers including young carers and parent carers to help shape the changes.

6 HEALTH IN ALL POLICIES (Agenda Item 6)

Dr Yannish Naik summarised his report which set out the collaborative approach of Health in All Policies, focusing on the wider determinants of health as a key way of addressing health inequalities. The proposal suggests that the impact on health and

wellbeing should be considered in all policy making. He referenced the progress made to date and outlined a two part approach: ways of working together with partners, and, exemplar trailblazers potentially including Merton as a 'borough of sport', supporting healthy weight and combatting frailty. The role of the Public Health team in this will be to hold the action plan and to support networks in the embedding of Health in All Policies.

The Locality Director for Merton and Wandsworth welcomed the report as exactly what we should be partnering on. The Chair asked how we can get embedded into different depts. The Director of Public Health said that Health in All Policies could be included in staff induction, appraisal and review. A trailblazer of 'borough of sport' would lend perfectly to be inclusive, linking to 'Active(ly) Merton'. Councillor Gould referenced the link to the Climate Action Plan and the Locality Director will take Health in All Policies to the Merton Health and Care Together Committee. Walk and Talk opportunities were referenced as was green social prescribing, Merton Can and Try 22 in Merton 2022. The Chair asked that a report on Health in All Policies be brought to a future Cabinet meeting.

RESOLVED:

That the Health and Wellbeing Board commented on the revised Health in All Policies Action Plan

7 NHS AND SOCIAL CARE ITEMS (Agenda Item 7)

Better Care Fund Plan

The Assistant Head of Transformation presented the Better Care Fund Plan for 2021/22 for the agreement of the Board. She advised that guidance for the Plan for 2022/23 is due, so she could bring to the September Board. The Chair asked how the Better Care Fund helps tackle health inequalities and the Assistant Head of Transformation outlined the funding of proactive care including: social prescribing for those most vulnerable; maintaining the community response hub post-pandemic to help people access services; the Living Well service run by Age UK; and, the Tuned-In project reducing isolation among men. The Chair suggested a written report on how the Better Care Fund is taking health inequalities be brought to the next Board as part of proposals for the 2022/23 Plan. Dr Vasa Gnanapragasam outlined some of the valuable work supported by the Better Care Fund and offered to help with this report.

RESOLVED: The Better Care Fund Plan 2021/22 was agreed.

Health and Care Plan

Gemma Dawson gave an overview of the Health and Care Plan and its approach of start well, live well and age well in a healthy place. The presentation included reference to Core 20+5 data and it was agreed that a further report will come to the Board in September, aligned with the Joint Strategic Needs Assessment, to help

inform a common understanding of health and wellbeing needs, as well as assets. The Chair requested that this include a clear description of the meaning of Core 20+5. Councillor Gould said that she would like to have access to Core 20 information. The Director of Public Health explained that understanding population need is an ongoing piece of work, including ward profiles and now developing understanding of Core 20. Dr Vasa Gnanapragasam explained that data will not be current, but can be used to help inform how we invest in the wider determinants of health and prevention, and that this is a key part of tackling health inequalities.

Epsom and St. Helier

The Locality Director for Merton and Wandsworth gave an update. He referenced that the Health Scrutiny Panel will be taking a fuller report in September in order to scrutinise latest proposals. It was suggested that the September Health and Wellbeing Board could consider health inequalities in relation to this, specifically the recommendations of, and response to, the Kings Fund report. The Chair referenced a recent Health Service Journal article reporting a cut in funding that could result in further delays. He said that residents deserve better and referenced a 'blight' on investment. The Locality Director said that the national programme is yet to confirm levels and dates of funding and that these are currently being lobbied for. Members commented and raised particular concerns on the impact on health equalities.

East Merton Health and Wellbeing Hub

The Locality Director for Merton and Wandsworth acknowledged that the project has been many years in gestation. He reported that the most recent consultation and engagement programme identified the Wilson as the preferred site for the 'hub' but this is not seen as a standalone development, linking, among other 'spokes', to the Rowans and Colliers Wood. A business case is currently being developed and the hub could be delivered in a couple of year. It was agreed that the Locality Director will visit the Rowans with Councillor Brenda Fraser. The Chair questioned the accessibility to the Wilson site for local people. The Locality Director agreed that he would see again if there can be any flexibility in disposal of property, though referenced that this would inevitably impact timescales.

8 PHARMACEUTICAL NEEDS ASSESSMENT (Agenda Item 8)

8
Pharmaceutical Needs Assessment (Agenda Item 8)

The Director of Public Health gave a brief outline of the Pharmaceutical Needs Assessment report circulated to members. In 2015 it became a statutory duty that Health and Wellbeing Boards publish a Pharmaceutical Needs Assessment, refreshed every three years, as a tool to assess market entry. She stressed that community pharmacies are an important part of healthcare and the Board was asked to comment, be active in the consultation, and share with their networks.

RESOLVED:

A. That The Board note the process to produce a revised Pharmaceutical Needs Assessment by 1st October 2022 has commenced and is being managed by the Merton PNA Steering Group.
B. That The Board agreed to share the draft Pharmaceutical Needs Assessment with their networks and to respond formally to the consultation, which will inform the final Pharmaceutical Needs Assessment in Merton.
C. That The Board delegate the sign-off of the final Pharmaceutical Needs Assessment to the Director of Public Health in order to meet the statutory deadline of 1st October 2022

9 THE BIGGEST ISSUE (Agenda Item 9)

Dr Mohan Sekeram outlined 'The Biggest Issue' of healthy weight, which has been a key priority of the Board and links to its earlier work on the Diabetes Truth Programme and Child Healthy Weight. He asked Board members to support the survey on the Biggest Issue and it was agreed that the findings of the survey will be reported back to a future Health and Wellbeing Board. The Chair asked that the Council's Communications Team help promote the survey and both the CCG and voluntary sector partners also agreed to share the link with their networks.

As this was Dr Vasa Gnanapragasam's final Health and Wellbeing Board meeting, the Chair thanked him for his huge and valuable contribution as Vice Chair.

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Committee: Health and Wellbeing Board

Date: 20th September 2022

Agenda item:

Wards: All

Subject: Preventing and tackling substance misuse

Lead officer: Dr Dagmar Zeuner, Director of Public Health

Lead member: Councillor Peter McCabe, Cabinet Member for Health and Social Care

Forward Plan reference number:

Contact officer: Barry Causer, Public Health Lead for COVID-19 Resilience.

Recommendations:

A. That the Health and Wellbeing Board support the approach and renew their commitment to work collaboratively on preventing and tackling drug and alcohol related harm.

B. That the Health and Wellbeing Board consider and agree governance of the Combating Substance Misuse Partnership and the proposed ways of working between the Health and Wellbeing Board, the Safer Stronger Executive and Merton Health and Care Together (Partnership and Committee).

C. That Health and Wellbeing Board member organisations support the delivery of the actions required, by nominating a senior lead officer to work with Public Health over the coming months.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This paper sets out the opportunity for the Health and Wellbeing Board to renew their commitment to preventing and tackling drug and alcohol related harm, including a commitment to reducing health inequalities. The discussion is intended to inform action in the coming months.

1.2. This paper sets out the specific asks of central Government; the development of a Combating Substance Misuse Partnership, production of a comprehensive system level needs assessment and the development of a local delivery plan. We propose to review and strengthen existing arrangements, rather than setting up additional time-consuming bureaucracy, building on strong foundations for preventing and tackling substance misuse which aligns with the priority of the HWB and the new LBM administration to reduce inequalities.

1.3. Finally, this paper sets out the need to redesign and re-procure the adults' substance misuse treatment and recovery service, informed by the recently published treatment and recovery commissioning quality standards and a programme of engagement to understand lived experience and to hear service user voice.

2 BACKGROUND

Introduction

2.1. Substance Misuse (drugs and alcohol) affects many people and communities across Merton. It can negatively impact on individuals and communities from all walks of life; it is not limited to areas of deprivation, those involved in criminal behaviour or vulnerable groups such as the homeless. It can lead to a range of harms for the user and community including poor physical and mental health, unemployment, homelessness, family breakdown and criminal activity and can contribute to and exacerbate existing inequalities.

2.2. Although substance misuse affects all parts of Merton, its harms are more pronounced in areas of high deprivation and on those from lower socio-economic groups. The Dame Carol Black Review of Drugs (2020) reports that geographical and socioeconomic inequalities lie beneath the trends (of highest on record drug deaths and the highest number of rough sleepers dying from drug poisoning, with many of these deaths involving alcohol) with entrenched drug use and premature deaths, occurring disproportionately in deprived areas of the country.

2.3. There is also a significant level of stigma attached to substance misuse, with society labelling individuals with substance misuse issues negatively which in turn makes individuals less likely to acknowledge that they need support and seek help.

2.4. Our strategic approach to preventing and tackling substance misuse problems is through a combination of delivering good holistic (person-centred) services, which is led by Merton Health and Care Together (Partnership and Committee) through the Health and Care Plan, and by creating the physical and social conditions for people to live a heathy life, which is led by the Health and Wellbeing Board and the Merton Health and Wellbeing Strategy; a Healthy Place for Healthy Lives.

Understanding substance misuse need in Merton

2.5. A detailed system wide needs assessment is required to be developed by the end of November 2022, in response to the ask from central Government. As well as informing the substance misuse delivery plan, this will also be used to support the re-design and recommissioning of the adults substance misuse treatment and recovery service. To help local areas understand local substance misuse need, the Office for Health Improvement and Disparities (OHID) provides a number of data profiles. Key messages for Merton include:

- there are an estimated 1,700 dependent drinker drinkers and a further 38,000 adults who drink to a level where they increase the risk to their health and wellbeing.
- there are an estimated 1,900 adults who use illegal or unprescribed drugs, of whom 591 are opiate users, and who might use other substances such as crack cocaine.
- there were 624 admission episodes (primary diagnoses) for alcohol-related conditions in 2020/21 (343 per 100,000 population), which is lower than London (348 per 100,000) and England (456 per 100,000). This is a decrease from 406 per 100,000 in 2019/20.
- there were 890 admission episodes (primary and secondary diagnoses) for alcohol-specific conditions in 2020/21 (485 per 100,000 population), which is lower

than London (515 per 100,000) and England (587 per 100,000). This is a decrease from 636 per 100,000 in 2019/20.

- there were 64 alcohol-related deaths in 2020/21 (40.4 per 100,000 population) which is higher than London (32.2 per 100,000) and England (37.8 per 100,000). This is an increase from 28.3 per 100,000 in 2019/20.

- in 2020/21 there were 720 clients in treatment for drug and alcohol misuse, of which 450 were new presentations to the service. This is an increase from 670 clients in treatment and 420 new presentations in 2019/20.

Further information is listed in the background Information.

2.6. Importantly, the system level needs assessment will explore the differences across Merton and to help understand more about the impact that substance misuse has on inequalities in Merton. One example is the 'alcohol harm paradox', reported in the previous substance misuse needs assessment (May 2017), that patterns of alcohol consumption and alcohol related harm in Merton, mirrors the national position i.e. lower socioeconomic groups are more likely to die or suffer from a disease relating to their alcohol use even though they often report lower levels of average consumption than their less deprived counterparts. Possible explanations for this phenomenon include drinking patterns such as increased binge drinking in lower socioeconomic groups; lower resilience; increased risk factors or co-morbidities; and differential access to healthcare.

<u>Substance misuse governance</u>

2.7. The Government published the national 'From harm to hope: A 10-year drugs plan to cut crime and save lives' strategy in December 2021, which aims to break drug supply chains, deliver a world class treatment and recovery system and achieve a shift in the demand for drugs. This strategy is led by the cross Government Joint Combatting Drugs Unit.

2.8. The national strategy relies on co-ordinated action from a range of local partners in enforcement, treatment, recovery and prevention and therefore central Government have asked that local areas set up a Combating Substance Misuse Partnership (CSMP), produce a system wide needs assessment and develop a delivery plan that outlines local action.

2.9. Following discussion within LBM and with a range of partners including the Metropolitan Police Service (MPS), our proposal is to build upon what we already have in Merton and to review and refresh the existing Substance Misuse Partnership Board and the Substance Misuse Strategic Framework Action Plan. To maintain the focus on Merton, our proposal is that the CSMP has a geographical footprint of Merton, has joint Senior Responsible Officers (Dr Dagmar Zeuner and Chief Inspector Barrie Capper) and, in line with existing arrangements, would report formally into the Safer Stronger Executive, with a 'dotted line' to the Health and Wellbeing Board. Its relationship to Merton Health and Care Together (Partnership and Committee) will be worked through as place based arrangements for the South West London Integrated Care Board are confirmed.

2.10. If agreed by the HWB, it is likely that Merton's CSMP will have its first meeting in early October 2022 and take action to:

- conduct a system level needs assessment (by the end of November 2022 and delivered through the formation of a task and finish group), reviewing local crime,

health, drug and alcohol data. This will include a number of products to enable the CSMP to understand the needs and priorities related to drug and alcohol harm, across the three outcomes of the national strategy.

- agree a local drugs and alcohol delivery plan and a local performance framework to monitor the implementation and impact of local plans (by the end of December 2022 and delivered through the formation of a task and finish group). This will set out plans across the three strategic priorities (breaking drug supply chains, delivering a world class treatment and recovery system and achieving a shift in the demand for drugs of the national strategy).

2.11. Linked to the national strategy, the Office for Health Improvement and Disparities (OHID) have recently confirmed Merton will receive an additional grant of £242,487 in 2022/2023, with proposals (subject to annual approval by OHID) for future years of £247,220 in 2023/2024 and £309,034 in 2024/2025. The terms and conditions of this ring-fenced funding set out that it must be used to secure improvements to the local treatment and recovery system in Merton. Merton's plans, approved by OHID, include a maintained focus on complex adults e.g. dual diagnosis (co-existing mental health and substance misuse needs), increased access to support for criminal justice clients and to better understand service user voice and lived experience. It was agreed by OHID that a small amount be used for additional programme management i.e. to support the development of the CSMP needs assessment and the development of the drug and alcohol delivery plan.

2.12. The Board are asked to agree the proposals including setting up of the Combatting Substance Misuse Partnership (CSMP), the ways of working between the HWB, the Safer Stronger Executive and the Merton Health and Care (Partnership and Committee) and for HWB partners to nominate a senior lead officer to work with Public Health over the coming months.

<u>Substance misuse services</u>

2.13. Merton's integrated substance misuse service for adults, currently provided by a Voluntary and Community Sector (VSC) provider Westminster Drug Project (WDP), is required to be recommissioned by April 2024. As part of the redesign and recommissioning of this service an engagement programme, to understand lived experience and listen to service user experience and voice, is proposed. This programme, planned to start in late December 2022 or early January 2023, will have a significant emphasis on prevention and engaging with the most vulnerable adults and will identify ways of engaging meaningfully with these service users, who often endure the worst outcomes including chronic ill health. The insights and findings, alongside the recently published Commissioning quality standard: alcohol and drug treatment and recovery guidance, will contribute to the service re-design and the key priority of the HWB of reducing inequalities.

2.14. Further details of the integrated substance misuse service and other substance misuse services can be found in appendix one.

2.15. HWB partners are asked to support the re-design and re-commissioning of the adults substance misuse service and engagement programme by each nominating a senior lead officer to work with Public Health over the coming months.

Next steps

2.16. An interim Partnership Manager has been recruited to help review and strengthen the partnership arrangements, to support the formation of the new CSMP in Merton and to take forward action including:

- The development of a task and finish group to deliver a system wide comprehensive needs assessment (by the end of November 2022), which includes local crime, health, drug and alcohol data to understand the needs and priorities related to drug and alcohol harm, across the three outcomes of the national strategy (supply, demand and treatment/recovery). The HWB's support for Public Health to have timely access to data will be required and this will be dealt with if the need arises.
- The development of a task and finish group to deliver the local drugs and alcohol delivery plan and a local performance framework to monitor the implementation and impact of local plans (by the end of December 2022). It is proposed that this plan and local performance framework comes back to the Health and Wellbeing Board, as well as the Safer Stronger Executive and the Merton Health and Care Together (Partnership and Committee) in early 2023.

3 ALTERNATIVE OPTIONS

3.1. NA

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. An engagement programme to understand lived experience and listen to service user experience and voice is being planned. This programme is being funded by the additional funding from Office for Health Improvement and Disparities (OHID) which, as required by the terms and conditions, is to be used to secure improvements to the treatment and recovery system. This will begin in late December 2022 and January 2023.

5 TIMETABLE

- End October 2022 – First meeting of the CSMP and agree Terms of Reference
- End November 2022 – Conduct a joint needs assessment
- End December 2022 – agree delivery plan and local performance framework
- By early January 2023 – engagement programme begins
- January 2023 - Adults Substance Misuse Market Engagement
- April 2023 - Tender documents published
- June 2023 - Tender period closes
- September 2023 - Contract Award
- April 2024 - Start of new contract

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. Linked to the national strategy, the Office for Health Improvement and Disparities (OHID) have recently confirmed Merton will receive an additional grant of £242,487 in 2022/2023, with proposals (subject to annual approval by OHID) for future years of £247,220 in 2023/2024 and £309,034 in 2024/2025. The terms and conditions of this ring-fenced funding set out that it must be used to secure improvements to the

local treatment and recovery system in Merton. Merton's plans, approved by OHID, include a maintained focus on complex adults e.g. dual diagnosis (co-existing mental health and substance misuse needs), increased access to support for criminal justice clients and to understand service user voice and lived experience. It was agreed by OHID that a small amount be used for additional programme management i.e. to support the development of the needs assessment and the development of the drug and alcohol delivery plan.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. The local guidance of 'From harm to hope: A 10-year drugs plan to cut crime and save lives' strategy sets out a number of requirements of LBM e.g. setting up a CSMP, conducting a system wide needs assessment and developing a local delivery plan.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. Illegal drugs cause far-reaching and devastating harm. Drug misuse currently costs society over £19 billion a year. Drug use drives crime, damages people's health, puts children and families at risk and reduces productivity – it impacts all of the country, with the most deprived areas facing the greatest burden.

9 CRIME AND DISORDER IMPLICATIONS

9.1. The benefits of combating illicit drugs can be significant and wide-ranging, improving people's safety, productivity, health and wellbeing. People in recovery from substance misuse are 'better than well', meaning they become active citizens, and give back to their community at a higher rate than the general population, helping the vulnerable and making the community a safer place for all.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. NA

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

11.1. Appendix One – Adult Substance Misuse Services in Merton.

12 BACKGROUND PAPERS

12.1. From harm to hope: a 10-year drugs plan to cut crime and save lives (publishing.service.gov.uk)

12.2. Drugs strategy guidance for local delivery partners - GOV.UK (www.gov.uk)

12.3. Local Alcohol Profiles for England - Data - OHID (phe.org.uk)

12.4. Public health profiles - OHID (phe.org.uk)

12.5. Adult substance Misuse Health Needs Assessment (merton.gov.uk)

12.6. Independent review of drugs by Professor Dame Carol Black - GOV.UK (www.gov.uk)

12.7. Commissioning quality standard: alcohol and drug treatment and recovery guidance - GOV.UK (www.gov.uk)

APPENDIX ONE – ADULTS SUBSTANCE MISUSE SERVICES

Adults Substance Misuse Services in Merton include the following-

- A fully integrated substance misuse service for adults, provided by a Voluntary and Community Sector (VSC) provider, Westminster Drug Project (WDP). This recovery focused service offers free and confidential treatment and support for individuals and their families who are affected by drug and alcohol problems. WDP have a specialist workforce including substance misuse case workers, doctors, nurses, volunteers and peer mentors who are based at the main WDP Merton premises in Mitcham.
- Inpatient detoxification is provided by WDP from their Passmores House clinic. This is a Care Quality Commission (CQC) registered, residential community drug and alcohol detoxification unit and provides medically supervised alcohol and drug detoxification programmes for people aged 18 and over. Additional inpatient detoxification capacity has been commissioned from Guy's and St Thomas' NHS Foundation Trust, as part of pan-London substance misuse commissioning arrangements.
- A number of support services delivered by Community Pharmacies across Merton including Needle Exchange, where service users are provided with clean injecting equipment, and Supervised Consumption services, where service users attend a pharmacy to consume their prescription medication e.g. Methadone. In addition to the primary service, these services also provide an opportunity for community pharmacists to ensure that service users are well, provide harm reduction information and actively encourage service users to continue to access services as part of their recovery.
- In addition to the Public Health commissioned services, there are a number of complementary services and activities that support residents with substance misuse problems, including:
    - A variety of VCS programmes that form part of the local recovery system e.g. Alcoholics Anonymous and Narcotics Anonymous.
    - Residential rehabilitation, which is a stay-in rehabilitation unit where in addition to managing detoxification with medication, service users participate in group work programmes and one to one key work sessions to assist them to recover and re-integrate into the community. Service users will be assessed by WDP Merton to ensure that they are suitable candidates and a separate funding assessment is completed by an adult social care social worker.

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Agenda Item 7c

Committee: Health and Wellbeing Board

Date:

Agenda item: Better Care Fund Plan (BCF) for 22/23

Wards: Merton

Subject:

Lead officer: Mark Creelman/John Morgan

Lead member: Councillor Peter McCabe

Forward Plan reference number:

Contact officer: Annette Bunka- Assistant Head of Transformation -Integrated Care (Merton)- SWL ICS/ Keith Burns -Interim Assistant Director- Community and Housing - LBM

Recommendations:

A. ***To approve the submission of the attached Better Care Fund Narrative, Better Care Fund 2022/23 Planning Template and the Demand and Capacity Template for Intermediate Care to NHS England by the deadline of 26th September 2022.***

B. ***To note the report on health inequalities and how the BCF helps tackle health inequalities in Merton.***

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

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

2 BACKGROUND

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

- minimum allocation from NHS
- disabled facilities grant – local authority grant
- social care funding (improved BCF) – local authority grant

3 DETAILS

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

4 ALTERNATIVE OPTIONS

4.1. Not applicable as an NHSE requirement

5 CONSULTATION UNDERTAKEN OR PROPOSED

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

6 TIMETABLE

2022-2023

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. The core Better Care Fund allocation (the minimum NHS contribution) has been uplifted by 5.66%. This uplift has been used to cover increases in staffing costs and other inflationary pressures, with the majority of the uplift funding the increasing costs of provision of community equipment.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. The Better Care Fund is underpinned by an agreement made pursuant to section 75 of the NHS Act (2006). The agreement for 2021/22 is in the process of being sealed, and the agreement for 2022/23 is in progress.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. The report in Appendix D attached sets out the ways in which the Better Care Fund contributes to reducing health inequalities.

10 CRIME AND DISORDER IMPLICATIONS

10.1. Not applicable

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

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

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

Appendix A: Summary Slide Deck

Appendix B: Better Care Fund Narrative

Appendix C: Better Care Fund 2022/23 Planning Template

Appendix D: Report on reducing health inequalities

Appendix E: Draft Intermediate Care Demand and Capacity Template

13 BACKGROUND PAPERS

13.1. Better Care Fund Policy Framework 2022 to 2023 (DHSC): 2022 to 2023 Better Care Fund policy framework - GOV.UK (www.gov.uk)

Merton Better Care Fund Plan for 22/23

By Annette Bunka and Keith Burns

to be presented at:

- SWLICB -Merton and Wandsworth Officers Meeting- 05/09/22
- LBM Corporate Management Team -06/09/22
- Merton Health and Care Together Committee – 14/09/22
- Merton Health and Well Being Board – 20/09/22

BCF – A Brief history

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

- minimum allocation from NHS
- disabled facilities grant – local authority grant
- social care funding (improved BCF) – local authority grant

- Owned by the Health and Wellbeing Board (HWB), these are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

BCF – resource and infrastructure (1)

Funding

Table 1: minimum contributions to the BCF in 2022/23 in Merton

BCF funding contributions	2022/23 (£)
Minimum NHS contribution	15,057,573
Improved Better Care Fund (iBCF)	5,009,679
Disabled Facilities Grant (DFG)	1,452,224
Total	21,519,476

BCF – National Objectives and Conditions

The **national objectives for the BCF** have been updated in 2022-23 and are to:

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

National conditions (that all plans must meet)

- A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
- Invest in NHS commissioned out-of-hospital services.
- Implementing the BCF policy objectives, including supporting safe and timely discharge, ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.

BCF metrics for 2022/23

Metrics

Beyond the national objectives and conditions, areas have flexibility in how the fund is spent over health, care and housing schemes or services, but need to agree ambitions on how this spending will improve performance against the following BCF 2022/23 metrics:

Metric	Proposed Ambition
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)	A modest reduction based on trends and impact of virtual wards
Improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of residence)	Maintaining position as Merton already above national and London average
Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes).	A modest reduction compared to 21/22 (but greater than 20/21)
Proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)	To meet an 82.4% target

BCF – local plans and priorities

The key priorities for integration within 2022/23 BCF Plan mirror the Merton Health and Care Together Programme and build on previous BCF Plans:

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

Appendices

- BCF Narrative Plan
- BCF Planning Template
- BCF Intermediate Care Demand and Capacity Template
- How the BCF helps tackle health inequalities

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Better Care Fund 2022 - 2023

Narrative Plan

London Borough of Merton

Version control	
Draft no	3
Date	07 September 2022

Introduction

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

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

Organisations Involved in Drawing Up the Plan

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

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

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

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

Involving Stakeholders

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

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

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

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

Executive Summary

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

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

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

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

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

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

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

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

Governance

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

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

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

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

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

Overall Approach to Integration

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

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

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

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

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

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

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

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

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

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

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

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

Implementing the BCF Policy Objectives

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

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

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

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

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

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

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

Supporting Unpaid Carers in Merton

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

Journey to date.

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

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

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

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

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

A life alongside caring

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

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

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

Disabled Facilities Grant

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

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

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

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

Equality and Health Inequalities

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

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

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

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

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

Areas of specific note include:

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

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

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

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

How the Better Care Fund helps tackle health inequalities in Merton

Introduction

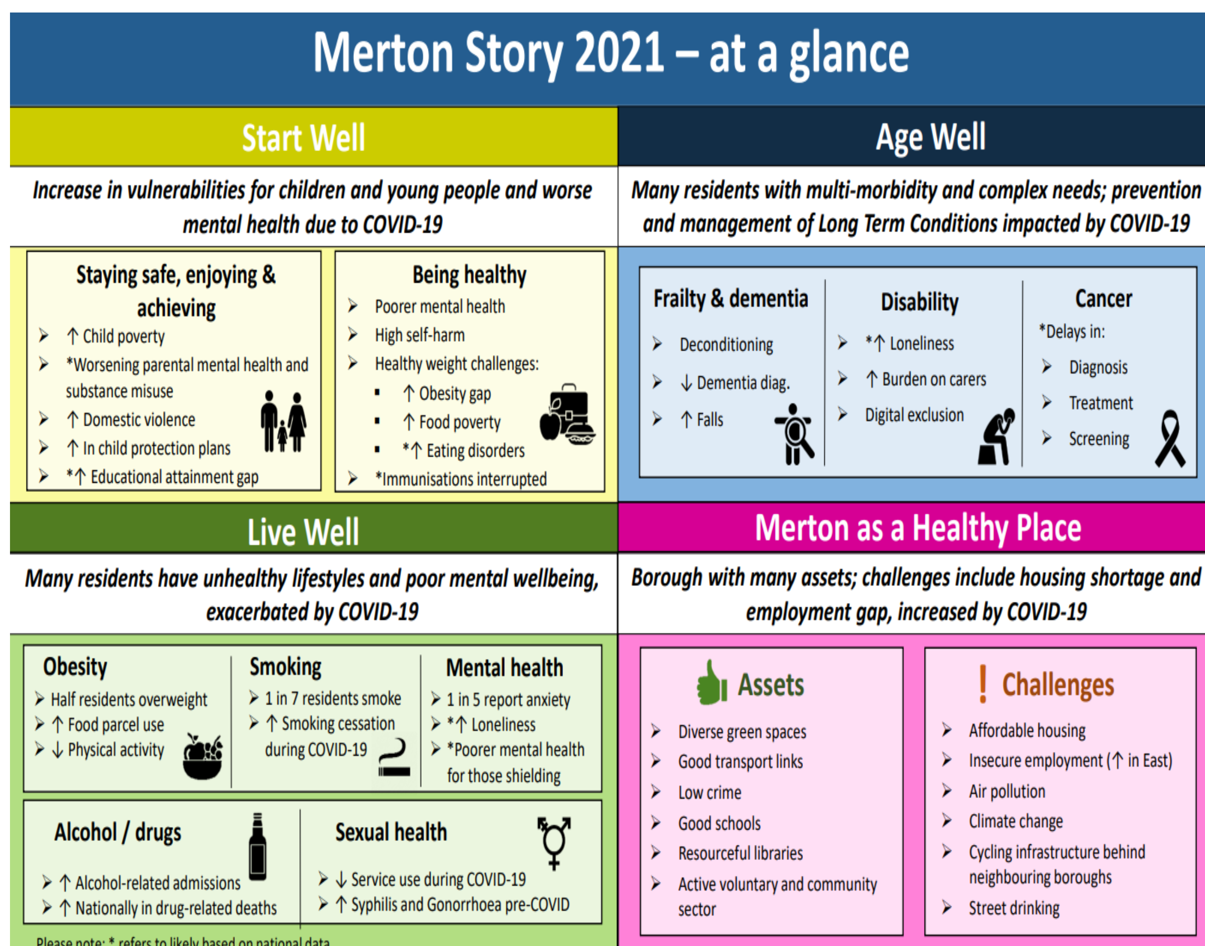
The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. There are two key policy objectives in 2022 to 2023:

- enable people to stay well, safe and independent at home for longer
- provide the right care in the right place at the right time

Part of the conditions of the BCF requires areas to agree a plan that sets out how health and social care will work together, and use BCF funding, to improve outcomes for each of these objectives.

Alongside the BCF submission for 2022/23, this report summarises how the BCF is currently spent, its impact on tackling inequalities and what are next steps are to help address this key issue.

Health Inequalities in Merton -The Merton Story



The focus of the BCF has been to support those with multi-morbidities and complex needs who are most at risk of hospital admission or requiring long term residential care to remain well and independent at home, and where support is required for this to take place in the community, where possible. This approach has focused on the people who need services most, many of whom will have health inequalities.

Population Health Management and Core 20 Analysis

We now have additional opportunities through population health management and use of Core20 data to support the reduction of health inequalities and potentially target those most at risk with support before their health deteriorates further.

Core20 analysis for South West London indicates 16% of Merton residents are in the Core20 population, of which approximately 29,000 live in East Merton, where there is deprivation in housing and environment, a significant school aged and older working age (44-64) population and is ethnically diverse.

Of this population, 31% have one or more long term conditions and this population is 43% more likely to be obese and 67% more likely to be diagnosed with a mental health condition.

Approaches to support the reduction of inequalities

To enable more people to maintain their independence for longer, in addition to supporting 'Home First' models, we aim to improve the health and wellbeing of Merton residents through enhanced access to community and voluntary sector services and greater sharing of assets and expertise as well as reduce health inequalities.

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

Proactive and preventative services, Integrated Locality Teams, providing proactive care for those at highest risk by providing personalised care and support in people's own homes. Within this cohort the multi -agency teams are able to prioritise those in greatest need of this approach within the GP practice footprint. BCF funding includes:

- A wide range of services from Central London Community Health, our community provider.
- Health Liaison Social Workers
- Age UK living well co-ordinators and Alzheimer's Society co-ordinators linked to PCNs
- Continued support for the most vulnerable through the Community Response Hub
- Improved response to crises and more effective reablement- working with the expanded rapid response service to respond to crises and work more closely across health and social care offers, including use of 24-hour care for short periods if required (linking to virtual wards as appropriate).

- Increasing the capacity within social work and significant recruitment to the reablement team which includes support for admission prevention.

Key to supporting recovery, especially older, frailer residents is through reducing length of stay in hospital and the BCF funding works to improve discharges through improved joint pathways with integrated teams enabling faster discharges from hospital, with the full implementation of discharge to assess and the focus on increased access to reablement alongside domiciliary packages of care where required.

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

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

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

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

In addition to the approaches highlighted above, we are working with the voluntary and community sector to support older people to re-engage with and access community resources for their health and wellbeing post Covid. Continuing the Community Response Hub, alongside social prescribing and case management through the Integrated Locality Teams, we aim to ensure we have the services in place to deliver services to match people's needs to deliver person centred care.

We know people in East Merton have worse health and shorter lives, so a range of services commissioned through BCF funding support those in most need in this area and where required across the borough.

Areas of specific note include:

- The Community Response Hub which initially started in response to the COVID 19 pandemic, but identified an ongoing need for independent advice and support.
- Living Well Service run by Age UK to improve physical and mental wellbeing
- Funding the voluntary sector to reduce factors that increase the likelihood of presentation to health or social care, including an enhanced lunch club offer, improving heating and insulation, supporting access to benefits and helping with small grants for energy, food and clothing.
- Reducing isolation especially amongst older men through our music workshops- Tuned In (A single has just been produced called Uptown Lockdown)

- Contribution to Social Prescribing, which has a particular focus on those areas and individuals where there is social complexity
- Falls and other prevention initiatives including ‘Merton Moves’ and ‘Happy and Active in Merton’ linking with libraries around digital inclusion
- Support for the Alzheimer’s Society and the Dementia Hub in Merton to support those with Dementia and their carers, funding to support Carers Support Merton, through funding night sitting services from Marie Curie and by contributing to the Ageing Well Programme which invests in and supports Merton’s local voluntary and community infrastructure, bringing together preventative services that provide information, advice and support in the community to strengthen Merton resident’s physical, social, emotional, and economic resilience and works to address inequalities within our borough.

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

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

Further Activities in 22/23

Merton is addressing health inequalities in a range of ways including use of population health management, both at place and at PCN level and a series of workshops focusing on use of this approach to support those with frailty are about to take place. The aim of this is to help focus our resources on those with greatest need and who may not currently access services and along the priority of those with frailty, look at how we can support CORE 20 plus 5 initiatives. The findings from this work will feed into the longer term ambitions as part of planning for 2023-25.