## Merton Integration & Better Care Fund Plan 2017/19

<table>
<thead>
<tr>
<th>Area</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constituent Health and Wellbeing Boards</td>
<td>Merton</td>
</tr>
<tr>
<td>Constituent CCGs</td>
<td>Merton</td>
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Executive Summary
The Better Care Fund (BCF) is a programme spanning both the NHS and local government with the aim of improving the lives of some of the most vulnerable people in our society, by placing them at the centre of their care and support, providing them with integrated health and social care. In order to support this aim, a Better Care Fund Plan has been developed and agreed across health and social care with the following objectives:

- Reducing the growth of emergency admissions
- Reducing length of hospital stay
- Reducing permanent admissions to care homes
- Improving service user and carer experience.

This plan outlines the work taking place across health and social care for 2017-19 that supports the above aims and contributes to the delivery of the ‘Whole Merton’ vision agreed in 2015 as well as aligning with the South West London Sustainability and Transformation Plan (STP), having a focus on the delivery of the following work streams to support this:

- Integrated Locality Teams
- Intermediate Care and Rapid Response in the Community
- Enhanced Support for Care Homes
- End of Life Care
- Dementia.

Merton Better Care Fund is made up of the following:

<table>
<thead>
<tr>
<th>Merton BCF Pooled Budget</th>
<th>2017/18</th>
<th>2018/19</th>
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<tbody>
<tr>
<td>Disabled Facilities Grant (DFG)</td>
<td>£1,087,914</td>
<td>£1,186,109</td>
</tr>
<tr>
<td>iBCF</td>
<td>£2,745,896</td>
<td>£3,523,032</td>
</tr>
<tr>
<td>CCG Minimum Contribution</td>
<td>£11,787,660</td>
<td>£12,011,626</td>
</tr>
<tr>
<td><strong>Total Pool</strong></td>
<td><strong>£15,621,470</strong></td>
<td><strong>£16,720,766</strong></td>
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The NHS Social Care Interface Dashboard indicates Merton as a ranking of 18 out of a national ranking of 150. Whilst Merton performs well overall, there is more work to do to improve all areas and in particular to reduce the level of emergency admissions and recording of older people still at home 91 days after discharge from hospital into reablement/ rehabilitation services. NHS England have set demanding targets for delayed transfers of care, which Merton will have difficulty in achieving. Merton has therefore taken the decision to include the trajectories as required by NHS England, but continue to dispute the validity of the baseline and therefore remain concerned regarding their achievability.
1. What is the local vision and approach for health and social care integration?

In 2015, the ‘Whole Merton’ vision was developed and agreed as the strategic direction of travel across Merton. This is a vision for the health and wellbeing of the people of Merton and was developed working with a range of our partners. It is summarised in Figure 1 below.
The whole population

This is a people focussed model that should work from the whole population through to the individual, ensuring fairness and equality of provision. In looking at “What would success look like for the population?” the vision is to receive responses in line with the following:

- I feel well and illness is not the defining feature of my life.
- When I do need the NHS I want all its parts to speak to each other.
- I am confident in the ability of the NHS to support me when I need it to.
- I know how to look after myself and manage my own health to a large extent – before I need to access the NHS.
- I want to have clear two-way communication at every step of my interaction with the NHS.

Within our Community Service Contract with Central London Community Healthcare NHS Trust (CLCH), we have included the requirement to collect patient reported experience measures (PREMs) and patient reported outcome measures (PROMs) which support getting an understanding of user views regarding these aspects of care.

Whole Health and Wellbeing System

Partnership is at the heart of our vision and Merton Clinical Commissioning Group (MCCG) and London Borough of Merton (LBM) have been working together with residents’ groups, voluntary and community sector groups and providers around the Whole Merton vision.

Our strategic partnering reflects a number of areas of shared interest:

- Improving the health and wellbeing of Merton residents.
- Developing more integrated and effective services to better meet the needs especially of vulnerable local people and ensure better use of diminishing public sector resources.
- Transforming the way services are commissioned and provided to meet our shared strategic challenges
- Leading the development of effective and vibrant partnerships with local voluntary and community sector, statutory partners, business and providers.

Central to improving the overall health and wellbeing of the residents of the borough, is the Health and Wellbeing Board (HWBB) which has a key strategic local leadership role. The work of the HWBB is central to informing and performance managing the commissioning and outcomes of health and social care services in Merton and it has a core role in encouraging joined-up services across the NHS, social care, public health and other local partners. The Merton HWBB brings together the Council, Merton Clinical Commissioning Group, Health Watch and the voluntary and community sector with a shared focus on improving health and wellbeing in Merton.

Merton has a rich history of integrated working. A core part of our focus since 2013 has been the development of integrated care between social and health care.
The focus continues to be based on two phases of individuals’ care:

- **A proactive phase**, including the identification of high risk individuals, allocation of a key worker, person-centred planning and a common care plan across organisations with the development of integrated locality teams and multi-disciplinary review meetings.

- **A reactive phase**, developing improved responses to short term crises and exacerbation of conditions, including rapidly available alternatives to hospital admission, supported hospital discharge, rehabilitation, intermediate care, reablement, and increasing the integration of these health and social care responses.

This has continued with our joint reprocurement of community services and has developed further operationally with many staff from our community provider now being co-located with council colleagues at the Civic Offices.

As indicated in our 2016/17 BCF Plan, 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.

A range of stakeholders have discussed how this might look and confirmed the commitment to progressing this model, combining the delivery of primary care, community services and care services at its core, incorporating a much wider range of services where that is the best thing to do. Figure 2 below describes an outline of the proposed core organisations in red with some of the key agencies which would contribute to the model in the blue section.

**Figure 2: MCP – core and supporting organisations**
The commissioning of this service would be through a single contract with ‘the core’ for a fixed sum of money to deliver certain outcomes for a defined population:
- Within an agreed process
- Informed by practical issues that make the system work sub-optimally

Incentives would need to be aligned and include:
- Ability to move resources to where they are most needed to support the needs of the agreed population
- Retaining savings within the system to reinvest in services
- Potential consequences of non-delivery, e.g. a procurement process to deliver the model, which would then open this up to other providers.

Enablers
- Information sharing
- Shared care plans
- Staff engagement/workforce

Priorities
- Integrated discharge process
- Rapid response in the community
- Proactive case management
- Trusted assessment
- ‘Can do- I can fix this’ attitude to minimise hand offs.

It has been agreed that the Core group of providers develop this further, starting initially with a defined cohort, with an expansion of the scope over time. The frail elderly population is currently being explored as the cohort to start this new way of working. The benefits of this approach with children and families is also of note, but will be a later phase.

Alongside the longer term strategic work to develop an MCP, it has been agreed that the priorities for unplanned care within the South West London Sustainability and Transformation Plan forms a key element of the Better Care Fund Plans. These include the priorities highlighted above and form key work streams being developed across South West London:
- Integrated Locality Teams
- Intermediate Care and Rapid response in the Community
- Enhanced Support for Care Homes
- End of Life Care
- Dementia.
Whilst we expect other schemes to support the overall aims of the Better Care Fund, for example our increase in Ambulatory Emergency Care, enabling more patients to return home sooner, these have not been included within this plan.

These schemes in addition to contributing to the aims and objectives of the Better Care Fund are key to delivering the ‘Whole Merton’ vision and unplanned care out of hospital elements of the South West London Sustainability and Transformation Plan. They also form the building blocks for the MCP development and delivery of key standards e.g. in relation to seven day services.

Alongside this, we are continuing to build on already undertaken to deliver key enablers to achieve better data sharing across the system, with a joined up approach to assessments and care planning with key workers supporting the co-ordination of care for people with complex needs.

2. Background and context to the plan

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which was announced by the government in 2013 with the aim of improving the lives of some of the most vulnerable people in our society, by placing them at the centre of their care and support, providing them with integrated health and social care. In order to support this aim, a Better Care Fund Plan has been developed and agreed across health and social care.

The key priority for integration in 2016/17 BCF was to strengthen the relationships and collaboration between providers in Merton with the aim of:

- Reducing the growth of emergency admissions
- Reducing length of hospital stay
- Reducing permanent admissions to care homes
- Improving service user and carer experience.

These objectives continue to be the focus of the work within this plan.

Our Population

Merton Borough Health Profile in Appendix 1 gives a summary of key characteristics of Merton Borough where in 2016 there were 207,140 residents.

Based on Office of National Statistics (ONS), there are approximately 24,936 people aged 65 and over in Merton in 2017 with a projection of 27,000 by 2020.

As a whole, Merton is less deprived than the average for both London and England, with health outcomes that are generally better than those in London and in line with or above the rest of England. However this masks pockets of deprivation within the borough with a number of wards in east Merton being more deprived. Life expectancy at birth is higher than the England average overall, but again this masks
the differing life expectancy within different wards in the borough and within different population groups.

The main causes of premature deaths in those aged 75 and under are circulatory disease (1 in 4), cancer, (2 in 5) and respiratory (1 in 12).

35% of Merton’s residents are of BAME background which is lower than London (40%) but higher than England (15%)

16% of households are overcrowded which is lower than 21.7% in London overall.

For our older population, 33% of residents aged 65 and over live on their own, compared to 35% in London and 32% in England.

Given a projected increase of over 2000 people aged 65 and over in the borough over the next three years, we need to look at innovative and proactive ways to better meet the needs of an increased number of potentially vulnerable people with diminishing public sector resources with an overall aim of keeping people well at home for as long as possible.

**Current state of health and social care market**

The home care market remains difficult, with limited spare capacity. Commissioners are working proactively with providers to try to ensure a sustainable supply of the right type of care. This has included a major re-contracting of home care, which is due to be completed in January. Commissioners are also working with a local care home provider to try to expand the number of nursing beds available in advance of winter. Despite difficult conditions in the home care market, Merton has managed to keep its delayed transfers of care (DToC) performance in the top quartile for both health and social care delays, which is evidence of the benefits to patients of improved system coordination.

There is a shortfall in local capacity for learning disabled adults with complex needs and challenging behaviours, so work is taking place across health and social care commissioners and potential providers to address this gap in provision. The council has also commissioned additional respite capacity, which will come on stream in late summer.

The quality of care remains a key issue. Whilst 55 out of 66 Care Quality Commission (CQC) inspected social care provisions were rated good or outstanding, concerns remain that 11 were rated as requiring improvement. One of the key delivery work streams is the provision of enhanced support to care homes. As part of this, a Joint Intelligence Group has been established to share knowledge across agencies and offer support to care homes where a particular focus or need for improvement is apparent.

As we develop the enhanced offer for care homes, where possible and appropriate we would wish to extend elements of this to the home care market, with relevant
training sessions already being offered out more broadly across health and social care.

In addition to publishing ‘Working with Us- Market Position Statement for Care and Support in Merton.’, where the need to work with providers was highlighted in order to build a sustainable local market for care and support, there have been closer working relationships with providers to identify needs and gaps in the market as well as encouraging a diversity of providers with different types of service solutions. This has included discussions with the new owners of several homes about the potential conversion of residential to nursing care in order to help meet demand.

**Key Issues the BCF Plan aims to address**

Building on the overall objectives, this plan aims to strengthen the relationships and collaboration between providers in Merton to support delivery of the Merton Vision and the SW London Sustainability and Transformation Plan with the aim of:

- Reducing the growth of emergency admissions by improving awareness of MERIT (rapid response) services and greater emphasis on proactive work namely early intervention and prevention as well as anticipatory care planning and service that help keep people well at home.
- Reducing length of hospital stay by improvement in the management of complex discharges, undertaking more assessments within the community within discharge to assess arrangements and increasing the number of people able to access reablement and rehabilitation services,
- Reducing permanent admissions to care homes by shorter hospital stays to minimise loss of functioning, maximising use of rehabilitation and reablement to help people to return home where possible.
- Improving service user and carer experience by better integration of health and social care services to reduce duplication and deliver the best possible service for local residents.

### 3. Progress to date

**Performance in 2016/17**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q4 Performance</th>
<th>Commentary</th>
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<tbody>
<tr>
<td><strong>Non-elective admissions</strong></td>
<td>The annual target of 18,819 for this performance measure has not been achieved for the 2016/17 reporting period with a year-end outturn of 19,900 for London Borough of Merton.</td>
<td>Factors for this variation include challenges early in the year regarding vacancies within community services which have now been addressed. Part of the additional growth was also found to be inappropriate short stay admissions (0-1</td>
</tr>
<tr>
<td><strong>Permanent admissions to residential care</strong></td>
<td>This target has been achieved, with an end of year out-turn of 104 against a target of 105.</td>
<td>Data will be validated by NHS Digital end of September 17</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Re-ablement activity</strong></td>
<td>149 reablement services were offered to customers aged 65+ during October to December, which was an increase from 2015/16 but did not achieve the proposed target</td>
<td>Data will be validated by NHS Digital end of September 17. It was not possible to include the data from Intermediate care services, which has reduced the expected position. Work to rectify this is taking place.</td>
</tr>
<tr>
<td><strong>Delayed Transfers of care</strong></td>
<td>The 2016/17 annual target of 2,799.1 per 100,000 population has now been met with a 2016/17 year end outturn of 2,622.6 per 100,000 population reported for London Borough of Merton.</td>
<td>The CCG and Local Authority have jointly monitored and managed this performance measure throughout 2016/17 which has helped deliver performance levels consistently below the London average.</td>
</tr>
<tr>
<td><strong>Social care-related quality of life</strong></td>
<td>This target has not been achieved with an end of year out-turn is 18.5, against a plan of 18.8.</td>
<td>London Borough of Merton outturn shows a marginal decrease in reported levels of quality of life from the 2015/16 score of 18.6. Data will be validated by NHS Digital end of September 17, following which benchmarking will be</td>
</tr>
</tbody>
</table>
NHS Social Care Interface Dashboard
This dashboard brings together a range of metrics which shows how health and social care partners in every Local Authority area in England are performing where health and social care work most closely together. It presents six key metrics from across the sector.

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>Merton figures</th>
<th>Merton ranking (within national ranking of 150)</th>
<th>London average rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Rank (Distance from mean calculation)</td>
<td></td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Emergency Admissions (65+) per 100,000 65+ population</td>
<td>Mar 2016 - Feb 2017</td>
<td>30,799</td>
<td>136</td>
</tr>
<tr>
<td>90th percentile of length of stay for emergency admissions (65+)</td>
<td>Mar 2016 - Feb 2017</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Total Delayed Days per day per 100,000 18+ population (NB includes, NHS, social care and jointly attributable)</td>
<td>Feb 2017 to Apr 2017</td>
<td>5.5</td>
<td>21</td>
</tr>
<tr>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services</td>
<td>2015/16</td>
<td>81.5</td>
<td>96</td>
</tr>
<tr>
<td>Proportion of older people (65 and over) who are discharged from hospital who receive reablement/ rehabilitation services</td>
<td>2015/16</td>
<td>4.4</td>
<td>26</td>
</tr>
<tr>
<td>Proportion of discharges (following emergency admissions) which occur at the weekend</td>
<td>Oct 2015 - Sep 2016</td>
<td>21.0%</td>
<td>14</td>
</tr>
</tbody>
</table>

Whilst Merton performs well overall, there is more work to do to improve all areas and in particular to reduce the level of emergency admissions and recording of older people still at home 91 days after discharge from hospital into reablement/ rehabilitation services.

Community services development
In April 2016, a new community contract commenced with a new community provider, Central London Community Healthcare NHS Trust (CLCH). A significant element of work has been the full implementation of this contract, which has included
building, expanding and transforming existing community services and as part of this, significant recruitment has taken place to deliver the new contract. On taking over the service on 1st April 2016 there were 189 staff (159.76 FTE) and as of 31st March 2017 there were 263 staff (227.9 FTE).

Key areas within the contract include the enhancement of the community rapid response service to patients in their own homes; the Merton Enhanced Rapid Intervention Team (MERIT), facilitates the prevention of unnecessary attendance at Accident & Emergency and/or admission to an acute hospital; the continued development of HARI (Holistic Assessment Rapid Investigation) service enables comprehensive multi-disciplinary assessment of complex potentially frail patients who may be deteriorating or who need consultant review, outside of the acute hospital. As a result of promotional activities and an agreed Alternative Care Pathway with London Ambulance Service, we have seen MERIT referrals for urgent assessments within 2 hours increasing from 62 in quarter one to over 200 in quarter four. A mental health liaison post is also part of the team. Referrals to HARI have also increased from 164 in quarter one to 214 in quarter 4. Building on these services have also enabled more robust responses seven days per week and access to some 24/7 services in the community.

CLCH have continued to drive increasing levels of performance, with increased use of mobile technologies to improve access to clinical systems, reduce duplication and improve care delivery and patient facing time.

**Frailty Case Finding Pilot**

The Merton GP Federation was commissioned to undertake a pilot, using a tool called e-Frailty to identify people as having moderate or severe frailty who may be at high risk of admission or longer term social care. The aim was to work in partnership with the newly appointed community case managers and care navigators from CLCH, health liaison social workers and the voluntary service sector to deliver proactive support in a multi-agency approach.

After gaining consent from the patients, the case managers from CLCH met with the individuals identified and discussions have taken place, working with the person to help understand what might help keep them as independent as possible for as long as possible. There has been positive feedback on the use of the tool and work has been taking place in 2017/18 to support its roll out across Merton, taking the learning from the pilot undertaken.

**Integrated Health and Social Care response**

The BCF plan identified co-location as an enabler to better integration and closer working between health and social care in order to support joint assessment, care planning and service delivery as well as supporting joint training and team building. CLCH have welcomed the opportunity to move their operational base to the Civic
Centre in Morden, thereby achieving co-location of clinical locality teams (including community nurses and therapists) and management support posts alongside council staff.

During quarter three CLCH took over the contract to directly commission the community rehabilitation beds, now 24, which has enabled an improved and more integrated service, with health liaison social worker input into discharge discussions.

Within the Council, following the transfer of line management of the re-ablement function to sit within the operational service, further alignment with the hospital to home team has been possible and work continues in 2017/18 to provide a more joined up response to complex discharges and enable the most effective use of available capacity.

Data Sharing
Merton CCG’s Information Management and Technology Strategy highlighted the importance of ensuring the capacity and capability of information sharing across providers in South West London. The Strategy sets out the technical solutions that need to be procured or aligned in order to deliver the objectives and is supported by a series of inter-related technical projects both at a Merton and at a South West London level. In order to deliver these projects, a robust data sharing framework needs to be in place that will provide an over-arching information-sharing protocol covering a series of peer-to-peer sharing agreements. The work to deliver this continues into 2017, with a view to full implementation in 2018. This will enable full exchange of patient-consented information between care settings in Merton.

The council has implemented a new social care information system, MOSAIC. Once fully embedded, this will improve data quality, reinforce good practice and better supports to data sharing than the legacy system.
4. Evidence base and local priorities to support plan for integration

This Better Care Fund Plan is aligned with the South West London Sustainability and Transformation Plan (STP), which aims to:

- use our money and staff differently to build services around the needs of patients
- invest in more and better services in local communities
- invest in our estates to bring them up to scratch
- try to bring all services up to the standard of the best.

The STP highlights that, as described earlier in this plan, our population is increasing and ageing. More people than ever before are living with complex physical and/or mental health problems. The aims of these plans to is help people live healthy, independent lives for as long as possible, by developing and improving services that treat people earlier or closer to home and do more to keep people well, treat them as soon as possible or help them to monitor and manage their health on a day-to-day basis.

The STP highlights that pressures on the NHS are made worse by cuts to local council budgets, especially social care and when there are service pressures within the local authorities, there is knock-on effect on what people look for from the NHS. In Merton we continue to contribute over and above the minimum required level of funding to our local social care services through the Better Care Fund in recognition of this.

In line with the STP, these plans aim to continue the change the way services are delivered, spend increasingly limited funding more effectively and working more productively by enabling more joined up care.

Analysis of need

Through the E-Frailty Pilot undertaken in 2016/17, each practice was asked to submit the number of patients on their register as having a frailty score in order to estimate the number of and levels of frailty in Merton. This identified that approximately:

- 2,000 people identified as having severe frailty
- 6,000 people identified as having moderate frailty
- 20,000 people identified as having mild frailty
The Integrated Locality teams Task and Finish Group whose work is described further in the next section, is developing a specific offer for patients identified within each of these cohorts to developing personalised and holistic proactive support according to need. The successes in 2016/17 have been highlighted within the progress to date. There were challenges in progressing integration early in 2016/17, due to the focus on the mobilisation of the new community provider, the changes in staff and relationship building as part of this change as well as significant senior management changes in both the CCG and more recently in the London Borough of Merton. Therefore some aspects of integration have been slower to progress than others. With substantive staff now in place for key posts, there are increased opportunities going forward, with providers now co-located at the Civic Centre and closer working practices developing as a result of this.

A review of the schemes included within the Better Care Fund took place in 2016/17, with a refocus on the areas making the greatest impact and or with the greatest potential.
**5. Better Care Fund Plan**

As outlined in the vision, the development of the Better Care Fund has focussed on the key priorities identified in the South West London Sustainability and Transformation Plan (STP) where they are expected to have a significant and positive impact on the delivery of the BCF objectives of managing and support people to remain well at home. These priorities have been brought together into three multi-agency task and finish groups that have been established to deliver this work:

- Integrated locality teams including support for complex patients, roll out of frailty work and case management support, end of life care, dementia and falls.
- Intermediate care and re-ablement, rapid response and discharge to assess.
- Enhanced support to care homes.

The task and finish groups report into Merton Integrated Delivery Group who will report into the Merton Joint Commissioning Group once established from a joint commissioning perspective and through to Right Care Best Setting Groups and The Wandsworth and Merton Transformation Board and the Emergency Care Delivery Board to provide assurance regarding delivery of the STP.

These schemes contribute to the savings identified within the complex patients QIPP proposal where we aim to reduce emergency admissions by 573 in 2017/18 resulting in a gross saving of £1.2 million. Further work is also being undertaken to establish the impact on acute bed capacity as these schemes is maximised.

A summary of the schemes and progress to date is outlined below:

**Integrated Locality Teams**

A multi-agency group has been established to further develop current multi-disciplinary working across health and social care to proactively support keeping people well at home and avoid unnecessary emergency admissions to hospital.

The Merton Model is based on multi-disciplinary teams working around the GP practice to support patients with complex needs. In addition to the management of patients referred into services, patients have historically been identified for proactive support through the Clarity Patients Adjusted Clinical Groups (ACG) Risk Stratification which provides risk stratification and clinical population management services to GP practices and to CCG users using a Sollis platform across Merton, using the Johns Hopkins University algorithm. This has been available in General Practice to help identify patients at high risk of avoidable unplanned hospital admission in Merton. In 2016/17 Merton Health, our local GP Federation were commissioning to undertake a pilot to use the efraity tool as work undertaken suggests this tool may be better than ACG/Sollis at identifying the right individuals.
for whom an intervention may be valuable. Users have reported that the people identified are generally more appropriate for multidisciplinary team management in community settings and this was borne out within the pilot undertaken in Merton. This has been reflected in the new GP contract which now requires routine frailty identification for people aged 65 and over using a validated tool (for example, the Electronic Frailty Index) to proactively identify and support older people living with frailty.

In addition to focusing on those with the most complex needs, proposals are being put in place to provide input for different levels of need. For example, the Age UK booklet on Ageing Well is currently being localised and will be shared with those identified as having frailty. For patients identified with moderate or severe frailty, not already receiving the support they need, they will be referred to the case management team within community services who will undertake a holistic assessment to look at their needs, including physical and mental health, current medication, need for equipment and whether social prescribing may help.

If the patient is identified as benefitting from multi-disciplinary review, this will be undertaken by the GP, community services and the health liaison social worker as the core MDT, with input from other professionals as required.

The HARI (Holistic Assessment and Rapid Investigation) service is in place as a specialist resource to undertake holistic geriatric assessment and provide support to primary care and the multi-disciplinary teams on how to manage the patient’s needs. We are working with the service to enable this service to be more widely available e.g. in a patient’s home or in a care home setting.

Work has started to agree integrated personalised urgent care plans and how best these will be shared, with use of CMC likely until a longer term south west London approach is agreed and implemented.

The Better Care Fund contributes to:

- The locality based community teams, made up of nurses (including case managers and care navigators as well as a range of specialist nursing and in particular specialist dementia and end of life nursing) and community domiciliary therapies.
- 3 health liaison social workers to contribute to MDT working and meetings,
- Voluntary sector services, including ageing well, the dementia hub and carers support.
- Telecare through MASCOT who respond to alarm and prevent avoidable admissions to hospital.
- Holistic Assessment and Rapid Investigation (HARI) service, a specialist multi-disciplinary, geriatrician led service.
Intermediate Care, Re-ablement, Rapid Response and Discharge to Assess.

A multi-agency group has been established to improve capacity and access to enable more people to go home sooner from hospital where possible and avoid unnecessary admission to hospital so that more people are able to remain independent in their own home.

Significant improvements have been put in train over the last year, with the focus of this work stream maximising the impact of services that have already been commissioned and identifying and addressing outstanding gaps. As part of this, a gap analysis has been undertaken and an action plan drawn up. This includes building on the co-location of services already undertaken and supporting joint assessment, care planning and service delivery as well as supporting joint training and team building.

Improved relationships are facilitating the bridging of gaps in care provision to prevent unnecessary hospital admission and facilitating a reduction of hospital length of stay.

Work is taking place to make the process of discharge for hospital teams as simple as possible, with work being undertaken to fully implement discharge to assess and enable the most effective use of available capacity by further integration of key services.

The Better Care Fund has been used to contribute to the following schemes to support this:

- MERIT (Merton Enhanced Rapid Intervention Team) offering a multi-disciplinary rapid two hour response service for patients at home to prevent admission to hospital.
- In reach services to St George’s University Hospital NHS Trust to help support complex discharges and streamline the discharge back into the community
- An increase in Intermediate care bed based provision.
- Reablement services, with an increase in staffing in 2017/18
- Integrated domiciliary packages of care
- Equipment, as part of an Integrated Community Equipment Service (ICES)
- Dedicated social work support to Continuing Health Care to help meet the requirements regarding completion of assessments and reviews and enable more assessments to be undertaken in the community, avoiding unnecessary time in hospital

Enhanced Support to Care Homes

To aim of this work stream is to provide enhanced support to care homes in order to provide improved quality, help people access the right care and support and provide more care out of hospital. This builds on learning from the National Vanguard
Programme and in particular the successes from the work undertaken by the Sutton Vanguard. It includes:

- Review and development of the support available to residential and nursing homes (including enhanced primary care support and MDT working),
- Development of care home workforce
- A Joint Intelligence Group has been established to identify where particular support may be required.
- Improvements in the hospital transfer pathway are planned with the use of the ‘Red Bag’ initiative undertaken in Sutton as well as work to support more joined-up commissioning and collaboration between health and social care.

These schemes and in particular the Integrated Locality Teams, are the precursor to Multi-speciality Community Provider (MCP) model.

**Adult Social Care**

The London Borough of Merton has provided £9.3m of growth to Adult Social Care budgets, including the iBCF funding and the 3% social care precept. The balance is funded from council reserves. Despite the difficulty of such a decision, the Council recognised the need to fund both the growth in demand and the increased costs of care. The iBCF additional funding provides welcome support to the Council's growth plan.

Merton engaged with providers during 2016/17 as part of our planning for 2017/18, which resulted in two key actions. Firstly a significant increase in residential and nursing home care fees, which was enacted in 2016/17 in order to secure the necessary beds. Secondly, following meetings with home care providers, a route to re-procure care at home was agreed, which will be at a new borough rate (£15.18 compared to current framework rate of £12.50). That rate reflects the National Living Wage, travel time and travel costs. It also aims to better secure a reliable flow of care. Direct Payment rates have increased from £10.50 ph to £12.50 ph.

**iBCF**

The £9.3m growth which includes the iBCF, will enable Merton to maintain its recent and planned investment in care home and home care fees, and in care home and home care capacity. A ‘home first’ approach where possible will be undertaken, allowing Merton to better meet people’s needs and wishes by supporting them in the community. From the iBCF funding we plan to commission additional care hours at a rate of more than 2,300 hours per week, which will support discharge from hospital and admission avoidance. Funding has also been allocated for a further 1356 weeks of interim placements.

**Disabled Facilities Grant**

The plan for Disabled Facilities Grant is to support 60 major adaptations in the year. In addition there will be exploration into how we could use DFG to support smaller
more rapid adjustments to enable efficient discharge from hospital and potential benefits of a more flexible use of the grant to better support hospital discharge and prevent admission through publishing a housing assistance policy in accordance with the Regulatory Reform Order 2008. Schemes could include a handyperson scheme to enable rapid minor works.

A summary of the proposed spend against the BCF is attached in Appendix 2.

Clearly our local acute trusts play a key part in the delivery of the plan’s objectives and we are working more closely with the lead commissioners to have a more aligned approach, particularly in relation to St George’s where Merton and Wandsworth CCGs will be commissioning community services from the same provider from October 2017.

6. Risk
A summary of key risks relating to the projects are attached in Appendix 3
7. National Conditions

National condition 1: jointly agreed plan

Merton Health and Wellbeing Board have overall responsibility for the Better Care Fund Plan and are regularly updated on its development and progress against its objectives. At its last meeting on 20th June 2017, the latest position was shared and it was agreed that delegated responsibility for the sign off of the BCF Plan would go to the co-chairs of the meeting namely Tobin Byers and Andrew Murray.

The Merton HWBB brings together the Council, Merton Clinical Commissioning Group, Health Watch and the voluntary and community sector with a shared focus on improving health and wellbeing in Merton. The lead Director for the BCF is the Director of Community and Housing. The Directors of Environment and Regeneration and of Public Health are also key members of the committee so as well as housing issues, there is an opportunity to look at the broader determinants of health and involve a wider range of stakeholders into the development of the plan.

The programme governance describes the reporting structures, focussing on the Integration perspective. Reporting also takes place to the STP and Emergency Care Delivery Board. This plan has also been shared with the Emergency Care Delivery Board.

BCF Funding including the iBCF has been signed off for 2017/18. Further discussions will be required to finalise and refine the spend for 2018/19 based on the learning within 2017/18, to ensure that the limited resources are focussed on the areas of highest priority which have the greatest impact.

The plan for Disabled Facilities Grant is to support 60 major adaptations in the year. In addition there will be exploration into how we could use DFG to support smaller more rapid adjustments to enable efficient discharge from hospital.

Summary of Merton Better Care Fund

<table>
<thead>
<tr>
<th>Merton BCF Pooled Budget</th>
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<th>2018/19</th>
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</thead>
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<tr>
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<tr>
<td>iBCF</td>
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<td>£3,523,032</td>
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<tr>
<td>CCG Minimum Contribution</td>
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<td><strong>Total Pool</strong></td>
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<td><strong>£16,720,766</strong></td>
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</tbody>
</table>
National condition 2: social care maintenance
A summary of the spend which includes social care is included in Appendix 2.

Merton CCG has agreed for 2017/18 to continue to contribute over the minimum mandated requirement in order to maintain the levels of funding required into social care, alongside the £9.3 million growth from the London Borough of Merton made up of the iBCF, 3% social care precept and the remainder from council reserves.

The schemes within the BCF have been included to reflect the key aspects of social care that contribute to the overall BCF objectives and these are monitored and reviewed via the Section 75 agreement.

National condition 3: NHS commissioned out-of-hospital services
A summary of the spend which includes NHS Commissioned out-of-hospital services are included in Appendix 2. The level of funding is above the minimum allocation for NHS commissioned out of hospital services.

These schemes contribute to the savings identified within the complex patients QIPP proposal where we aim to reduce non elective admissions by 573 in 2017/18 resulting in a gross saving of £1.189 million.

National Condition 4: Managing Transfers of Care

An action plan for implementation of outstanding areas within the High Impact Change Model is included in Appendix 4. The table also includes the achievements to date.

Where local action is required, this is being addressed through the Intermediate Care and Rapid Response Task and Finish Group and the proposed Enhanced Support to Care Homes Group. We are working with Wandsworth CCG as lead commissioners in relation to actions required from St George’s University Hospital NHS Foundation Trust. An improving discharge CQUIN has been developed which will be incorporated into the contract with St George’s once signed off.

As structures and functions develop further across the Merton and Wandsworth Local Delivery Unit, further work is being undertaken to align the work in Merton with Wandsworth and work in a more integrated way with the Emergency Care Delivery Board.

Further discussions are required at an STP level to enable the shift of resources required to maximise the flow of patients out of hospital as soon as possible.

Further information in this area is included in the National Metrics section.
8. Overview of funding contributions

A detailed breakdown is included in Appendix 2.

In addition to the areas described elsewhere in this plan, the BCF Plan also contributes to the delivery of the following:

Care Act 2014
Merton has taken a number of steps to implement the Care Act during 2016/17, using funding from BCF as required and appropriate to support initiatives including:

- Further developing the carer offer through the carers hub.
- Embedding the wellbeing grants programme
- Further developing the dementia hub to support people post-diagnosis but pre-social care eligibility
- Reviewing social work practice
- Progressing integrated working with health partners, including implementing NHS numbers in care records, colocation with community health and developing an implementation plan for the HICM
- Engagement with providers through a number of events, resulting in the re-commissioning of home care and the development of a project to re-procure supported living.

In 2017/18 the focus will be on:

- Delivering better quality home care through the new framework
- Improving choice in supported living and improving care options for those with complex needs and challenging behaviours
- Developing providers forums to support the HICM and re-commissioning work
- Integrate wellbeing grant funding
- Review and develop social work practice, with a focus on the hospital team
- Progress information sharing now that the new social care information system is in place
- Further develop joint working with community health to create a single point of entry for discharge/admission prevention.

Support to Carers
In addition to the services highlighted in the last section, there are a range of initiatives supporting carers. These include Ageing Well Programme, The Dementia Hub and associated services around the borough, Carers Support Merton and Marie Curie Night Service.

Ageing Well Programme
As part of the programme of work to develop Merton as a good place to grow older, a range of voluntary organisations have been awarded grants for Phase 2 of the Ageing Well Programme which commenced on 1st April 2016 for a period of up to
three years. The key aim of the programme is to promote independence and one of the main priority areas is supporting carers. The programme principles include:

- Building resilience (helping people to find their own solutions and groups to manage their own networks);
- Building connectedness (helping people keep in touch with the local community and people who matter to them);
- Achieving effective customer signposting and follow up processes; and

Dementia Hub

The Alzheimer’s Society delivers a range of support services for people with dementia and their carers across the borough and in the Merton Dementia Hub which opened in Mitcham in April 2014, and was specifically designed as a dementia friendly environment.

The Alzheimer’s Society provide personalised support, information and guidance for people with dementia, their families and carers. There is also a range of activities that people with dementia, carers, friends and family can enjoy together, for example attending dementia cafés (which take place at the Hub and around the borough) and ‘Singing for the Brain’.

The CCG and the Local Authority will be undertaking a joint procurement for dementia support services over the next year. The learning from the Dementia Health Needs Assessment and service evaluation undertaken by Public Health, both of which focussed on feedback from carers and their needs, will be drawn upon to guide the service model going forward.

Carers Support Merton

Carers Support Merton provides a range of support services for individuals who have an informal caring role for a relative, partner or friend for any reason (including age and frailty, physical or learning disability and mental or physical illness). A range of accessible and flexible information and support is provided in a manner that is responsive to the individual needs, preferences and wishes of service users.

As part of Phase 2 of the Ageing Well Programme, Adult Social Care has worked in partnership with Carers Support Merton to develop a Carers Support Hub. Carers Support Merton now undertake statutory carers’ assessments on behalf of the Local Authority which has helped to improve continuity and the pathway for individuals.

Marie Curie Night Service

The Marie Curie Night Service provides one-to-one palliative care overnight to patients in their normal place of residence. As well as supporting the person who is at the end of life, the service provides valuable respite for carers that can help to support them to continue to care for their loved one at home, including if a carer experiences a crisis situation and is not able to provide care for a period of time.
9. BCF Programme Governance

The programme governance, demonstrates the alignment of the Better Care Fund initiatives with the South West London Sustainability and Transformation Plan and the importance of the various partners and interfaces working together to achieve the required changes.

In addition to the above governance, the schemes described in this plan contribute to the savings identified within the complex patients QIPP proposal, through which a comprehensive project planning process is in place and quality impact assessment, an equality impact assessment and a privacy impact assessment have been undertaken and mitigating action in train where issues identified. This also provides an analysis of the key components of the plan and how they contribute to reducing emergency admissions.
This plan aims to contribute to reducing health inequalities, particularly in relation to the protected characteristics of age and disability. The programme is also interlinking with a variety of other schemes in place and under development across Merton, for example The East Merton Model and Health and Wellbeing which is focused on improvement and health and wellbeing in the more deprived areas within the borough.

We are seeking to commission local specialist provision for people with complex learning disabilities, which will ensure better contact with family and other networks and continuity of health care. The increasing integration with community health will improve the health outcomes for older people at risk of admission or recently discharged from hospital by better ensuring that health interventions are coordinated with personal care and that the health needs of those with a predominantly social care need are met.

The Better Care Fund is managed through a Section 75 agreement and part of the management of this agreement is the measuring and performance management of schemes within it, identifying and putting in place mitigating actions where schemes are not performing as expected. There are also robust contract management arrangements with our community provider, CLCH and the other providers that support the delivery of this plan.
10. Assessment of Risk and Risk Management

The key risks relating to the delivery of the plan are detailed in Appendix 3.

We continue to review risks and ensure plans are in place to help mitigate these where possible. Implementation Plans have been developed for the key schemes and are monitored and reviewed within the relevant task and finish groups. Key performance measures are reviewed monthly, with scrutiny and plans developed to address any shortfalls undertaken through the QIPP Savings Delivery Group as well as across agencies within Merton Integrated Delivery Group and The Emergency Care Delivery Board.

Risk Sharing Arrangements

<table>
<thead>
<tr>
<th>2017/18</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk sharing (based on reduction of non-elective admissions within QIPP for improving the management of complex patients aged 50+)</td>
<td>£1,189,000</td>
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<tr>
<td>percentage risk sharing for LBM</td>
<td>40%</td>
</tr>
<tr>
<td>percentage risk sharing for MCCG</td>
<td>60%</td>
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</table>

The BCF risk pool would be called off as a proportion of non-achievement of the QIPP, i.e. if 50% of QIPP is not achieved, 50% of the risk pool will be called off for payment of non-elective over performance. This does not affect the minimum contribution to social care or the IBCF grant.

In addition to this element of risk share above, it has been agreed to risk share the cost of any DTOC fines levied by St George’s University Hospitals NHS Foundation Trust. This will be managed on a 60:40 split (LBM: MCCG) and any episodes that reach this threshold will be reviewed to ensure accuracy of data recording and root cause analysis to enable learning for future cases.
11. National Metrics

A summary is included within Appendix 7.

Admissions to residential care homes
The proposal is to maintain this target at 105 which was achieved in 2016/17. Whilst there are a number of schemes to maximise independence and where possible implement ‘home first’ principles, this is offset by the increasing demand due to dementia prevalence and increased acuity of people living longer.

The focus within care homes for 2017-19 is to provide enhanced support to improve quality within the homes. This is a key work stream the details of which are within the BCF Plan section.

Non-elective admissions
An analysis of the number of emergency admissions for those aged 50 and over was undertaken in late 2016 and an assessment of the savings that could be made through implementing the schemes identified in this plan was made, which is a gross saving of £1.2 million which would come from reducing non-elective admissions by 573. A summary of the analysis is attached in Appendix 6.

In 2016/17 a similar approach identified £1.1m savings by reducing emergency admissions by 525. Unfortunately in mobilising the new community services contract which commenced in April 2016, there were a large number of vacancies early on in the year which resulted in only 60% of the savings (£609k) being achieved and no reduction in the number of admissions. The vacancy issue has now been addressed and additional investment has been put into key pressure areas as part of year two of the community contract. Work is on-going to increase referrals into the admission prevention services developed. Being able to fully implement the Community Services Contract, together with the delivery of the other key work streams being implemented in 2017/18 are expected to achieve the shift in activity from emergency admissions to more proactive out of hospital care.

Contingency arrangements are in place should the QIPP scheme targets not be met and these are detailed in the Assessment of Risk and Risk Management section.

The profile for non-elective admissions overall and specifically for those aged 50 and over are included in Appendix 5.
Effectiveness of reablement.
149 reablement services were offered to customers aged 65+ during October to December, which was an increase from 2015/16 but did not achieve the proposed activity for that quarter. In relation to the effectiveness of the reablement service, the 2016/17 provisional ASCOF is 76.5%, whereby achieving the target for 2016/17.

Some additional funding has been redirected into reablement, recognising this as key to supporting people to be as independent as possible for as long as possible.

It is proposed that the target for 2017/18 and 2018/19 for the proportion of people still at home after 91 days reflect current performance as the percentage reflects the complexity of patients going through reablement services.

Delayed transfers of care

Previous Performance
Merton has managed to keep its delayed transfers of care (DToC) performance in the top quartile for both health and social care delays, despite a challenging environment, which is evidence of the benefits to patients of improved system coordination. A summary of performance and benchmarking across London is included in Appendix 8, which illustrates that Merton performance is considerably below the London average.

Proposed Targets
A summary of historical performance, the original CCG submission on 21st July 2017 and the proposed targets set for Merton are set out in Table 1 below. Merton challenged the proposed targets set for 2017/18, as the original proposal from NHS England included the month of February 2017, which was approximately 64% lower than the monthly average during the last financial year and as such this reduction was felt to be unachievable. A revised plan was submitted which was based on reductions from November 2016 – January 2017 baseline (which took into account the winter months but excluded February 2017). This amendment however was not supported by NHS England, with advice that plans submitted that do not meet the prescribed HWB trajectory, would not be approved.

Merton has therefore taken the decision to include the trajectories as required by NHS England, but continue to dispute the validity of the baseline and therefore remain concerned regarding their achievability. This performance will be closely monitored and where possible mitigating actions put in place. We believe that a more realistic trajectory would be to achieve the stated 1.8 days per month reduction, from the November 2016 – January 2017 baseline, reflecting that this would represent in real terms, year on year reduction in DTOCs during the most challenging months of the year in the context of significant growth in underlying pressure on capacity and resources as set out elsewhere in this plan.
Reason for delays
The majority of delays are attributed to the following:

- Awaiting nursing home placement or availability
- Waiting for further NHS non-acute care
- Housing (patients not covered by NHS and Community Care Act)
- Awaiting residential home placement or availability
- Patient or family choice
- Awaiting care package in own home

There have also been a number of inaccuracies identified with the reporting of delays and MCCG and LBM are working with providers and their respective lead CCGs to address this.

Actions to reduce length of stay and DTOC
Work to reduce DTOC and length of stay in hospital were commissioned within 2016/17 within the new community services contract and through the BCF. These included in reach nurses at St George’s University Hospital NHS Trust to help support complex discharges and streamline the discharge back into the community and an increase in intermediate care bed based provision. Maximising the effectiveness of the bed based capacity as well as further more integrated pathways across health and social care in order to improve the management of complex discharges, undertaking more assessments within the community within discharge to assess arrangements and increasing the number of people able to access more integrated reablement and rehabilitation services.

These closely to align to the wider implementation of the High Impact Change Model, the actions outstanding in the implementation of this are detailed in Appendix 4.

In 2017/18, Wandsworth CCG has led on the development of a discharge CQUIN with St George’s University Hospitals NHS Foundation Trust that Merton will benefit from. The CQUIN incentivises early discharge planning, embedding of systems to monitor patient flow, support multi agency discharge teams and home first /discharge to assess processes. The aim is to contribute to better management of transfers of care out of hospital to prevent delays and create capacity in the hospital.

Delayed transfers of care within mental health have been closely monitored within the contract with our main provider SWL and St George’s Mental Health NHS Trust and an action plan implemented. The impact of this is monitored on a monthly basis across SW London. The latest position for Merton, 10.3%, shows that the Trust are currently not achieving their target of 3% of DTOC bed days as a proportion of their overall bed days. Remedial action will be required to get this back on track, which North East London Commissioning Support Unit have been asked to undertake on our behalf. A formal updated South West London DTOC plan has been requested and is under development.
In terms of commissioner specific changes regarding mental health, in order to speed up decision making regarding funding, in addition to the funding panel that meets weekly, decisions regarding funding are also made, where required, in between panel meetings. A member of staff who supports complex cases now also represents the CCG at weekly DTOC meetings.

As described in the background section, there have been closer working relationships with providers in order to encourage a diversity of providers with different types of service solutions, in order to help develop the most appropriate provision to meet the needs of individuals.

As the Local Delivery Unit structures are fully implemented, it is expected that capacity to enable more regular input into DTOC/ bed management meetings across each of our main trusts.
### Table 1 Delayed Transfer of Care - Delayed Bed Days Performance Measure (BCF) 2017/18 Plan

<table>
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<tr>
<th></th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
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<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
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<tr>
<td>NHS Total Delayed days</td>
<td>218</td>
<td>194</td>
<td>207</td>
<td>263</td>
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<td>311</td>
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### 2017/18 PLAN

#### CCG Submission (21/7/17)

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<th>Feb-18</th>
<th>Mar-18</th>
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<td>111</td>
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<td>365</td>
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<td><strong>ONS Population estimate 16/17</strong></td>
<td>163,294</td>
<td>163,294</td>
<td>163,294</td>
<td>163,294</td>
<td>163,294</td>
<td>163,294</td>
<td>163,294</td>
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<td>163,294</td>
<td>164,920</td>
<td>164,920</td>
<td>164,920</td>
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</tr>
<tr>
<td><strong>Merton Rate per 100,000 pop</strong></td>
<td>167.18</td>
<td>216.17</td>
<td>170.86</td>
<td>223.34</td>
<td>258.25</td>
<td>275.39</td>
<td>234.49</td>
<td>307.24</td>
<td>286.42</td>
<td>212.04</td>
<td>151.35</td>
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<tr>
<td><strong>Av. Delayed Days</strong></td>
<td>9.1</td>
<td>11.4</td>
<td>9.3</td>
<td>11.8</td>
<td>13.6</td>
<td>15.0</td>
<td>12.4</td>
<td>16.7</td>
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<td>8.9</td>
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*Actual real time data*

### 2017/18 PLAN

#### NHSE Expectation

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<tr>
<th></th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
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<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
<th>YE 2017/18</th>
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<tr>
<td><strong>NHS Total Delayed days</strong></td>
<td>144</td>
<td>199</td>
<td>111</td>
<td>150</td>
<td>130</td>
<td>111</td>
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<td><strong>ASC Total Delayed days</strong></td>
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<td>137</td>
<td>103</td>
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<td>95</td>
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<td>82</td>
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<td><strong>Joint Total Delayed days</strong></td>
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<td>37</td>
<td>31</td>
<td>33</td>
<td>30</td>
<td>29</td>
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<td>31</td>
<td>31</td>
<td>28</td>
<td>31</td>
<td>371</td>
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<tr>
<td><strong>TOTAL Delayed Days</strong></td>
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<td>353</td>
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<td>286</td>
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<td><strong>ONS Population estimate 16/17</strong></td>
<td>163,294</td>
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<td>164,920</td>
<td>164,920</td>
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<tr>
<td><strong>Merton Rate per 100,000 pop</strong></td>
<td>167.18</td>
<td>216.17</td>
<td>170.86</td>
<td>175.14</td>
<td>158.61</td>
<td>143.91</td>
<td>188.62</td>
<td>149.42</td>
<td>154.38</td>
<td>152.86</td>
<td>138.07</td>
<td>152.86</td>
<td>1,953</td>
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<td><strong>Av. Delayed Days</strong></td>
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<td>9.3</td>
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<td>8.1</td>
<td>8.1</td>
<td>8.1</td>
<td>8.1</td>
<td>8.8</td>
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</tbody>
</table>

*Actual real-time data*  
*New model* staggered  
NHSE pre-populated
12 Approval and Sign off

The content within the Merton BCF Plan 2017-19 is a culmination of discussions and developments over a wide time span, ranging from the Merton Strategy development to the SW London Strategy and Transformation Plan, building year on year on developments to support integration and out of hospital care, aiming to keep people well at home for as long as possible. The stakeholders are therefore expansive.

More specifically, discussions within the Merton Integrated Delivery Group and the key implementation groups include key stakeholders from the CCG, London Borough of Merton, our Community Provider, CLCH, Primary Care, Acute and Mental Health Trusts, Voluntary and Independent Sector as well as London Ambulance Service have been involved in the development and delivery of the schemes within this plan.

Discussions regarding the plan have taken place at Merton Health and Wellbeing Board on 28th March 2017 and 20th June 2017, with agreement to delegate the review of the BCF Plan submission to the Chair and Vice-Chair, and to delegate the final sign-off of the BCF submission to the Chair of the Health and Wellbeing Board.

The Plan was presented and supported at the Wandsworth and Merton LDU Executive Management Team on 23rd August 2017.
Signatures
The authorised signatories for the Merton BCF Plan 2017-19 are as follows:

Councillor Tobin Byers, Cabinet Member for Adult Social Care and Health, London Borough of Merton, Chair of Merton Health and Well Being Board.

Dr Andrew Murray, Chair, Merton CCG- Vice Chair of Merton Health and Well Being Board.

Hannah Doody, Director of Communities and Housing, London Borough of Merton.

James Blythe, Managing Director, Merton and Wandsworth Clinical Commissioning Groups.
Appendix 1 – Merton Health Profile

About Merton

- 3,758 hectares
- 25 GP Practices
- 40 Pharmacies
- 11 Children’s Centres
- 54 Schools

Population

- 207,140 residents in 2016
- 36% of Merton’s residents are of BAME background, which is lower than London (40%), but higher than England (16%).

Life Expectancy at Birth

- Males 80.2
- Females 84.0
- The male life expectancy at birth in England is 80.5 years, which is lower than the England average of 82 years.
- The female life expectancy at birth in England is 85 years, which is higher than the England average of 82 years.

Crime Rate

- 5.4 offences per 1,000 population
- Lower than London (7.7 per 1,000 population)
- Highest number of offences
  1. Anti Social Behaviour
  2. Violence Against the Person

Deprivation

- Children and Older People Deprivation
  - 17% children (0-10) live in income deprived households.
  - 16% older people (65+) live in pension credit households.

- Overcrowding
  - 16% of households are overcrowded (lower than 21.7% in London).
CHILDREN & YOUNG PEOPLE

School Readiness
60%
(proportion of children achieving a good level of development at age 5)

This is similar to London (62%) and England (60%).

Obesity at Year 6
21%
(obese in Year 6)

This is lower than London (23%) and higher than England (19%).

GCSE Achievement
68%
(grades A to C, including English and Math)

This is higher than London (66%) and England (57%).

Children and Young People Admissions for Injury
Merton has a rate of 966 PER 100,000
(children and young people (0-17 years) admitted to hospital because of unintentional and deliberate injuries. This is higher than London (750) and lower than England (1117).

HEALTHY EATING

40%
of over 16s consume 5 or more portions of fruits and vegetables every day. This is higher than London (36.4%).

ADULTS

Smoking
19%
of residents in Merton have smoked in the past year. This is lower than England (20%).

Obesity
19%
(obese adults)

This is lower than London (21%) and England (24%).

OLDER PEOPLE

Living Alone
33%
of residents aged 65 and over live on their own. This is lower than London (35%) and higher than England (32%).

Long-term Limiting Disability
25% LIMITED A LOT
26% LIMITED A LITTLE
49% NOT LIMITED

49% of residents aged 65 and over reported that their day-to-day activities were not limited. This is higher than London (47%) and England (47%).

POOR HEALTH & PREMATURE DEATHS

Hospital Stay for Alcohol-Related Harm

MERTON
LONDON
ENGLAND

The borough has a SARI of 78.4 for hospital admissions for alcohol attributable conditions. This is lower than England (100.0).

(Standardized Admission Ratio)

Main Causes of Premature Deaths*

1 IN 4
due to circulatory disease (incl. heart diseases).

1 IN 5
due to cancer

1 IN 12
due to respiratory diseases

(*deaths in people aged 70 and under)
## Appendix 2 – Breakdown of BCF Spend

<table>
<thead>
<tr>
<th>Scheme ID</th>
<th>Scheme Name</th>
<th>Source of Funding</th>
<th>2017/18 Expenditure (£)</th>
<th>2018/19 Expenditure (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health Liaison Social Workers</td>
<td>CCG Minimum Contribution</td>
<td>£152,000</td>
<td>£152,000</td>
</tr>
<tr>
<td>2</td>
<td>Telecare (MASCOT)</td>
<td>CCG Minimum Contribution</td>
<td>£404,000</td>
<td>£404,000</td>
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<tr>
<td>3</td>
<td>Voluntary Sector (including Ageing well, dementia hub, carers support Merton)</td>
<td>CCG Minimum Contribution</td>
<td>£217,000</td>
<td>£217,000</td>
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<tr>
<td>4</td>
<td>Seven day working</td>
<td>CCG Minimum Contribution</td>
<td>£505,000</td>
<td>£505,000</td>
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<tr>
<td>5</td>
<td>Community Equipment and Adaptions (ICES)</td>
<td>CCG Minimum Contribution</td>
<td>£306,000</td>
<td>£324,815</td>
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<td>6</td>
<td>Reablement</td>
<td>CCG Minimum Contribution</td>
<td>£1,668,000</td>
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<td>7</td>
<td>Integrated Domiciliary packages of care</td>
<td>CCG Minimum Contribution</td>
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<td>£2,000,000</td>
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<tr>
<td>8</td>
<td>Falls Prevention</td>
<td>CCG Minimum Contribution</td>
<td>£12,000</td>
<td>£24,000</td>
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<tr>
<td>9</td>
<td>Integration project capacity</td>
<td>CCG Minimum Contribution</td>
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<td>10</td>
<td>Integration project capacity 2</td>
<td>CCG Minimum Contribution</td>
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<td>11</td>
<td>Personal Health Budgets</td>
<td>CCG Minimum Contribution</td>
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<td>12</td>
<td>Dedicated Social Worker in CHC Team</td>
<td>CCG Minimum Contribution</td>
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<td>13</td>
<td>Marie Curie Night Service</td>
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<td>14</td>
<td>Hospice at Home</td>
<td>CCG Minimum Contribution</td>
<td>£100,000</td>
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<td>15</td>
<td>Expert Patient Programme</td>
<td>CCG Minimum Contribution</td>
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<tr>
<td>16</td>
<td>Case Managers and care navigators</td>
<td>CCG Minimum Contribution</td>
<td>£512,000</td>
<td>£512,000</td>
</tr>
<tr>
<td>17</td>
<td>Falls Prevention</td>
<td>CCG Minimum Contribution</td>
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<tr>
<td>18</td>
<td>Dementia Specialist Nurses</td>
<td>CCG Minimum Contribution</td>
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<td>19</td>
<td>End of Life Care Specialist Nurses</td>
<td>CCG Minimum Contribution</td>
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<td>20</td>
<td>HARI (Holistic Assessment Rapid Investigation) Service</td>
<td>CCG Minimum Contribution</td>
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<td>21</td>
<td>MERIT Urgent and Inreach</td>
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<td>22</td>
<td>Home-based Rehabilitation</td>
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<td>23</td>
<td>Bedded Rehabilitation (Intermediate care)</td>
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<td>Community Navigation Service</td>
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<td>25</td>
<td>Community Services Performance Payment</td>
<td>CCG Minimum Contribution</td>
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<td>26</td>
<td>Residential Placements</td>
<td>Improved Better Care Fund</td>
<td>£990,323</td>
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<td>27</td>
<td>Home care activity</td>
<td>Improved Better Care Fund</td>
<td>£1,755,573</td>
<td>£2,252,430</td>
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<tr>
<td>28</td>
<td>DFG - Adaptions</td>
<td>Local Authority Contribution</td>
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<td>£1,186,109</td>
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<td><strong>Total</strong></td>
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<td><strong>£15,621,470</strong></td>
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### Appendix 3 – Risks

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<tr>
<th>Risk description</th>
<th>Unmitigated Likelihood</th>
<th>Unmitigated Consequence</th>
<th>Unmitigated Risk</th>
<th>Mitigating action</th>
<th>Mitigated Likelihood</th>
<th>Mitigated Consequence</th>
<th>Mitigated Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient capacity and funding constraints in primary care, community health and social care services to fully support a single patient pathway meaning that many of the patients on the new pathway are more likely to become an emergency admission in the following days.</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Community services staffing and activity have increased as CLCH have recruited additional staff to support both proactive and reactive work streams; this includes medical input into the urgent care pathway. An incentive scheme is also in place with CLCH to support the reduction of emergency admissions. Pilot undertaken with the GP federation to establish input required for proactive management. BCF funding, iBCF and reserves allocated to retain social services offer, integration to maximise impact of staff within the pathway.</td>
<td>2</td>
<td>4</td>
<td>8</td>
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<tr>
<td>Hospital based systems do not embrace new model - particularly in terms of the Interface Geriatrician model</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>St George’s Geriatricians form part of the community offer. Multi-agency discussions including acute trusts. Further discussions regarding frail elderly pathway taking place and links to Wandsworth programme.</td>
<td>2</td>
<td>4</td>
<td>8</td>
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<tr>
<td>Unable to recruit appropriate professionals with skill mix required across health and social care</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>CLCH have been recruited to a significant number of posts and there has been positive feedback to date from staff who have transferred so attrition very low. Recruitment to social care and private provider workforce remains a challenge. Increases to the rates paid for home care should help and enhanced support to care homes should help.</td>
<td>2</td>
<td>4</td>
<td>8</td>
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<tr>
<td>New model fails to make savings / is more expensive. (Activity takes place in the community but there is not a corresponding shift of activity in secondary care)</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Broader discussions, including linking A&amp;E Delivery Board. On going work required to ensure thresholds for admission do not reduce if capacity is freed up.</td>
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<td>4</td>
<td>8</td>
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<tr>
<td>Insufficient capacity within the commissioning team across health and social care to deliver and adequately monitor and support all schemes and elements of the pathway.</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Recruitment to vacant posts, multi agency monitoring function now started, working more closely with Wandsworth in relation to St George’s.</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Quality of care in social care provisions</td>
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<td>4</td>
<td>12</td>
<td>Support to services where CQC inspection identified that improvements were required. Use of Enhanced support to care homes to improve quality.</td>
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<td>4</td>
<td>8</td>
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<tr>
<td>The labour market for care workers to support home care provision is restricted due to competition and the loss of EU workers, meaning a lack of supply</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Re-commissioning of home care to have three prime providers with whom we can work to promote recruitment and retention</td>
<td>3</td>
<td>3</td>
<td>9</td>
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<tr>
<td>There is a shortage of residential beds for those with more complex or challenging behaviours (OP and LD), meaning people may be delayed in transferring from hospital</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Securing of local specialist LD provision and negotiation with the purchaser of three older people’s care homes to provide complex care.</td>
<td>3</td>
<td>3</td>
<td>9</td>
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<tr>
<td>Local CCGs who host acute trusts do not align themselves with our model</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Engagement and joint working with predominantly Wandsworth and Sutton CCGs to align models of care.</td>
<td>2</td>
<td>3</td>
<td>6</td>
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</table>

41
## High Impact Change Model

<table>
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<tr>
<th>Impact Area</th>
<th>Achievements</th>
<th>Actions Outstanding</th>
<th>Resources For Implementation (if applicable)</th>
<th>Timescales</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early discharge planning</td>
<td>For elective care – some examples of best practice e.g. SWLEOC but not yet documented as being established across all pathways. For non-elective, plans are in place to develop integrated discharge pathways at an earlier stage of the pathway. Implementation of the Safer Bundle is part of SGH’s improvement plans</td>
<td>Work to be formalised with CLCH to deliver a single point of access and immediate response to get people out of hospital settings. Work to improve trust and understanding of community health and social services with St George’s staff. Acute Trusts, CLCH and local authority to collectively work together to identify what is required to facilitate timely discharge from the time of admission. Progress with the implementation of the Safer Bundle needs to be more visible to all parties.</td>
<td>Within existing resources Within existing resources Within existing resources</td>
<td>Pilot – September 2017</td>
<td>LBM and CLCH. IC and RR Group</td>
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<tr>
<td>Systems to monitor patient flow</td>
<td>Not yet established across partner agencies. Some monitoring undertaken by CSU but unclear if it is shared and used by all relevant partners Work has begun within Council to</td>
<td>Work to be done with acute trusts to understand patient flow and share it with partners rather than reliance on reactive demand</td>
<td>Within existing resources</td>
<td>October 2017</td>
<td>LBM MCCG</td>
</tr>
<tr>
<td>Multi-disciplinary, multi-agency teams (including voluntary and community sector)</td>
<td>Teams in community health services and LA now co-located and detailed discussions ongoing about single point of access and joint response.</td>
<td>Improvements in the daily MDT discussion to take place to make it effective. Additional investment through STP needs to be committed to enable additional capacity to be commissioned.</td>
<td>Within existing resources Work taking place across the STP to further refine the business case to enable this.</td>
<td>September 2017 On-going LBM and CLCH MCCG</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Home First Discharge to Assess</strong></td>
<td>Established through Reablement team</td>
<td>Need to extend to customers/patients who require interim residential/nursing placement from hospital and health input To make the pathways standardised and consistent for all patients “Ready for Home”</td>
<td>Additional funding within Year 2 of Community Services Contract and additional funding for reablement, home care and care home packages to support this.</td>
<td>December 2017 December 2017 LBM RR &amp; I Group</td>
<td></td>
</tr>
<tr>
<td><strong>Seven-day services</strong></td>
<td>Established and health and social care teams working 7 days</td>
<td>Work to extend 7 day response from providers outside of Reablement Some services in hospitals need scaling up to 7 days ie pharmacy and transport</td>
<td>Discussions within new contracts for the home care market and within care home developments. Closer working arrangements across health and social care to support this.</td>
<td>December 2017 March 2018 LBM MCCG</td>
<td></td>
</tr>
<tr>
<td><strong>Trusted Assessors</strong></td>
<td>Principle accepted that all assessments will be accepted and will enable the allocation of resources</td>
<td>Work to be continued to develop a single assessment recording tool Work with care providers to encourage them to accept assessments from trusted assessors, while still taking into account care providers duty to assess whether they can meet someone’s needs with the staff and facilities they have available.</td>
<td>Within existing resources</td>
<td>November 2017 December 2017 RR &amp; IC Group LBM</td>
<td></td>
</tr>
<tr>
<td>Focus of choice</td>
<td>No choice protocol routinely used by acute trust. Draft leaflet and information in place</td>
<td>Project officer capacity to be created to improve the information and advice offer. Self funder offer to be revised. Promoting use of choice protocol in the acute trust</td>
<td>Funding through the BCF</td>
<td>Post filled - October 2017. October 2017 November 2017.</td>
<td>LBM LBM Trusts</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Enhancing health in care homes</td>
<td>Plans in place to roll out Vanguard approach used elsewhere</td>
<td>Learn from Vanguard approach already in place in neighbouring borough</td>
<td>Recruitment of a member of staff has taken place to support this.</td>
<td>Work already taking place to implement aspects. Detailed Implementation Plan by mid Sept.</td>
<td>MCCG</td>
</tr>
</tbody>
</table>
## Appendix 5 Operating Plan - Non Elective Admissions

### Plans @ 19.07.17

### Table 1

<table>
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<th>Mar</th>
<th>YTD</th>
<th>Year End Totals &amp; Forecast Outturn</th>
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### Table 2

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Source: SUS SEM
### Appendix 6 Analysis of Non-elective Admissions for those aged 50+

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<th>Number of Non-elective admissions</th>
<th>Sum of Individual Patients</th>
<th>Sum of Total Cost (Incl MFF)</th>
<th>Average Spell Cost</th>
<th>Reduction %</th>
<th>QIPP No. of Admissions</th>
<th>QIPP Saving</th>
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<td>Grand Total</td>
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<td>£ 2,132.06</td>
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<td>573</td>
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## Appendix 7 National Metrics

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<th>2016/17 Q4 Actual</th>
<th>2017/18 Target</th>
<th>2018/19 Target</th>
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<tr>
<td>1</td>
<td>Total non-elective admissions into hospital (general and acute) for London Borough of Merton</td>
<td>Below 18,819</td>
<td>19,900</td>
<td>20,485</td>
<td>21,053</td>
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<tr>
<td>2</td>
<td>Permanent admission of older people (aged 65 and over) to nursing and residential care homes per 100,000 population</td>
<td>Below 105 admissions</td>
<td>104 admissions</td>
<td>Below 105 admissions</td>
<td>Below 105 admissions</td>
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<tr>
<td>3</td>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>73.2%</td>
<td>76.5%</td>
<td>76.3%</td>
<td>76.3%</td>
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<tr>
<td>4</td>
<td>Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)</td>
<td>No more than 2,799.1 days per 100,000 population</td>
<td>2,706 per 100,000 population</td>
<td>1,953 per 100,000 population</td>
<td>Formal expectations to be finalised.</td>
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</table>
Appendix 8 – DTOC reporting
This information is taken from NHS England published data.

Note: The reporting of DTOCs within the Better Care Fund reporting will change in-line with new targets set by NHS England.
**BCF (Better Care Fund) Performance Measure:** Delayed transfers of care from hospital per 100,000 population (aged 18+): (bed days)

**Polarity:** Smaller is better

Delayed transfers of care is collected for acute and nonacute patients, including mental health and community patients. The focus is to identify patients who are in the wrong care setting for their current level of need and it includes patients waiting for external transfer in all NHS settings, irrespective of who is responsible for the delay.

### Benchmarking Data:

- **London Av:** 492 days (YTD) [428 days (YTD)]
- **LB Merton (days):** 278 days (YTD) [360 days (YTD)]

#### 2016/17 Merton YTD:
- **833 days**
- **904 days**

#### 2015/16 Merton YTD:
- **1009 days**

### CCG Performance Comment:

Latest data (June-17: snapshot: 159.8 per 100,000 / 253 days) demonstrates good performance levels being maintained considerably below the London average.

ASC delays are attributable for the highest number of delayed days for June 2017 (137days compared to NHS delayed days of 85 and 31 delays coded under both / split of NHS 38% / ASC 62%).

In terms of reasons for the delays, ‘awaiting completion of assessment’ was the highest scoring reason for delays for this reporting period (see graph 1.3).

A provisional 2017/18 target of 9% annual reduction has been submitted to NHS (currently awaiting validation). The overall 9% represents: 2016/17: 4153 delayed days / 2017/18 (target): 3779 delayed days. The % reduction split between NHS / LA is yet to be agreed.

#### Acute/Non Acute Delays:

Breakdown of the monthly snapshot delayed days by acute and non acute delays.

#### NHS/ASC/Both:

Breakdown of the monthly snapshot delayed days by organisation responsible.

#### Snapshot (total days):

Monthly snapshot of the total number of delayed days (NHS/ASC/Both) combined.

#### YTD per 100k:

Total number of delayed days year-to-date (cumulative) expressed as a rate per 100,000 population. Based on Merton adult population of 158,356.

### Data Source: