DRAFT 0.3

Merton Better Care Fund plan 2016/17

Consultation history

Version	Audience	Date	Outcome
DRAFT 0.1	Merton Adults Health and Care Board	15/3/16	Inclusion of NEL activity in BCF budget Amendment of Reablement target Creation of Risk pool
DRAFT 0.2	Adam Doyle and Simon Williams	18/3/16	Amendments to reablement target
DRAFT 0.2	NHSE	21/3/16	Submission
DRAFT 0.2	Merton CCG Clinical Transformation Committee	05/04/16	Comments via e-mail
DRAFT 0.3	Adults programme board, CCG EMT.	05/04/16	Inclusion of Risk sharing arrangements. Amendments following initial feedback from NHSE KLOE.
DRAFT 0.3	Merton Health and Wellbeing board	19/4/16	
Final 1.0	NHSE	24/4/16	

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Executive Summary

- Merton has a rich history of integrated working between health and social care.
- 2015/16 delivered the foundations for integration in Merton. Whilst the 2015/16 BCF plan aimed for a 0.4% reduction of non-elective admissions, for the period April – Dec, a 2.4% reduction was realised.
- The 2016/17 BCF plan needs to deliver an enhanced local community response through a joint health and social care infrastructure delivered by community services, mental health services, primary care, social care and voluntary sector partners.
- In order to develop this response, Merton stakeholders have committed to integrate health and social care services by 2020 through a Multi-speciality Community Provider (MCP) as the vehicle for integration. Building on the 2015/16 BCF plan and budget of £12.2m, the 2016/17 BCF plan lays the foundations for further integration through a substantially greater pooled budget of £91.4m.
- The CCG and local authority will ringfence an amount of £1,015k from the BCF pool and retain this as part of the risk share agreement. These funds will be retained and remain uncommitted with the terms of managing the fund set out in the Section 75 between the CCG and the Local Authority. These funds will be released at the end of the year, should the CCG meet the NEL QIPP target and spent as agreed by the Health and Wellbeing board. However, if the CCG do not meet the NEL QIPP target, the fund will be used to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand
- Reporting and monitoring the 2016/17 BCF budget will reflect the current service line reporting for health and social care services and therefore individual scheme investments may be subject to cost improvement and QIPP plans. This enhanced transparency of reporting has been agreed in order to allow:
    a. Greater understanding of commissioned services and expenditure across health and social care provision
    b. Greater freedom for resourcing interim and permanent health and social care reablement packages of care
    c. Joint understanding of current resources for potential inclusion in future population based capitated budgets.
- The key priority for the 2016/17 BCF plan is to strengthen the relationships and collaboration between multiple providers in Merton through 3 interlinked projects and a DTOC action plan:
    a. Integrated health and social care assessments
    b. Seven day working
    c. Improved communication enabled by information technology
    d. Action plan to address DTOC.
- The 2016/17 BCF plan is not about introducing new services, but about simplifying the existing processes and pathways to achieve a more responsive, better quality response for people with support needs. We therefore recognise that a significant amount of engagement is required to bring all partners on board with the vision, create an environment for change, truly listen to what support people need to prevent admission or long term care and empower front line staff to make these changes.
- The Merton Adults programme board has been established to act as the BCF Programme Board and will report to the CCG's Governing Body and the Council's Cabinet via the Merton Health and Wellbeing board.
- The Merton Operational Integration group is re-constituted from the previous Merton Model group. The group and have responsibility for delivering the BCF projects and DTOC action plan.

History and context

Merton has a rich history of integrated working between health and social care.

The 2015/16 BCF plan, submitted in September 2015 was approved following the Nationally Consistent Assurance Review (NCAR) process by NHS England and acknowledged to be clear and ambitious.

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.

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

The table below sets out the vision for services as set out in the 2015/16 BCF plan and remains the key principle of service delivery for 2016/17.

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	Timely and responsive multi-disciplinary working.
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 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 localities working to a single pathway in coordination with social work teams. Single, agreed support planning process developed and

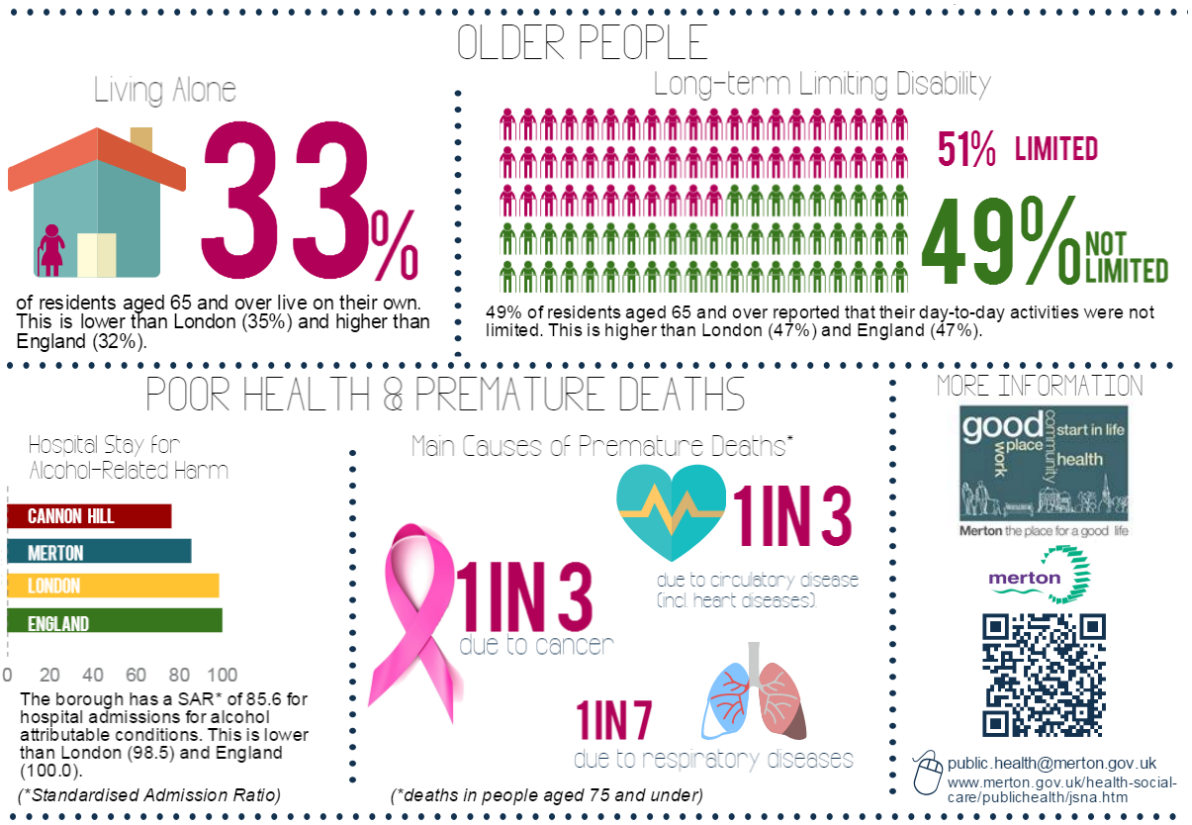
Ref	Stakeholder/Service	What will success look like?
		operated across localities with teams working consistently to the agreed process and operating procedures. A single assessment process delivered at least through a 'trusted assessor' arrangement.
2.6	MILES, reablement and step up beds	Processes for straightforward referral to reablement in place.
2.7	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.
2.8	Location	Explore options for co-location in 2016/17.
2.9	End of Life	End of life services integrated into the locality pathways.
2.10	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.
2.11	Acute Trusts	Fewer inappropriate admissions, as patients being managed by integrated teams in the community. Early involvement of community services following non-elective admission. Coordinated discharge function with single pathway of access to all locality services resulting in fewer Delayed Transfers of Care.
2.12	Voluntary Sector	Integrated into locality pathways and overall patient and service user processes.
2.13	Equipment	Local access to equipment, including swift prescribing and delivery to prevent unnecessary delays to discharges.
2.14	Management	Collectively managed resources identified.

Our population

JSNA

Merton's 2014 population projection is 203,200 people living in nearly 80,400 occupied households. Population density is higher in the east wards of the borough compared to the west wards. Based on GLA trend-based projections, Merton's population will increase by 13,245 people between 2014 and 2020 with the number of people aged over 65 forecast to increase by over 2,100 people (9.2%).
As a whole, Merton is less deprived than the average for both London and England. However, three wards are more deprived than the average for London: Cricket Green, Figge's Marsh and Pollards Hill.

Health outcomes are generally better than those in London and in line with or above the rest of England. However, there are inequalities between East and West, and within population groups.
Greater London Authority (GLA) population data (2014) shows Merton's current BAME population is 76,188. Black, Asian and Minority Ethnic (BAME) groups make up 35.1% of the population, lower than London (40.2%).



Risk stratification

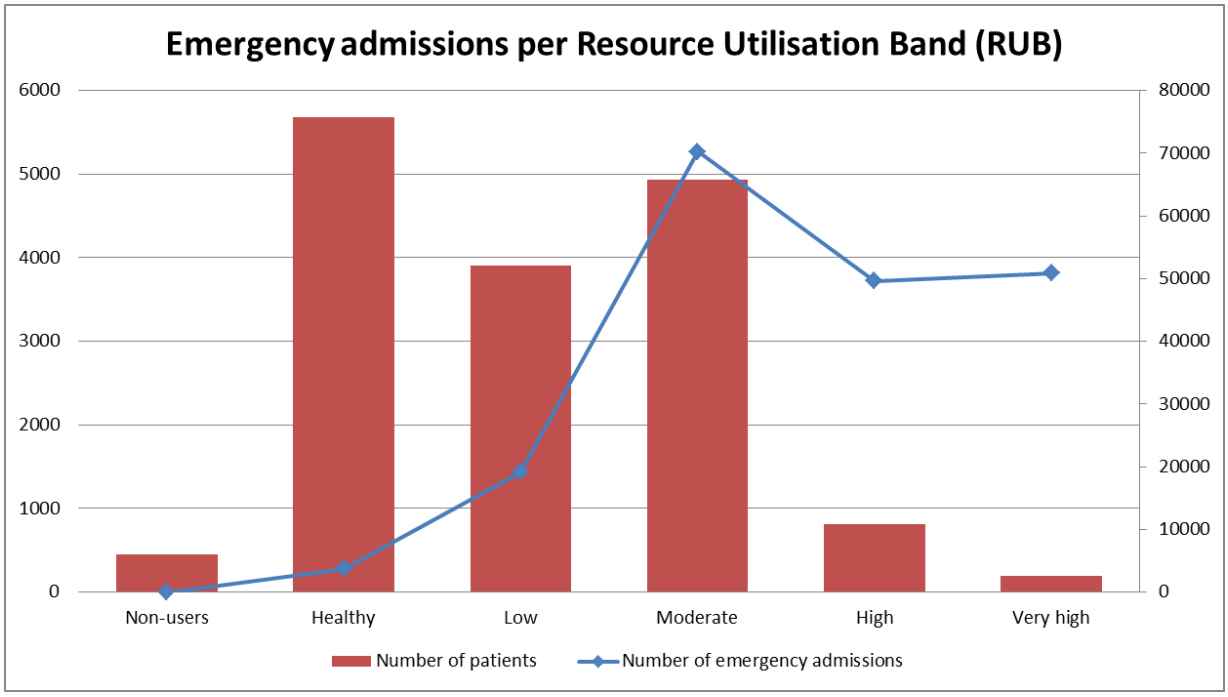
All twenty-five GP practices in Merton undertake risk-stratification profiling to identify patients at high or very high risk of:

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

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

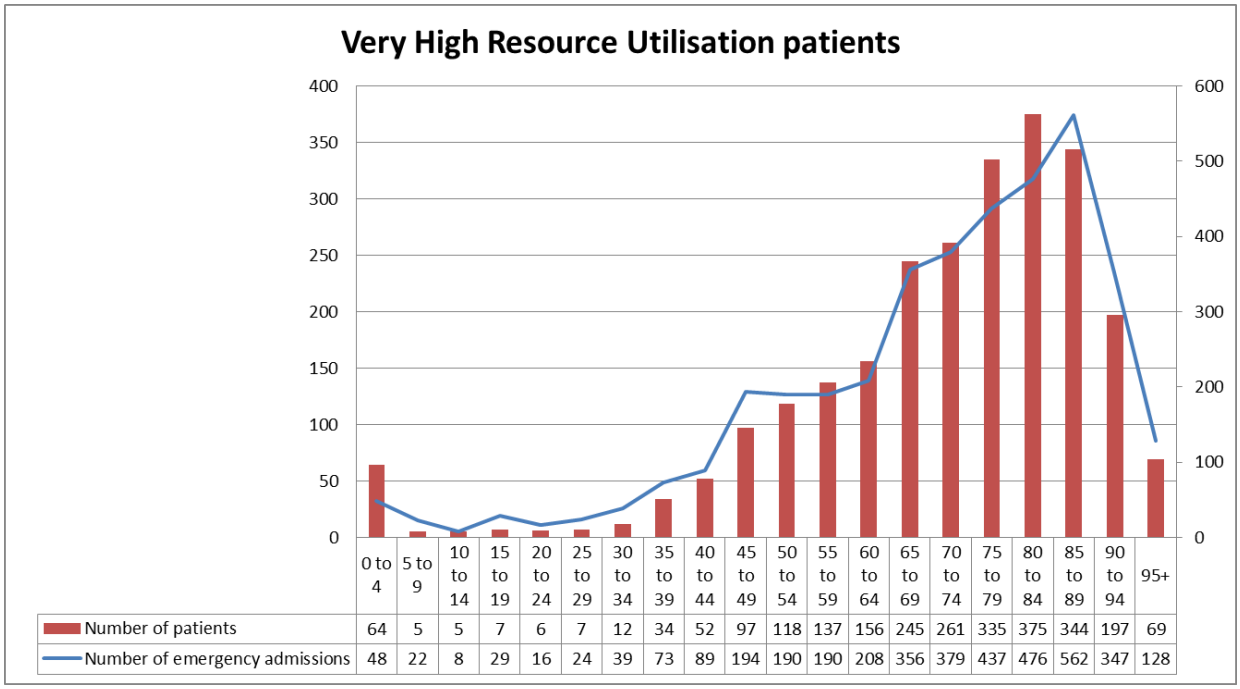
Merton uses the ACG SOLLIS system and practices have been trained in using this to identify the high risk cohort of the population. Figure 1 shows the number of patients and number of emergency admissions for each of the Resource Utilisation Bandings (RUB). This shows that there are a small number of patients in the Very High and High RUB categories who experience a high number of emergency admissions. For this reason, the 2016/17 plan is shaped based on the typical needs of those patients in these two RUB categories.

FIGURE 1 MERTON REGISTERED PATIENT PROFILE AS PER RISK STRATIFICATION



Over the past 12 months there were 2526 patients who were grouped in the "Very High Resource Utilisation Banding". These patients had 3815 emergency admissions in the past 12 months. Figure 2 shows that the very high risk patients who are 60 years old or above account for 76% if emergency admissions for this population group.

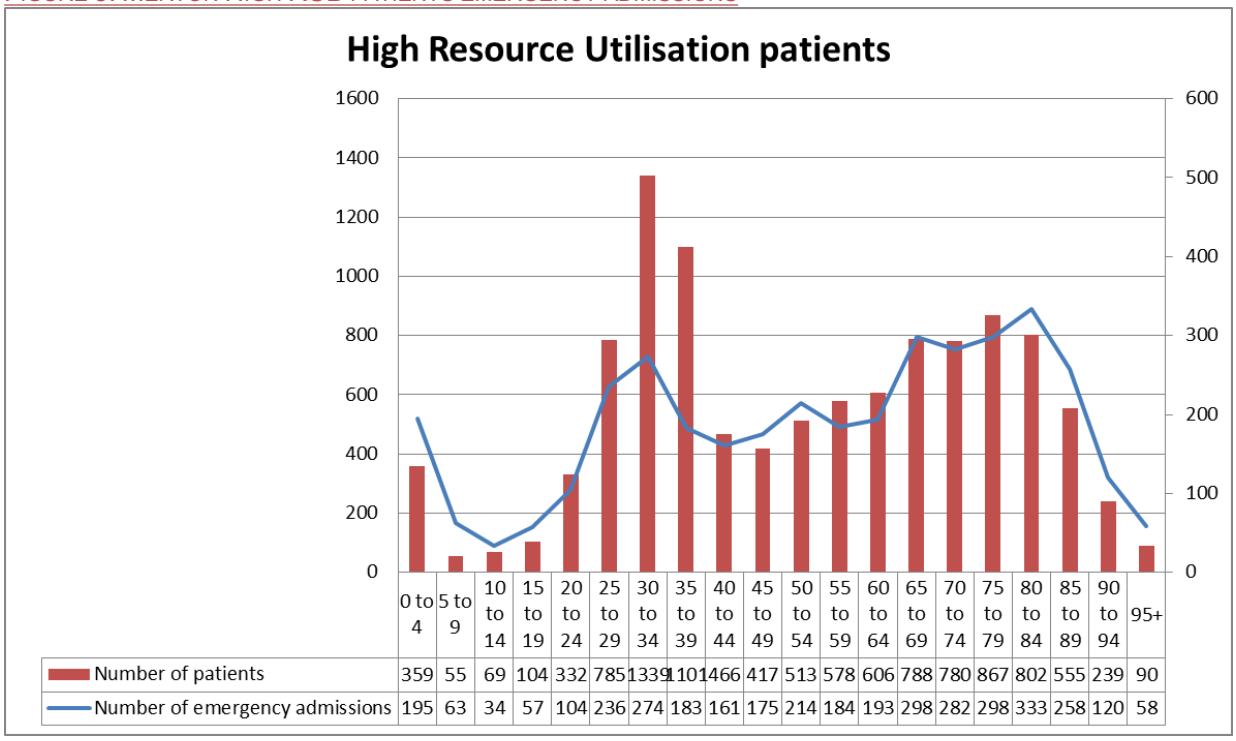
FIGURE 2: MERTON VERY HIGH RUB PATIENTS EMERGENCY ADMISSIONS



	0 to 4	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 to 94	95+
Number of patients	64	5	5	7	6	7	12	34	52	97	118	137	156	245	261	335	375	344	197	69
Number of emergency admissions	48	22	8	29	16	24	39	73	89	194	190	190	208	356	379	437	476	562	347	128

There were 10854 patients grouped in the High Resource Utilisation Band who had a 3720 emergency admissions in the past 12 months. Whilst this group had a lower rate of emergency admissions, there was a similar pattern of increased rate of admissions for those people who are 65 years or older.

FIGURE 3: MERTON HIGH RUB PATIENTS EMERGENCY ADMISSIONS



Integrated working

In the absence of an integrated health and social care data set, Merton CCG compared the number of patients identified as high risk of admission, those that were assessed for continuing care and those who accessed community health services to establish the level of integrated working between these parts of the health system as shown in figure 4.

Whilst it can be postulated that the people with the highest care and support needs should be supported through case management, community services and continuing care, the analysis revealed poor integrated support packages for these individuals with only 80 people in support of all 3 health service support services. These individuals accounted for 234 non-elective admissions.

FIGURE 4: OVERLAP OF HEALTH SERVICE RESPONSE FOR TOP 2% OF PATIENTS.

RUB/Risk Data	Number of Patients	Number of Emergency (NEL Admission) Events
No. within Top 2%	**4276**	**5980**
No. in Community Care	**11,987**	**8779**
No. in Continuing Care	**736**	**437**
No. within Top 2% AND on AUA	2082	2870
No. within Top 2% AND NOT on AUA	2194	3110
Pts in Top 2% AND Community Care	2122	5147
Pts in Top 2% AND Continuing Care	212	408
In Top 2% AND Community Care AND Continuing Care	130	355
In Top 2% AND Commnuity Care AND Continuing Care and AUA	80	234
In Community Care AND Continuing Care NOT Top 2%	201	25
In Community Care ONLY	9,663	3626
In Continuing Care ONLY	322	9

As part of the CCG QIPP planning, non-elective admissions for people older than 50 years were analysed. This analysis showed that there is a cohort of people who experience multiple admissions:

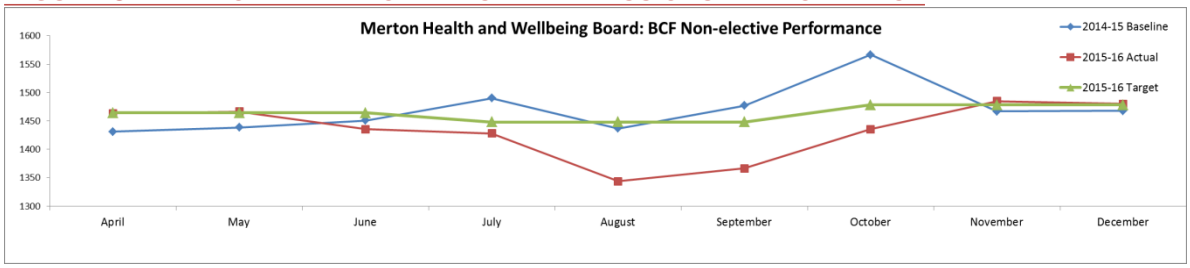
Number of admissions	Sum of Individual Patients	Sum of Total_Cost_Inc_MFF	Sum of Excess_Bed_Days_Cost	Average Spell Cost
16	2	£ 60,516	£ -	£ 1,891.13
15	2	£ 32,656	£ -	£ 1,088.53
11	1	£ 20,915	£ -	£ 1,901.36
10	3	£ 24,875	£ -	£ 829.17
9	5	£ 55,115	£ -	£ 1,224.78
8	9	£ 172,782	£ 10,493.91	£ 2,254.00
7	14	£ 133,841	£ 6,520.58	£ 1,299.19
6	26	£ 300,402	£ 10,563.90	£ 1,857.94
5	45	£ 466,890	£ 24,461.73	£ 1,966.35
4	92	£ 801,468	£ 35,207.31	£ 2,082.23
3	267	£ 1,863,396	£ 164,978.60	£ 2,120.37
2	746	£ 3,255,140	£ 247,418.07	£ 2,015.90
1	2839	£ 5,779,095	£ 539,191.84	£ 1,845.69

This data was reviewed and discussed by GPs as part of the CCG QIPP planning process. Based on the age distribution, HRG treatment category and number of admissions, it is anticipated that, based on the number of admissions people experience, a percentage of these NEL admissions could be reduced with an improved integrated health and social care response.
While every person who has experienced a non-elective admission will be considered for case management, the CCG estimate that approximately 1/5 of very high resource band patients (505) would benefit from case management, resulting in 525 prevented admissions.

2015/16 BCF Performance.

Whilst the 2015/16 BCF plan aimed for a 0.4% reduction of non-elective admissions, for the period April – Dec, a 2.4% reduction was realised.

FIGURE 5: MERTON HWB NON-ELECTIVE ADMISSIONS PERFORMANCE



Permanent admissions of older people to residential and nursing care homes are however above plan with a likely outturn of 105 new admissions for 2015/16. The Merton system has experienced significant challenges with Delayed Transfers of Care during 2015/16. We are aware that this is aggravated by silo processes between various health responses, silo processes between health and social care and lack of capacity in the residential- and care home market. The local metric for number of people accessing reablement is on track to exceed the target.

FIGURE 6: MERTON HWBB METRICS PERFORMANCE DASHBOARD

Health and Wellbeing board Metrics	2015.16 target	Target for Previous Year	YTD	RAG Status	Direction of Travel	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	<395.3	342.6	272.4	AMBER	↓	37.1	78.4	115.6	156.8	177.5	218.8	239.4	272.4	309.6
Number of new placements to Permanent Care Homes 65+ (C72) (monitoring of number of people)	< 100 new admissions	83.0	66.0	AMBER	↓	9	19	28	38	43	53	58	66	75
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (effectiveness of the service)	85.7%	81.2%	N/A	N/A										
Proportion of older people (65 and over) who were offered a Reablement or Intermediate Care Service during the period October to December	2.5%	NA	N/A	N/A										
Number of older people (65 and over) who were offered a Reablement or Intermediate care service - (clients Reablement services started per month)	91	9	372.0	GREEN		25	21	29	39	53	50	54	53	48
Delayed transfers of care from hospital per 100,000 population (Quarter)	239		696	RED		617			565			907		
Number of delayed transfers of care from hospital	393.0		380	RED	↓	404	294	311	289	280	356	529	453	502
Social care-related quality of life (User Survey) Enhancing quality of life for people with care and support needs sed.	18.8	18.8%	TBD	N/A										

Strengthening the vision

Merton's five-year planning process is created in partnership with the SW London Commissioning Collaborative with our Sustainability and Transformation plans currently in development. 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 with the development of more proactive out-of hospital services. The Merton BCF plan sets out the planned health and social care response that will be available to support people out of hospital in Merton. This will inform the assumptions about the level of non-elective activity that can be shifted from acute to community settings. The STP will therefore be able to consider the workforce implications across South West London related to the shift in Merton activity

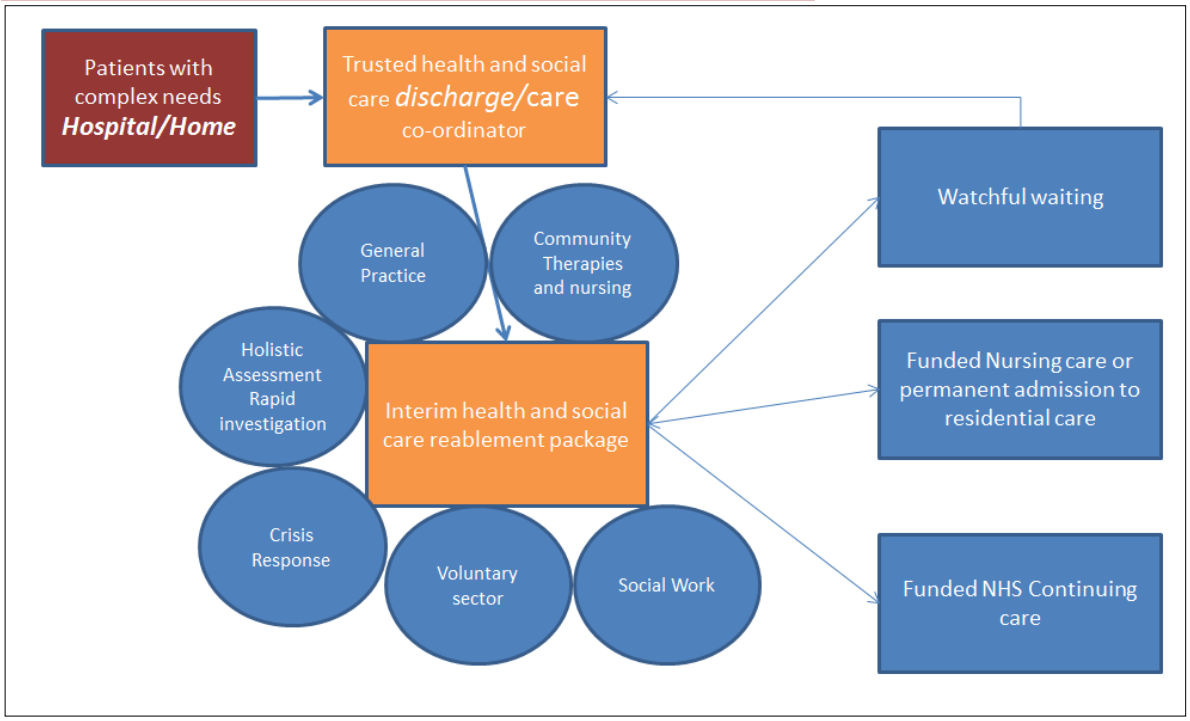
Whilst the BCF schemes and their impact in 2015/16 have been successful, we know that there are challenges with the current delivery model that needs to be addressed. Current challenges identified following review of 2015/16 BCF progress:

1. **Case finding**
   Whilst risk stratification is a helpful tool, it currently only captures health related factors impacting on people's wellbeing. As a historical reporting tool with a two month time lag, it also identifies people who have already experienced an increase in health resource utilisation. Although intangible, local knowledge of people's circumstances has proven to be more predictive to identify increased support needs, however local processes have not yet been embedded to respond to this local knowledge. There are therefore a number of instances when people who have not benefitted from a health and social care co-ordinated support response.
2. **Multi-disciplinary working**
   Whilst formal MDT meetings are in place across Merton's 25 GP practices, these are considered to be of varying degrees of effectiveness due to advance planning, attendance and nature of people's care and support needs. Whilst MDT meetings can be effective, local feedback has been that communication outside of formal meeting structures is a better mechanism to co-ordinate support for people.
3. **Silo processes with multiple points of access**
   For people with either pro-active and/or re-active support needs, there are multiple points of contact and access routes implying duplication, multiple handovers and depending on the point of access, predestined pathways.
4. **Push vs pull**
   There are limiting access criteria for a number of Merton services which means our services transact with people based on contracting arrangements and budgetary responsibility. This hampers working in partnership to customise support and create individualised support packages for those with the highest needs.

The 2016/17 BCF plan therefore needs to enhance our local community response through a joint health and social care infrastructure delivered by community services, mental health services, primary care, social care and voluntary sector partners.

The key focus of work for 2016/17 will therefore be to harmonise existing services and responses around individual's support needs. Figure 7 depicts the vision for an integrated health and social care response for Merton enabled by a greater pooled budget across health and social care. .

FIGURE 7: MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE RESPONSE



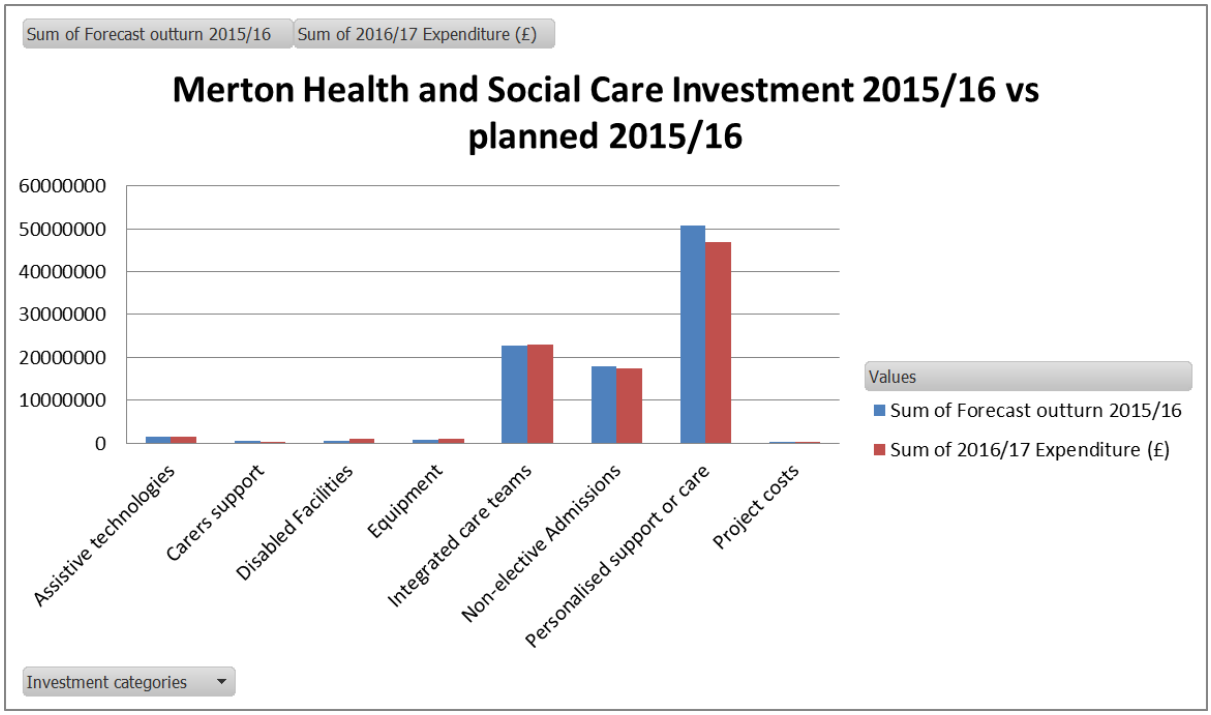
In order to develop this model, Merton stakeholders have committed to integrate health and social care services by 2020 through a Multi-speciality Community Provider (MCP) as the vehicle for integration. Building on the 2015/16 BCF plan and budget of £12.2m, the 2016/17 BCF plan lays the foundations for further integration through a substantially greater pooled budget of £91.4m.

2016/17 BCF Budget

The scheme level investment of the Merton 2016/17 BCF budget is set out in Appendix 1. Reporting and monitoring the 2016/17 BCF budget will reflect the current service line reporting for health and social care services and therefore individual scheme investments may be subject to cost improvement and QIPP plans. This enhanced transparency of reporting has been agreed in order to allow:

1. Greater understanding of commissioned services and expenditure across health and social care provision
2. Greater freedom for resourcing interim and permanent health and social care reablement packages of care
3. Joint understanding of current resources for potential inclusion in future population based capitated budgets.

FIGURE 8: TYPE OF INVESTMENT FOR MERTON 2016/17 BUDGET



2016/17 BCF plans

The key priority for the 2016/17 BCF plan is to strengthen the relationships and collaboration between multiple providers in Merton through 3 interlinked projects:

1. Integrated health and social care assessments
2. Seven day working
3. Improved communication enabled by information technology

The Draft programme plan is included in Appendix 3, with the high level project deliverables described below:

Project 1: Integrated health and social care assessments for people with support needs

The 2015/16 BCF plan implemented the foundations of integrated working. This included formation of locality MDT teams with access to dementia nurses and end of life services, community prevention of admission teams, in-reach nursing, intermediate care bed provision, Holistic Assessment and Rapid Investigation service (HARI) and restructuring reablement services. During 2015/16 the CCG achieved a 67% diagnosis rate for people with dementia, making it possible to better support people who have dementia and the carers who support them. The CCG also procured a new community service contract with the new provider delivering to an outcomes based service specification from the 1st of April 2016.

During 2016/17 we will build on these foundations by:

1. Aligning the access and operating criteria between the various health and social care services in order to reduce the number of handoffs during people's support journey.
2. Strengthening case management of people through improved case finding of people with support needs across health and social care.
3. Improve links between pro-active and reactive services so that people can benefit from step-up and step down of support.
4. Expand the intermediate care offer across health and social care so that people benefit from reablement before permanent packages of care are set up.

Whilst there are tangible deliverables for this project, much of the benefit relies on a change in culture to facilitate person centred support. This project will therefore follow a change management methodology with a number of the "Plan, Do, Study Act" cycles. Two of the likely outcomes will be greater co-location of health and social care staff and single point of contact for a joint health and social care response.

Through this vehicle Merton will maintain provision of social care services in 2016-17 as people with support needs will be met by a joint health and social care response. This is consistent with the 2015-16 BCF plans.

As a unitary authority, Merton benefits from close working between social care and housing with a direct referral route to the occupational therapy team for people who may require home improvements. The Disabled facilities Grant will therefore be used to facilitate improved access to capital costs for home improvements in order to support people in their own homes.

This project will also ensure that informal family carers continue to be supported by the by the local authority and the NHS. Currently Merton Social Care staff assess, develop support plans and arrange services for carers via commissioned agencies, a contract for carers support, small one off grants and Direct Payments. Funding is provided through and Ageing Well grant to Carers Support Merton to provide support such as information and advice, support groups and mentoring for carers.

We are now working with Carers Support Merton to develop a Carer's Hub. During 2016/17 this will become a wraparound, one stop shop for carers to offer advice and information, carer's assessments, support planning, reviews in addition to the bespoke services this type of voluntary organisation can offer to carers. One off grants and Direct Payments for Carers will also continue. This comprehensive service to carers will support carers to continue in their caring role and also promote early intervention when circumstances change and needs increase, thus preventing the need for hospital admissions due to carer breakdown. Interim care arrangements will be put in place if a carer needs hospital treatment with extra support should it be required at the time of hospital discharge to shorten length of stay and risk of readmission.

This project in the whole will ensure that the national condition of a joint approach to assessments and care planning is met with an embedded process for identifying an accountable professional where funding is used for integrated packages of care.

To enable this approach, the CCG has, as part of BCF, invested an increased amount into a new community service contract for increased provision of out-of-hospital services. This includes specific investment in community dementia nurses, as supporting people living with dementia is a high priority. The CCG has also invested additional funds into the Memory Assessment service so that it is better aligned with best practice guidance. Merton is in the process of developing a new dementia 5 year strategy in collaboration with all key stakeholders.

This project is the vehicle for delivering the CCG QIPP (Quality, Innovation, Productivity and Prevention) for non-elective admissions and aims to curtail growth and prevent 525 emergency admissions during 2016/17. The consequential impact of this project will be shared and agreed with our main acute providers, St. Georges NHS Foundation Trust, Epsom and St. Helier University Trust and Kingston Hospital Foundation Trust as part of the annual contract negotiation process.

The value of the QIPP will be retained as part of the local risk sharing agreement and is set out in section 10: Risk Pool

Project 2: Seven day working

The 2015/16 BCF plan delivered a 7 day working response for community prevention of admission and social work assessments in hospitals. We need to extend this offer so that all people with support needs get a similar response over weekends as they do during the week. This will improve flow across the system and assist with the action plan to reduce the number of Delayed Discharges of Care from hospitals.
To achieve improved flow requires us to understand where the bottle necks currently occur and what actions need to be taken to address these bottle necks.
During 2016/17 we will:

1. Identify what responses the system requires in order to meet people's support needs 7 days a week, 365 days per year.
2. Identify the current resources available to the system to meet these needs
3. Map current resources to current requirements in order to identify the gaps.
4. Redeploy resources in order to meet 7 day working system requirements.

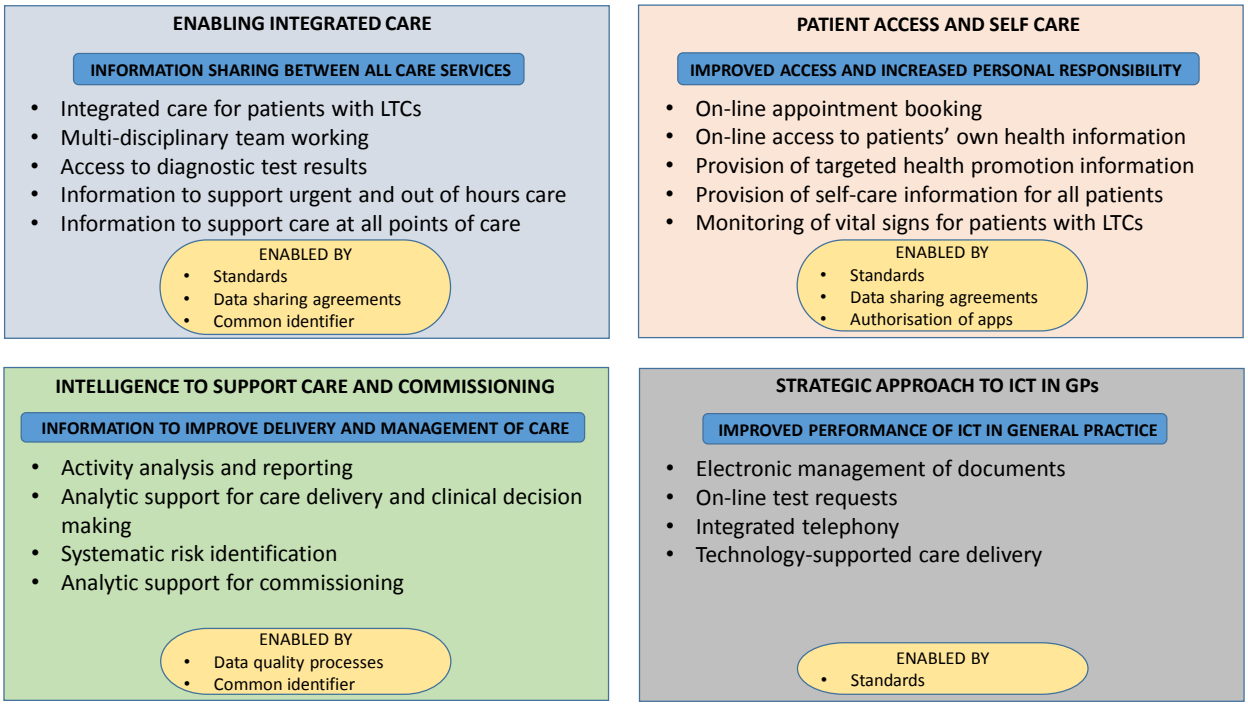
This project will ensure that Merton works towards national condition of meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;

Project 3: Improved communication enabled by information technology.

Our strategic ICT objective is "To have in place robust and fit-for-purpose ICT systems and services that support service transformation and enable integration across commissioners and care providers." We will work with our GPs, key providers and partners to ensure interoperability and the effective use of ICT across the local healthcare system.

The strategic components required to deliver our ICT strategic objective are grouped under four themes and supporting enablers; they have been aligned to the national and local objectives and commissioning and business plans and are summarised in figure 9.

FIGURE 9: MERTON ICT STRATEGIC OBJECTIVES



The focus for information technology project is to support the model for integrated care through information sharing between health and care providers within Merton.

All Merton NHS providers currently use the NHS number as unique patient identifier. 85% of Merton Adult Social Care clients have their NHS number recorded on their social care records. This places the system in a good position to share patient information to improve direct patient care across health and social care.

The key expected benefit from delivering the projects is that, where appropriate, clinicians and decision makers will have the most complete, accurate and up to date information concerning their patients; including consultation, diagnosis, referral, treatment and medical history; available at all points of care. Access to this information will allow clinicians to provide better care for patients. It will also allow the sharing of patients' records so that their flow through routine, urgent and emergency care services is improved and all patients are seen by the right clinician in the right place first time.

To achieve this, we will be working to implement an interoperability platform that links to our providers patient and client records. The project will involve:

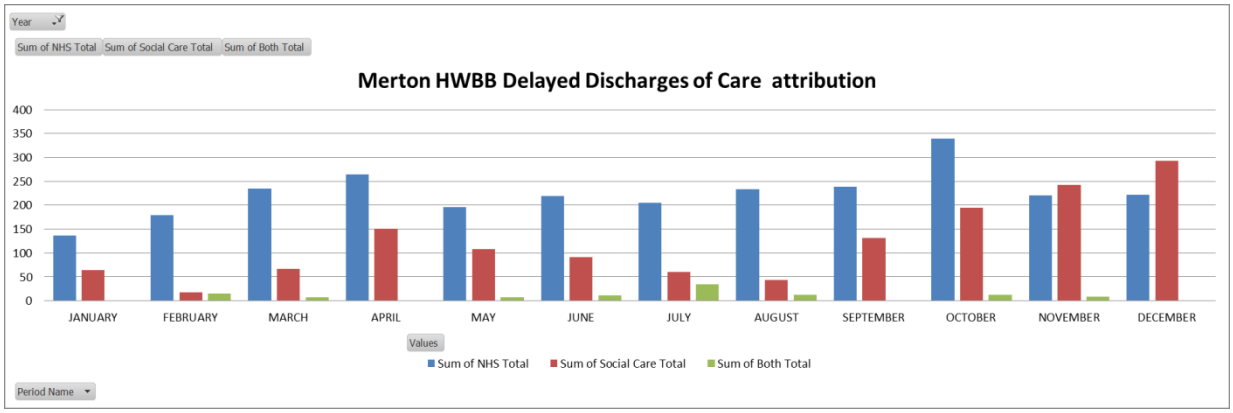
1. Identification of an Interoperability platform
2. Provider engagement to explore benefits of sharing patient information across organisational boundaries
3. Data sharing agreement between service providers
4. Patient and service user engagement about sharing and use of personal information
5. Implementation of interoperability platform

This project will deliver on the national condition Better data sharing between health and social care, based on the NHS number.

Action plan: Delayed Transfers of care (DTOC)

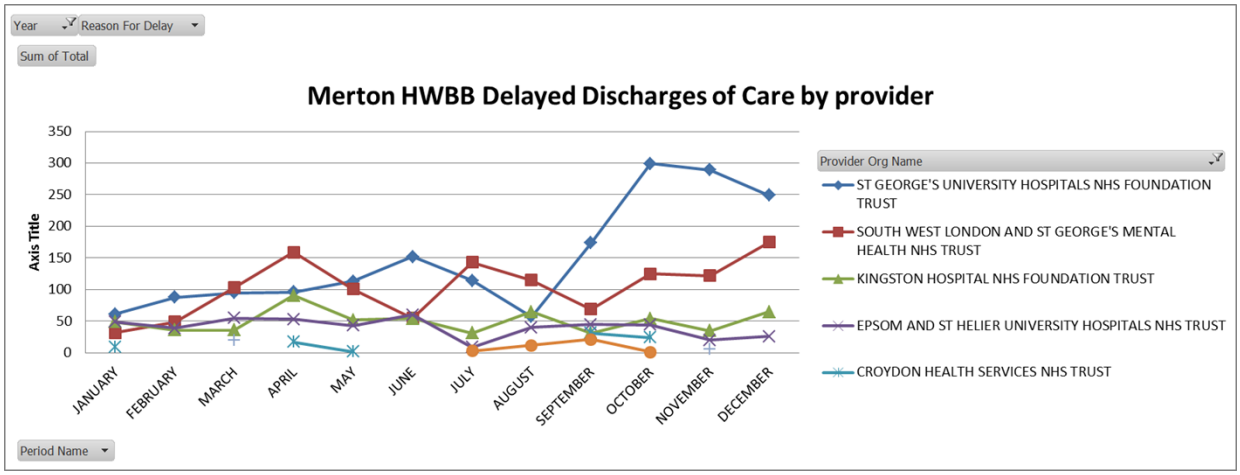
Historically, Merton has compared favourable to other HWB areas for the number of DTOC days. DTOC pressures have been managed through commissioning of health responses such as in-reach nursing, local authority provision of reablement and local escalation of complex cases. However, we have experienced an increased number of DTOC bed days for the period Oct – Dec 2015 due to increased pressures, particularly with social care supported discharges. This has been ascribed to lack of residential and domiciliary care provision in the local care market.

FIGURE 10 MERTON HWB DTOC ATTRIBUTION



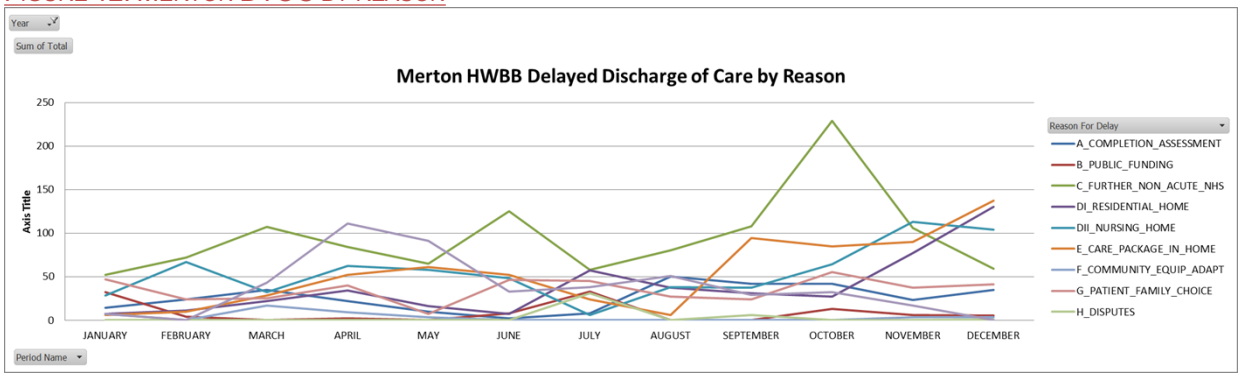
These increased pressures have been more evident at our main acute provider, St. Georges NHS Foundation Trust.

FIGURE 11: MERTON DTOC BY PROVIDER



Whilst Q2 saw an increase in DTOC due to awaiting care packages in people's homes, awaiting further NHS non-acute care has seen greater increases in overall number of delayed bed days despite provision of in-reach nursing by our community services provider.

FIGURE 12: MERTON DTOC BY REASON



Improving Delayed Discharges of care is a priority for the local health economy. The CCG and local authority have engaged with our main acute trusts to gain a better understanding of the issues contributing to DTOC. We participated in the Epsom and St. Helier winter pressures discharge event to facilitate discharges prior to the Christmas period and gained an understanding of the system pressures causing delayed transfers of care. Initiated following the St. Georges System Resilience group's "One version of the Truth" deep dive, we participated in the Multi-disciplinary Accelerated Discharge event (MADE) on 18th and 19th of January followed by a complex discharge workshop on the 24th of February. We join the bi-weekly Kingston hospital DTOC conference call and regularly attend the St. Georges weekly discharge meeting.

This engagement has informed a more strategic approach to managing DTOC. We have therefore development an action plan to ensure the key enablers for improved DTOC are implemented. The accountable officer overseeing delivery of this action plan is the Merton Director of communities and housing. The various actions will be delivered through the 3 BCF projects as listed in the DTOC action plan in Appendix 4. The main themes for the DTOC action plan are:

1. Improved care and support out-of-hospital for people delivered through Integrated Health and social care assessments. (Project 1)
2. Improved system flow to facilitate discharges 7 days per week. (Project 2)
3. Development of Discharge to Assess pathway. (Project 1)
4. Joint health and social care domiciliary and care homes market management approach

Merton do not consider it necessary to implement additional measures such as a risk sharing arrangement, as our levels of DTOC compare favourable to other HWBB. However, we will be working in partnership to stimulate and manage the local residential and domiciliary care market through a more collaborative brokerage function for continuing health care and social care.

Stakeholder engagement

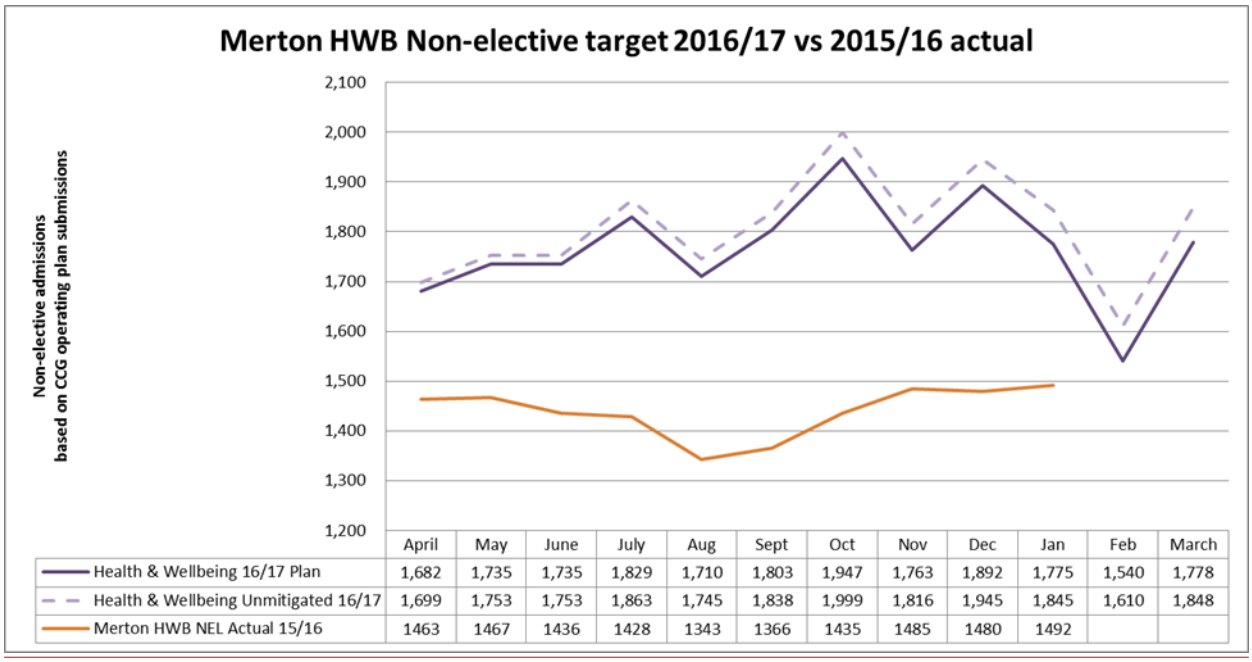
Merton intends to use the BCF plan as a vehicle for system transformation to enable integrated health and social care by 2020.
The 2016/17 plan is not about introducing new services, but about simplifying the existing processes and pathways to achieve a more responsive, better quality response for people with support needs. We therefore recognise that a significant amount of engagement is required to bring all partners on board with the vision, create an environment for change, truly listen to what support people need to prevent admission or long term care and empower front line staff to make these changes. Stakeholder engagement needs to be an integral part of how we do things and shapes the change journey.
At the time of writing, a number of events and forums were identified as opportunities to engage with various stakeholders. This included System Resilience Groups, Voluntary sector engagement events and public engagement events. The stakeholder engagement plan as shown in Appendix 5 will be further developed over the course of the year to ensure system wide engagement with the transformation plan.

Health and Wellbeing Board Metrics

1. Non-elective admissions

Figure 13 presents the forecast vs target position for Non-elective admissions for the CCG and Merton Health and Wellbeing board. This HWB unmitigated position reflects the forecast position without any QIPP reductions, whilst the target reflects the reduction with the CCG complex patients QIPP applied.

FIGURE 13: HWB AND CCG NON-ELECTIVE PERFORMANCE

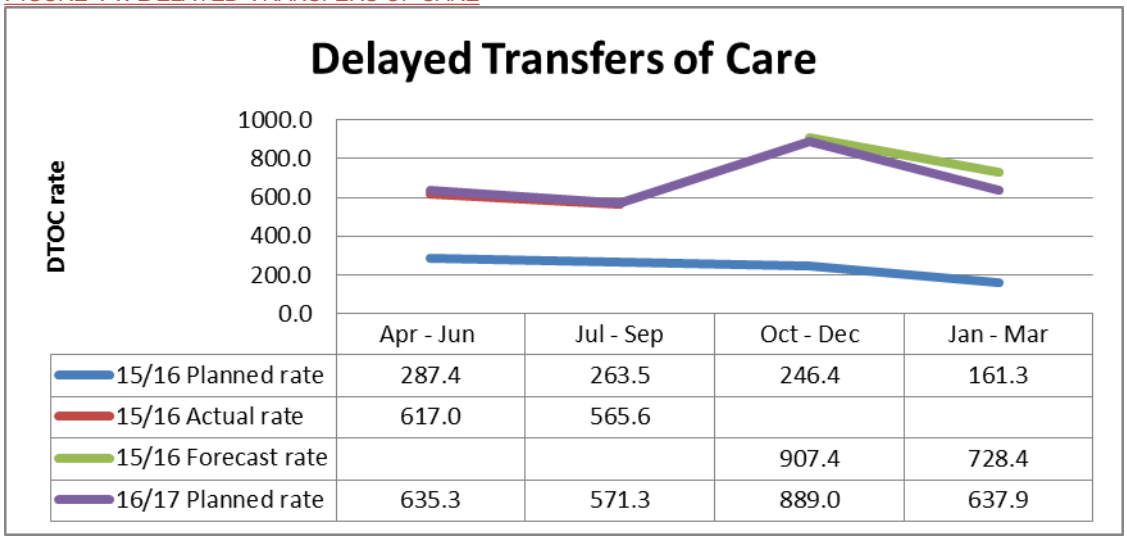


	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Health & Wellbeing 16/17 Plan	1,682	1,735	1,735	1,829	1,710	1,803	1,947	1,763	1,892	1,775	1,540	1,778
Health & Wellbeing Unmitigated 16/17	1,699	1,753	1,753	1,863	1,745	1,838	1,999	1,816	1,945	1,845	1,610	1,848
Merton HWB NEL Actual 15/16	1463	1467	1436	1428	1343	1366	1435	1485	1480	1492		

Figure 14 – 18 presents the forecast outturn for 15/16 Health and Wellbeing Board metrics and the targets for 2016/17.

2. Delayed Transfers of Care

FIGURE 14: DELAYED TRANSFERS OF CARE

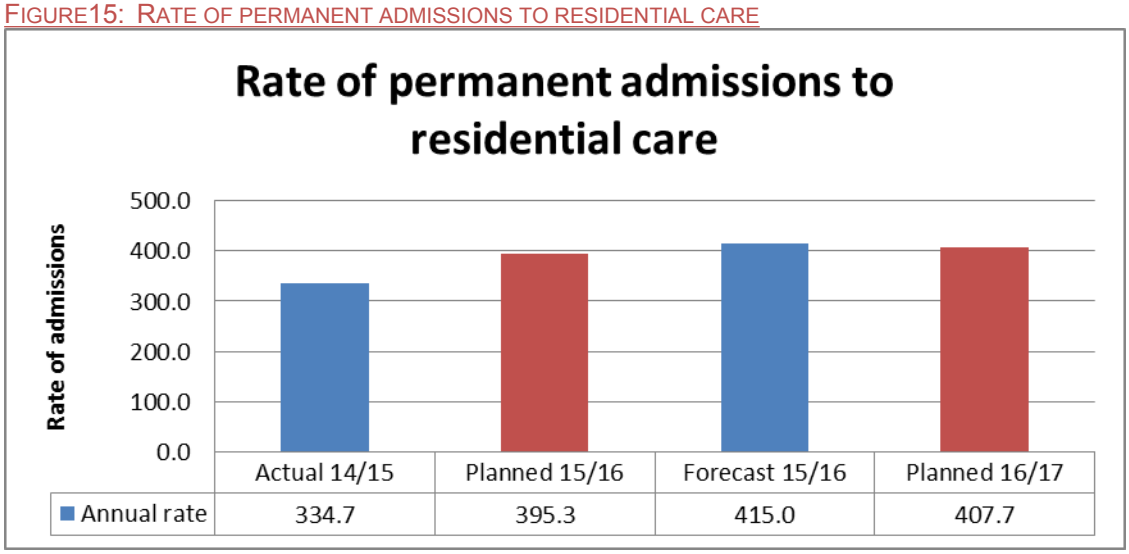


	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar
15/16 Planned rate	287.4	263.5	246.4	161.3
15/16 Actual rate	617.0	565.6		
15/16 Forecast rate			907.4	728.4
16/17 Planned rate	635.3	571.3	889.0	637.9

The system has experienced significant challenges with delayed discharges of care during 2015/16. We are aware that this is caused by silo processes between various health responses as well as between health and social care. An action plan to address this has been developed, however we anticipate that the effects of these actions will begin to take effect from Q3 and 4. Therefore, although we are planning for a reduced rate of DTOC in 2016/17, we expect to see a more significant reduced rate of DTOC from 2017/18.

3. Permanent admissions to residential care

FIGURE15: RATE OF PERMANENT ADMISSIONS TO RESIDENTIAL CARE



	Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Annual rate	334.7	395.3	415.0	407.7

Merton currently performs well compared our peer comparators for permanent admissions to residential care. With an ageing population and people requiring increasing levels of care, maintaining this rate will be a challenging target.

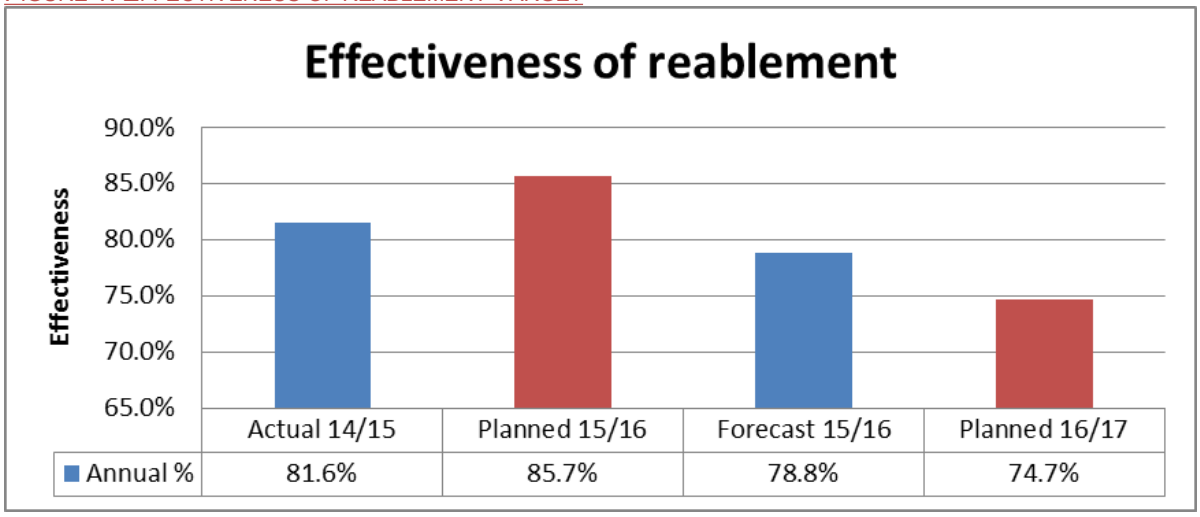
4. Effectiveness of Reablement

The HWB plan to offer more people reablement during 2016/17 through a combined health and social care offer. This means that a number of people with higher acuity will be supported and therefore the overall effectiveness of the service is forecast to decrease:

FIGURE 16: EFFECTIVENESS OF REABLEMENT CALCULATION

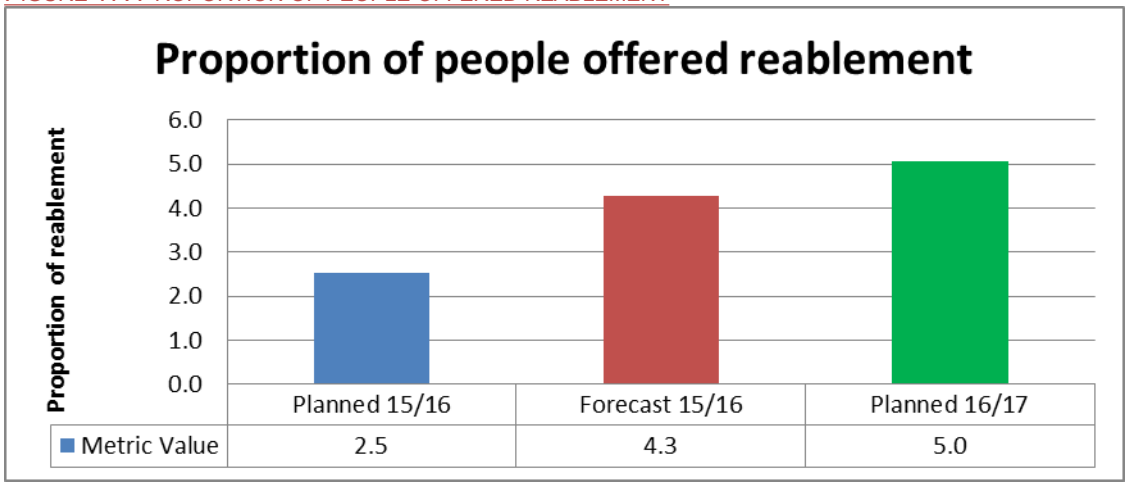
	Number of people at home 91 days after reablement	Number of people offered reablement	Effectiveness of reablement
Number of people offered reablement 2015/16	130	165	78.8%
Number of people offered reablement 2016/17 at same level of acuity as in 2015/16	130	165	78.8
Additional people offered reablement at increased acuity level 16/17	12	25	50%
Planned Reablement Total 2016/17	**142**	**190**	**74.7%**

FIGURE 1: EFFECTIVENESS OF REABLEMENT TARGET



5. Proportion of people offered Reablement

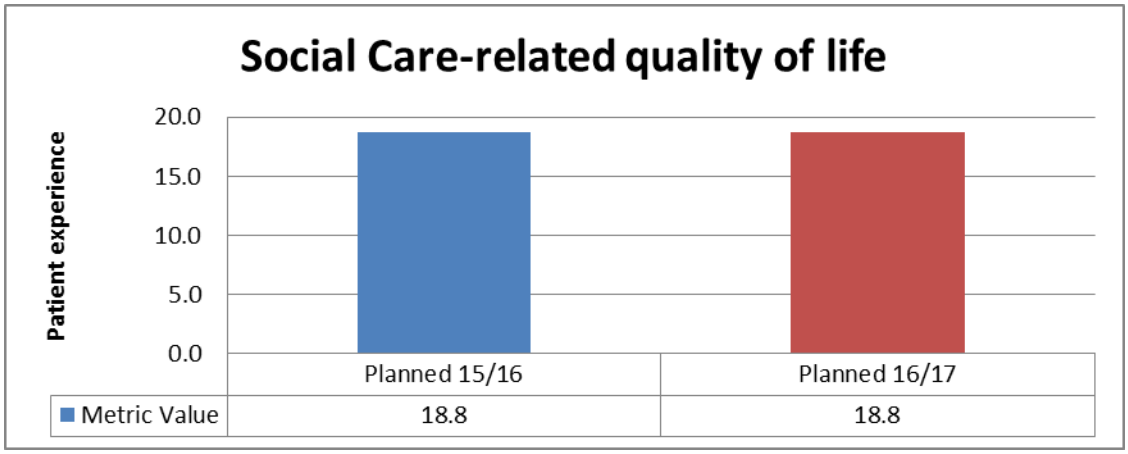
FIGURE 17: PROPORTION OF PEOPLE OFFERED REABLEMENT



During 2016/17 more people will be offered reablement through a combined health and social care reablement response that prevents admissions to hospital as well as facilitate earlier discharge.

6. Social care related quality of life

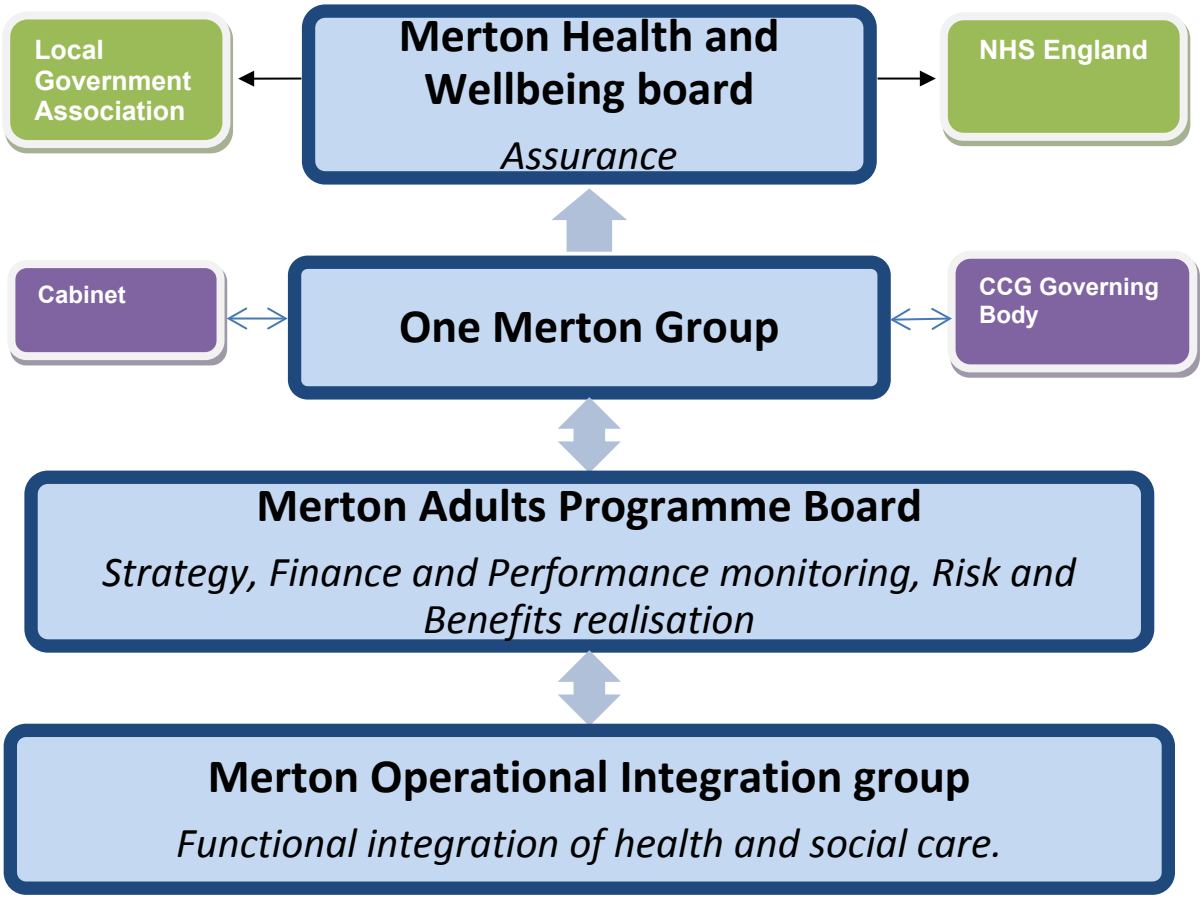
FIGURE 18: SOCIAL CARE-RELATED QUALITY OF LIFE



Merton currently compares well to our comparator peers. Maintaining current satisfaction levels will therefore be a challenging target with an ageing population and more people requiring support.

Programme Governance

The Merton Adults group has been established to act as the BCF Programme Board and will report to the CCG's Governing Body and the Council's Cabinet as set out in the diagram below.



The Merton Adults Programme Board is a newly established group which will take on the Merton BCF programme board responsibility. This group will be chaired by the Director of Adult Social Care and will meet monthly to provide strategic direction to the BCF programme, monitor implementation of the programme plan and monitor the impact and benefits of the programme.

The Merton Operational Integration group is re-constituted from the previous Merton Model group. The group and have responsibility for delivering the BCF projects and DTOC action plan. The group will be chaired by the Assistant Director of Integration, will meet monthly and will co-ordinate delivery of the various task and finish groups.

Risk Pool

There is currently a signed section 75 in place between the CCG and local authority. This will be updated to reflect amendments to the 2016/17 pooled budget and include a ring-fenced risk pool with supporting risk and gain sharing arrangement. The risk pool will be the same value of the Merton CCG QIPP for avoiding emergency admissions, currently £1,015k.

The CCGs non-elective plan has been calculated as follows and sets out the value of the NEL QIPP plan and therefore the required value of the Risk pool.

	Activity*	Cost **
NEL admissions 2015/16 FOT	23,225	30,415k
NEL admissions forecast growth 2016/17 (3%)	697	1,853k
NEL BCF QIPP	525	1,014k
CCG NEL operating plan target	23397	31,254k

*Activity forecasts at 18th March and subject to change prior to final CCG Operating plan submission on 24th April 2016
**Forecast costs and QIPP values based on 26th Feb 2016 CCG Operating plan submission and are subject to change prior to final CCG Operating plan submission on 24th April 2016

The CCG and local authority will ringfence an amount of £1,015k from the BCF pool and retain this as part of the risk share agreement. These funds will be retained and remain uncommitted with the terms of managing the fund set out in the Section 75 between the CCG and the Local Authority. These funds will be released at the end of the year, should the CCG meet the NEL QIPP target and spent as agreed by the Health and Wellbeing board.

However, if the CCG do not meet the NEL QIPP target, the fund will be used to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand.

Risk management and reporting

The Merton BCF programme will be managed as per recognised programme governance arrangements. Therefore a risk register will be maintained and reported to the BCF programme board on a monthly basis.

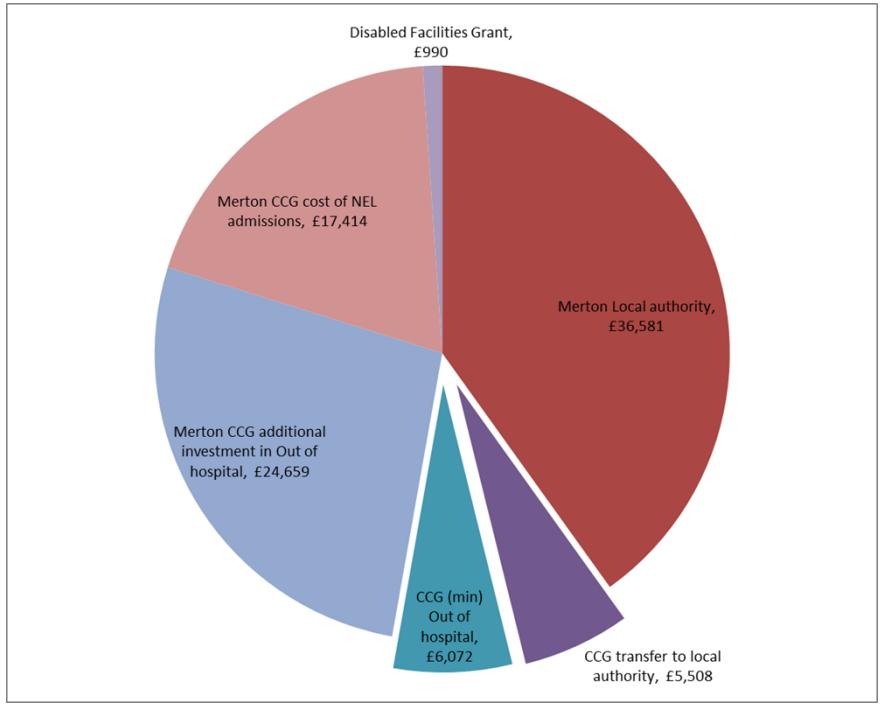
Appendix 1: 2016/17 Scheme level budget

Scheme Name	Investment categories	Area of Spend	Provider	Forecast outturn 2015/16	2016/17 Budget
Non-elective admissions for over 50s.	Non-elective Admissions	Acute	NHS Acute	£17,892,383	£17,414,310
Community Services contract	Integrated care teams	Community Health	NHS Community Provider	£16,098,000	£16,670,000
Community Services Contract performance payment	Integrated care teams	Community Health	NHS Community Provider	£0	£409,000
Merton integrated equipment store	Equipment	Community Health	Private Sector	£752,687	£776,950
13/14 underspend Merton Integrated equipment store	Equipment	Community Health	Private Sector	£0	£200,000
Ene of life care - local enhanced service	Integrated care teams	Primary Care	NHS Community Provider	£19,000	£19,209
Nursing - Marie Curie Cancer	Integrated care teams	Community Health	Charity/Voluntary Sector	£100,000	£101,100
Bereavement service	Integrated care teams	Mental Health	Charity/Voluntary Sector	£65,000	£65,715
Hospices	Integrated care teams	Community Health	Private Sector	£527,000	£532,797
Intermediate care beds	Integrated care teams	Community Health	Private Sector	£656,000	£594,216
Expert patient programme	Integrated care teams	Community Health	CCG	£80,000	£96,000
End of life support	Integrated care teams	Community Health	Private Sector	£105,500	£100,000
Data sharing	Project costs	Other	CCG	£0	£30,000
Continuing care placements	Personalised support or care	Continuing Care	Private Sector	£7,350,750	£8,526,870
Joint funded placements	Personalised support or care	Social Care	Private Sector	£559,000	£564,590
Funded nursing care	Personalised support or care	Social Care	Private Sector	£1,428,500	£1,657,060
Local Enhanced Services - Diabetes	Integrated care teams	Primary Care	NHS Community Provider	£15,000	£15,150
Local Enhanced Services - Care of older people	Integrated care teams	Primary Care	NHS Community Provider	£1,089,000	£1,099,890
Mascot	Assistive technologies	Other	Local Authority	£1,424,604	£1,444,920
Voluntary services grant - Ageing well	Integrated care teams	Community Health	Charity/Voluntary Sector	£807,131	£450,000
Reablement	Integrated care teams	Community Health	Local Authority	£2,467,053	£2,038,350
Placements Care Packages	Personalised support or care	Social Care	Private Sector	£41,302,841	£36,172,283
Carers support including respite	Carers support	Social Care	Private Sector	£417,200	£365,377
3 Health liaison officers	Integrated care teams	Social Care	Local Authority	£150,000	£150,000
Health liason 7 day working	Integrated care teams	Social Care	Local Authority	£500,000	£500,000
Hoist maintenance contract	Equipment	Social Care	Local Authority	£57,000	£57,000
Data sharing (NHS number cross reference)	Project costs	Social Care	Local Authority	£42,000	£42,000
Market management - packages of care	Project costs	Social Care	Local Authority	£15,000	£15,000
Project costs	Project costs	Social Care	Local Authority	£30,000	£30,000
Project costs - staff	Project costs	Other	CCG	£94,000	£94,000
Disabled Facilities Grant	Disabled Facilities	Social Care	Local Authority	£528,000	£989,719
				£94,572,649	**£91,221,506**

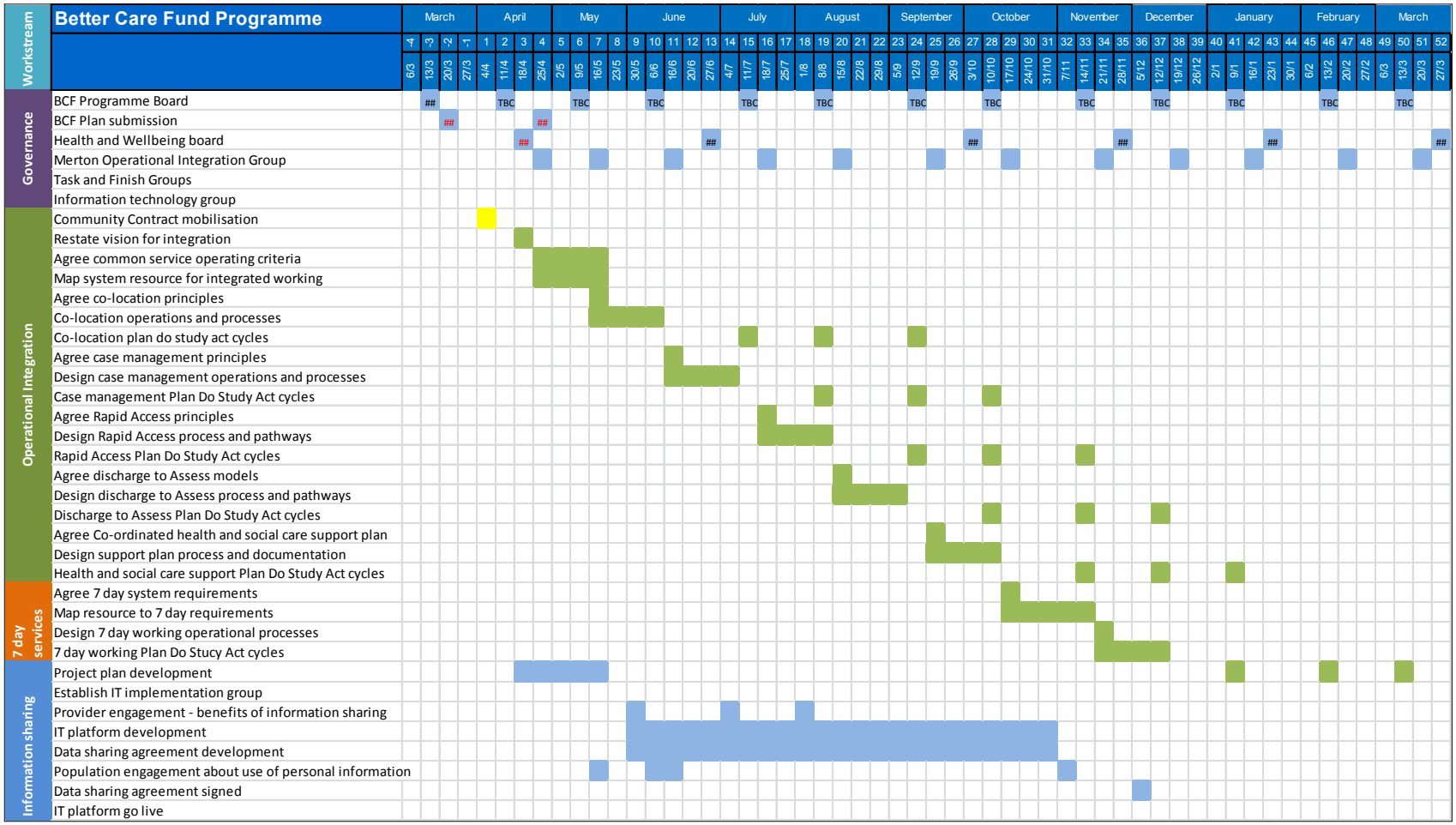
*At the time of writing, the CCG operating plan was not finalised. Therefore, the amounts in this table are subject to minor amendments.

Appendix 2: Merton 2016/17 BCF Funding Sources

Merton BCF HWBB Funding Sources	BCF budget (000)	Gross contribution (000)
Local Authority Contribution(s)		£ 36,581
Merton Local authority	£ 36,581	
CCG Minimum Contribution		£ 11,580
CCG transfer to local authority	£ 5,508	
CCG (min) Out of hospital	£ 6,072	
Additional CCG Contribution		£ 42,073
Merton CCG additional investment in Out of hospital	£ 24,659	
Merton CCG cost of NEL admissions	£ 17,414	
Capital Funding		£ 990
Disabled Facilities Grant	£ 990	



Appendix 3: 2016/17 BCF programme plan



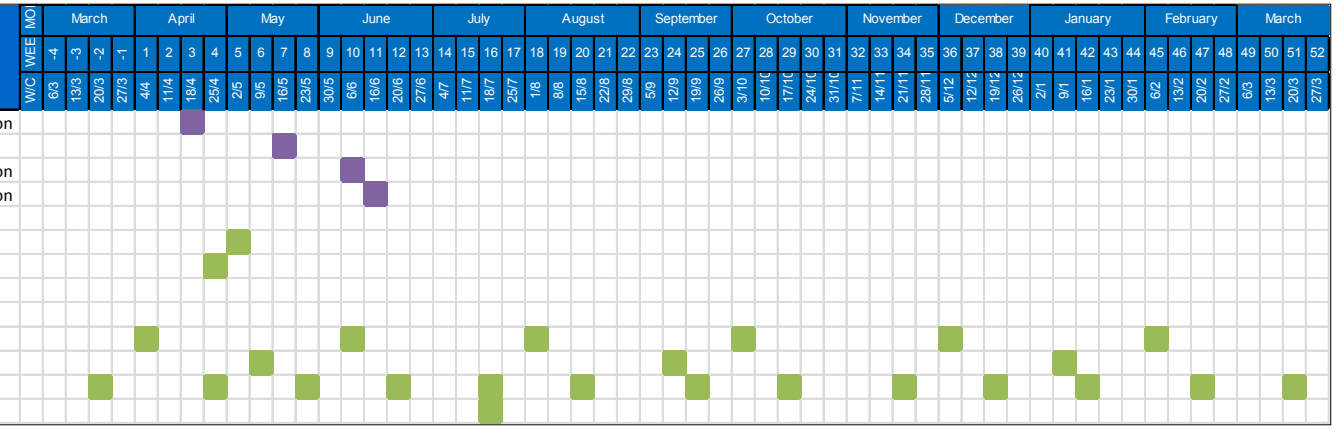
Appendix 4: DTOC Action plan

DTOC Action plan at 11/3/2016

Theme	Reason for delay	Issues	Required Action	Owner	Status
		Merton DTOC lower than Wandsworth	Establish what is different between Wandsworth and Merton provision	Simon	Open
Discharge planning process.	Awaiting Completion of assessment	Timings of issuing Section 2s and 5s	Local authority to present proposed timings of notifiying LA of discharges that need packages of care. To be presented for discussion and agreement at weekly Platinum command meeting. Jenny and Betty to agree proposed standards to be presented.	Jenny	Open
	Awaiting Completion of assessment	MDT assessment and recommendations for HNA etc (Assessments not complete or accurate)	Betty to present to Trust what the proposed standards and content of a HNA is and discuss via Platinum command meetings.	Betty	Open
	Awaiting Public Funding	Timing of notification of outcome of CHC panel	Health and Social Care to agree common pathway. James Holden, Jenny and Betty to meet to discuss	Jenny	Open
	Awaiting further NHS non acute care	Health input required post discharge (TTOs, Community services follow-up, GP follow-up, Mental Health follow-up)	Agreed that integrated health and social care response is required. Workshop - 3rd week of April.	Murrae	Open
	Awaiting further NHS non acute care	Mental Health input required to arrange discharge plan	Invite mental health representatives to hospital discharge meetings. MH team invited to Hospital Discharge Meeting on 21 March	Jenny	Complete
	Patient / family choice	Patients and family changing decisions due to information provision during in-patient spell.	Draft of information leaflet to be shared with key stakeholders, including St. Georges Hospital. Jenny to arrange review meeting and share output with Simon	Jenny	Open
	Disputes	DTOC counting not trustworthy	To continue raising at person level	Murrae	Open
		DTOC counting not trustworthy - no common audit trail of discharge process	Betty to discuss with Trust to investigate common audit process such as a discharge planning tracker.	Betty	Open
Care market	Awaiting Nursing Home	Timing and need for care homes to assess people in hospital	To negotiate with care homes to accept recommendations from Health and social care assessment	Jenny	Open
	Awaiting Nursing Home	Timing of discharge from hospital to care homes so that people have time to be settled before staff numbers reduce	No action identified		Open
	Awaiting Nursing Home	Providers not trusting recommendations for recommended level of care	To negotiate with care homes to accept recommendations from Health and social care assessment	Jenny	Open
	Awaiting Care Package / own Home	Market capacity for complex patients	Commissioning strategy for complex provision required	Head of Commissioning	Open
Advance planning	Housing: not covered by NHS and Community Care Act	People who are homeless	To agree process of dealing with cases that have no recourse to public funds. Meeting between Simon, Steve and Betty to be arranged	Simon	Open
	Patient / family choice	People refusing to accept family member home after admission	Negotiate with Trust to classify these cases as patient choice	Betty	Open
	Patient / family choice	People refusing to accept family member home after admission	Work with Trust to implement discharge policy	Betty	Open
	Patient / family choice	People refusing to accept family member home after admission	Investigate options for temporary placements	Jenny	Open
Crisis post discharge	Failed discharge	Insufficient care and support arranged at point of discharge - family going into crisis as not able to cope	Work with Trust and Voluntary sector to arrange: 1. Point of contact for people post discharge if require support 2. Work with voluntary sector to support people who have recently been discharged	Jenny	Open

Appendix 5: Stakeholder engagement plan

Better Care Fund Programme Stakeholder Engagement plan	Planned Start Date	Action by:
Merton Patient Engagement Group	26/04/2016	M. Wallington
Public data sharing workshop	TBC	M.Tolson
Mitcham Carnavall	11/06/2016	M. Wallington
Wiimbledon Village fair	18/06/2016	M. Wallington
Merton Senior's forum	Monthly meetings	M.Tolson
St. Georges SRG workshop	06/05/2016	A. Walker
Epsom and St. Helier SRG workshop	26/04/2016	A. Walker
Merton Centre for independent living	Monthly forums	K. Mahdi
Merton Involve	Quarterly forums	K. Mahdi
Merton CCG Clinical Transformation Committee	Bi-monthly	T. Foote
Merton CCG Clinical Reference Group	Monthly	T. Foote
Merton Adult Social Care managers meeting	Monthly	H. Begg
Merton CCG Annual General Meeting	14/06/2016	



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