Merton Better Care Fund Update for 19/20

For Merton Health and Well Being Board 8th October 2019

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Summary

- Better Care Fund Overview
- Funding Allocation
- Update on Initiatives Funded through the BCF
- High Impact Change Model
- Performance Targets

Better Care Fund Overview

- A programme spanning both the NHS and local government, the plan has been developed and agreed across health and social care.
- With the aim of improving the lives of some of the most vulnerable people, by placing them at the centre of their care and support, providing them with integrated health and social care.
- Key objectives for the plan include:
  - Reducing the growth of emergency admissions.
  - Reducing length of hospital stay and delayed transfers of care (DTOC).
  - Reducing permanent admissions to care homes.
  - Increasing the proportion of older people who were still at home 91 days after discharge from hospital into reablement.
  - Improving service user and carer experience.

Funding Allocation

Funding Sources	2018/19	2019/20
DFG	£1,186,109	£1,279,883
Minimum CCG Contribution	£12,011,626	£12,871,787
iBCF	£3,523,032	£4,114,486
Winter Pressures Grant*		£747,910
Total	£16,720,766	**£19,014,066**

*Not included in BCF in 2018/19

Of the CCG minimum contribution, £6,214,073 is allocated as a minimum sum to schemes where social care supports the system.

SUMMARY OF SCHEMES TYPES FUNDED THROUGH THE BCF	
Assistive Technologies and Equipment	£404,000
Carers Services	£348,000
Community Based Schemes	£843,380
DFG Related Schemes	£1,279,883
Enablers for Integration	£2,084,523
HICM for Managing Transfer of Care	£505,000
Home Care or Domiciliary Care	£1,755,573
Housing Related Schemes	£50,000
Integrated Care Planning and Navigation	£1,666,372
Intermediate Care Services	£6,469,402
Personalised Budgeting and Commissioning	£105,000
Personalised Care at Home	£2,100,000
Prevention / Early Intervention	£539,084
Residential Placements	£238,910
Other	£624,940
Total	£19,014,067

Context

- The key priorities for integration in 2019/20 BCF Plan mirror the Merton Health and Care Together Programme and support for the 3 key Age Well projects:
  - Integrated Locality Teams
  - Integrated Intermediate Care
  - Enhanced Support To Care Homes.
- We are also measured against key metrics and the high impact change model

Integrated Locality Teams

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

The BCF contributes to:

- The locality based community teams, made up of nurses (including case managers, care navigators, dementia specialist nurses, end of life care nursing)
- 4 health liaison social workers (1 additional post from previous years)
- Voluntary sector services, including Dementia Hub, Carers Support, falls and other prevention initiatives
- Telecare through MASCOT
- Holistic Assessment and Rapid Investigation (HARI) service (a specialist multi-disciplinary, geriatrician led service) and other falls preventions initiatives.

Integrated Intermediate Care & Rapid Response

- Single Point of Access (SPA) in place for referrals to CLCH Intermediate Care and LBM Intake team (which includes reablement) to avoid admissions and support people home from hospital sooner.

The BCF contributes to:

- Reablement services (with increases in provision in 2019/20 to support evenings, weekends and admission avoidance)
- Home and bed based rehabilitation
- Integrated domiciliary packages of care (increases in 2019/20 as part of iBCF)
- Rapid Response (MERIT) offering rapid two hour response to prevent admission to hospital
- In reach nurses at St George's to help with admission avoidance and complex discharges
- Community Equipment (ICES) (with increase in funding to support increasing demand)
- Dedicated social work input into Continuing Health Care processes
- 7 day working

Enhanced Support to Care Homes

- A range of initiatives and services providing enhanced support within care homes in order to improve quality, help people access the right care and where possible out of hospital.
- Initiatives include a successful Care Home Fora, the multi-agency Joint Intelligence Group and more tailored training and support.
- The Red Bag has been implemented and embedded which has supported getting residents back to their care home sooner following admission to hospital.
- A Care Homes Steering Group has just been established to co-ordinate the range of initiatives.

The BCF contributes to:

- Support given by Rapid Response (MERIT), End of Life Care Nurses and other specialists to care homes
- Equipment to pick up fallers in care homes (new funding from BCF and to be implemented in 2019/20)

Other initiatives through the BCF

- Through the winter planning funding as well as increasing capacity, we intend to build on our Winter Warm programme:
  - with the voluntary sector reducing factors that increase the likelihood of presentation to health or social care, including an enhanced lunch club offer, reducing isolation amongst older men through our music workshops, improving heating and insulation, supporting access to benefits and helping with small grants for energy, food and clothing.
- Disabled Facilities Grant (DFG). Support 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
  - Emergency Adaptations
  - Dementia Friendly Aids and Adaptations Grant
  - Helping Hand Service for Low Level Hazards
  - Help with Energy Efficiency

High Impact Change Model

- A steering group comprising key system partners including St George's Hospital, Merton and Wandsworth CCGs, the Local Authorities and CLCH, agreed a work plan to support ongoing developments.
- A summary of the current assessed position and the aspiration for the year is detailed below:

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020
Chg 1	Early discharge planning	Established	Established
Chg 2	Systems to monitor patient flow	Established	Established
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Established	Established
Chg 4	Home first / discharge to assess	Established	Mature
Chg 5	Seven-day service	Plans in place	Established
Chg 6	Trusted assessors	Established	Established
Chg 7	Focus on choice	Established	Established
Chg 8	Enhancing health in care homes	Established	Mature

BCF Performance Targets

- Delayed Transfers of Care (total) On track
  - Below London average
  - Challenges in delays at St George's (attributed to health)
- Non Elective Admissions (HWBB) On track
- New Permanent Admission to Residential and Nursing Homes On track
- Number of People Offered Reablement and still at home after 91days On track

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