Better Care Fund 2019-2020 Summary Plan Report

London Borough of Wandsworth

Contents

1.0 Introduction

In Wandsworth our vision is that we want people to remain as healthy as they can for as long as they can. We are focused on prevention, joining up care where it is appropriate to deliver a better service, and supporting and developing resilience in individuals and local communities.

The Better Care Fund (BCF) programme in 2019-20 will continue to facilitate health and social care integration. The 2019-20 BCF Plan outlines the joint intentions of Wandsworth Borough Council (WBC) and Wandsworth Clinical Commissioning Group (WCCG) for achieving the long term aim of health and social care integration and person-centred care.

The BCF Plan will be a continuation from the 2017-19 Plan and represents the joint plan for integration of health and social care locally. The BCF Plan will retain a focus on improving hospital discharge process, avoiding unnecessary admissions and increasing the availability of reablement services through the commissioning of jointly-led health and social care services.

During 2018-19, Wandsworth has been in consultation with local people and key stakeholders on what their priorities are for the local health and care system. Reflecting on evidence from the Joint Strategic Needs Assessment (JSNA) and informed by wide consultation with residents, staff and stakeholders the priorities of Wandsworth Health and Care Plan have been developed. The Health and Care Plan has been developed across the whole life course of “Start Well, Live Well and Age Well” and the Better Care Fund will predominately support Age Well priorities.

Through the BCF schemes and delivery of the Health and Care Plan we want to join up health and social care services to provide a better service to residents. The priorities for “Age Well” are **Joined Up Health and Social Care, Dementia** and **Isolation.** There is also a priority on supporting unpaid **Carers** across the whole life course.

1.1 Summary of Funding Contributions

The BCF provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from CCG allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures Grant.

The table below summaries the contributions made to the Wandsworth BCF by WCCG and WBC for 2019-20.

Contributions	2019-20 Income
CCG Minimum Contributions	£21,869,611
WBC Contribution to Falls Service	£362, 650
iBCF	£15,188,334
Winter Pressures Grant	£1,297,456
Disabled Facilities Grant	£1,551,147
Total BCF Pooled Budget	**£40,269,198**

1.2 Signatories to the BCF Plan

The BCF Plan 2019-20 is jointly written and owned by WBC and WCCG with authorised signatories for each organisation:

I. Councillor Melanie Hampton, Chairman of the Wandsworth Health and Wellbeing Board
II. James Blythe, Managing Director of Merton and Wandsworth CCGs
III. Liz Bruce, Director of Adult Social Care and Public Health, Wandsworth Borough Council
IV. Sarah Blow, Clinical Commissioning Group Accountable Officer
V. Paul Martin, Chief Executive, Wandsworth Borough Council
VI. Mark Maidment, Director of Resources, Wandsworth Borough Council.
VII. Sydney Hill, Head of Health and Care Strategy, Wandsworth Borough Council
VIII. Busayo Akinyemi, Head of Integrated Care and Mental Health, Merton and Wandsworth Clinical Commissioning Group

The Wandsworth BCF Plan has also been agreed by:

I. BCF Programme Board held on 13th September 2019
II. Health and Wellbeing Board held on 24th September 2019

2.0 The Better Care Fund

The BCF is a national policy programme between health and social care systems to promote joint working and sustainable integration. Jointly managed by CCGs and local authorities, organisations work in partnership to coordinate existing systems and develop more diverse services. Created with stakeholders from NHS England, the Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and the Local Government Association (LGA) the BCF places importance on the wider determinants of wellbeing within communities.

Services, supported by the BCF, aim to achieve integrated person-centred care by supporting all aspects of a person's wellbeing so that they can live independently in the community. The BCF predominantly supports vulnerable older people, many of

whom live with frailty and multi-morbidity creating a greater demand for support from care services and acute hospitals. The success of BCF initiatives is monitored against a variety of performance indicators, including delayed transfers of care (DToCs); measuring any delays in discharging a patient home from hospital. NHS England sets out the focus of the BCF during the planning period through the policy framework and policy requirements.

2.1 National Context of the BCF in 2019-20

Nationally, the BCF in 2019-20 is designed to be a continuation of the local priorities set out in the 2017-19 planning process. The yearly reporting period provides the opportunity for continued monitoring and reflection, to survey the data and information on the impact of the BCF. NHS England have simplified the entire planning process, so that there is minimal duplication of information between the 2019-20 and 2017-19 plans.

For this reason, there is no requirement to submit a Narrative Plan, and the narrative has been incorporated into the planning template. The BCF Narrative Plan for 2017-2019 set out how Wandsworth would make progress towards integration by 2020, and this year plan will focus on updates to the 2017-19 plan.

In Wandsworth the BCF Plan 2017-19, outlines how WBC and WCCG are committed to strategic joint commissioning, within the wider commissioning structure of the South West London vision for cross-borough integrated services. In 2017-19, WBC and WCCG named a key priority of improving the hospital discharge process, preventing unnecessary admission to hospital and improving the capacity of reablement services.

The plan also outlines extensive schemes to promote integration, including supporting unpaid carers. By acknowledging the weight of future pressures with an ageing population, the BCF Plan 2017-19 establishes how joint working and services will continue to meet the growing complexity of need in Wandsworth. All schemes supported by the BCF are continually reviewed and appropriate adjustments made to ensure that WBC and WCCG achieve the best outcomes for residents.

Please find the published Wandsworth BCF Plan 2017-19 on the Wandsworth Health and Wellbeing Board Website:
https://democracy.wandsworth.gov.uk/documents/g5437/Public%20reports%20pack%2026th-Sep-2017%2019.00%20Health%20and%20Wellbeing%20Board.pdf?T=10 (page 17)

2.2 BCF Policy and Planning Requirements in 2019-20

The BCF in 2019-20 will continue to provide a mechanism for personalised, integrated approaches to health and care that support people to remain independent at home or return to independence after an episode in hospital.

The continuation of the national conditions and requirements of the BCF from 2017-19 to 2019-20 provides opportunities for health and care partners to build on their plans from 2017 to embed joint working and integrated care further.

The BCF Policy Framework for 2019-20 provides continuity from the previous round of the programme.

The four **national conditions** set by the government in the Policy Framework are:

1. That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grand determinations, **must be signed off by the Health and Wellbeing Board (HWB) and by the constituent Local Authority and CCG**

2. A demonstration of how the area will **maintain the level of spending on social care services** from the CCG minimum contribution in line with the uplift to the CCG minimum contribution

3. That a specific proportion of the area's allocation is invested in NHS-commissioned **out of hospital services,** which may include seven-day services and adult social care

4. A clear plan on **managing transfers of care,** including the implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all Health and Wellbeing Boards must adopt the centrally-set expectations for reducing on maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans.

The BCF Plan 2019-20 must also demonstrate how areas will improve performance against **four national metrics** of the fund:

1. Non-elective hospital admissions (specific acute)
2. Admissions to residential and care homes
3. Effectiveness of reablement; and
4. Delayed transfers of care (DToC)

2.3 The BCF from 2020 and the NHS Long Term Plan

In June 2018, the government announced a review of the "current functioning and structure of the Better Care Fund" to ensure it supports the integration of health and social care.

The NHS has set out its priorities for transformation and integration though the NHS Long Term Plan, published in January 2019. This includes plans for the investment in integrated community services and next steps to develop Integrated Care Systems. The government will set out further proposals for social care and health integration in the forthcoming Green Paper on adult social care.

The BCF Review is expected to be completed in 2019 and an update on the BCF beyond 2020 is expected from NHS England later this year. The Chancellor's 2019 Spending Review announced on 4 September 2019, did confirm continuation of BCF and iBCF funding for 2020-21.

3.0 Progress since 2017

The ongoing approach to integration has brought to improvements in the delivery of health and social care services in Wandsworth. In 2017-19 the focus centred on but was not limited to:

- Avoiding unnecessary hospital admissions
- Improving hospital discharge process
- Improving the quality and availability of reablement care

By reviewing pathways and improving the quality of services, Wandsworth continues to have steadily improving performance of BCF supported schemes as it matures. This is reflected in improving the hospital discharge process, which remains a key priority of the borough.

A key indicator used by NHS England to monitor the success of the BCF programme is the number of delayed transfers of care (DToCs). It provides an insight into the efficiency of health and social care services in working together to discharge a person from hospital in a safe and timely manner. Between 2017/18 to 2018/19, Wandsworth has reduced DToCs by 27.4%. Wandsworth has consistently remained in the top quartile in London.

The significantly lower average demonstrates the level of sophistication of the local schemes in Wandsworth. The graph below demonstrates Wandsworth steadily improving performance as the number DToCs reduce as the BCF matures. As Wandsworth is performing well, the target for 2019-20 has been focused on maintaining performance.

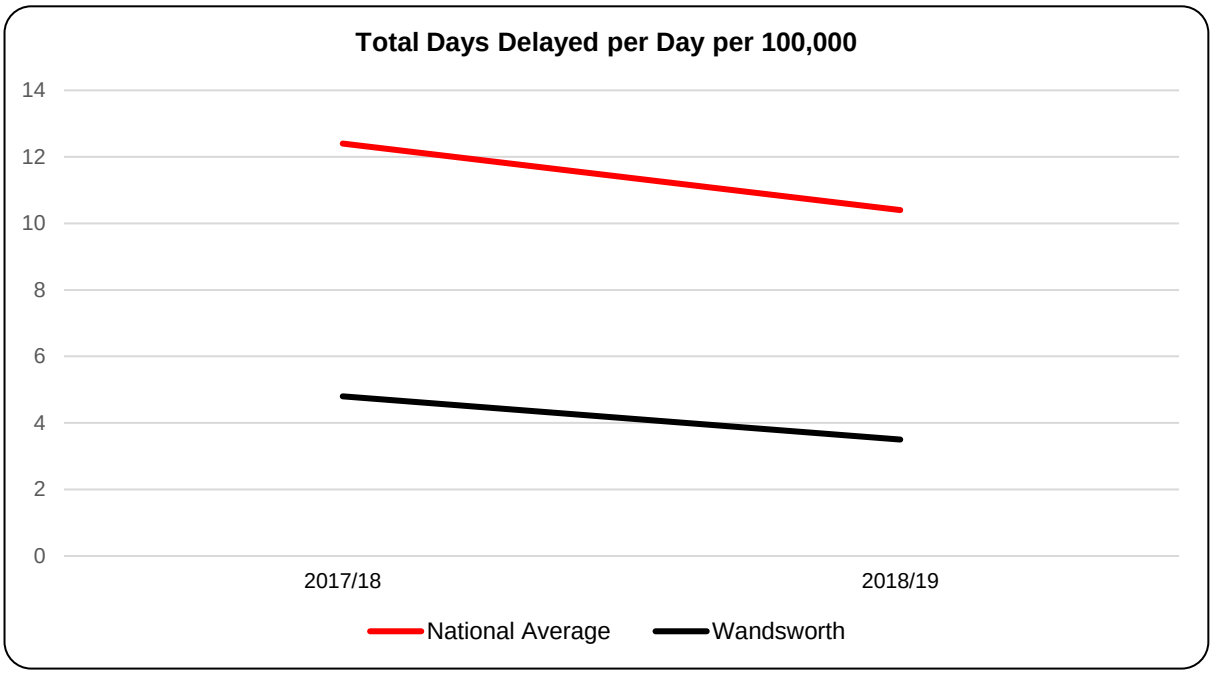

Figure 1: Graph above demonstrating the DToC average per day for 2017/18 to 2018/19

Another indicator used by NHS England is the non-elective admissions into hospital, which shows the non-planned admittances, such as emergency, hospital transfer or maternity admission. Please see graph below for data on 2017-19.

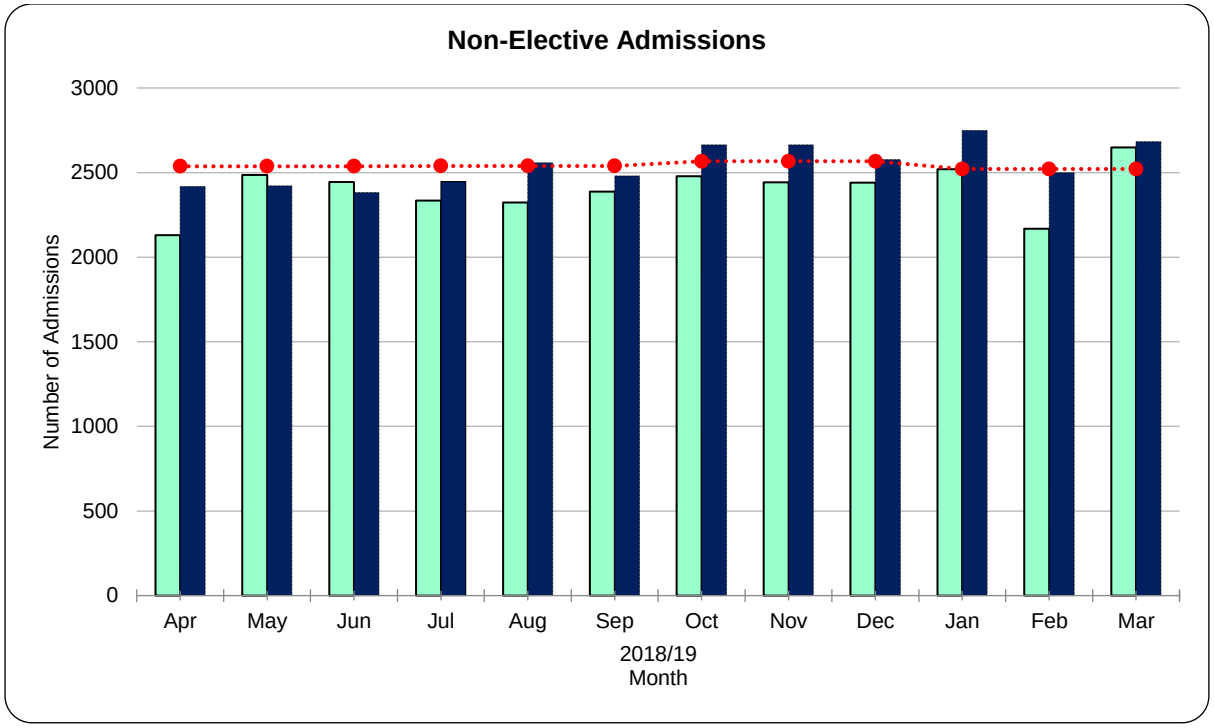

Figure 2: Graph demonstrating the NEA per month for 2017/18 to 2018/19

In Wandsworth, the average number of non-elective admissions per day was 79 in 2017-18 and 83.7 in 2018-19. Although the number of admissions has increased, for the first two quarters of the year admissions came in under projected trajectory. However, an incremental rise in admissions rates into the winter months demonstrates the severity of winter pressures in 2018-19 and the subsequent pressure on the system.

For 2019-20, it is aimed that schemes will continue to have a positive impact on system outcomes as schemes develop greater maturity and lessons can be learnt from previous years, such as measures to relieve winter pressures. The BCF schemes will continue to be closely monitored and adjusted accordingly to ensure that better outcomes are achieved for residents.

4.0 BCF Planning Template 2019-2020

The BCF in 2019-20 is a continuation of the priorities set out in the 2017-19 plan. The main change in the BCF Planning Requirements from 2017-2019 is the separate Narrative Plans have been replaced with a single planning template that will include short narrative sections covering local approach to integration; plans to achieve metrics and plans for ongoing implementation of the High Impact Change Model for managing transfers of care.

Please see the sub headings below for the strategic narrative on how WBC and WCCG plan to focus the BCF programme in 2019-20 to meet the 2019-20 priorities set by NHS England.

4.1 System Level Alignment

Wandsworth has a good partnership across WBC and CCG to work together to deliver improved health and care to our local people. WCCG and WBC work in partnership across health and social care, with our local population, to prevent ill health, reduce inequalities and support people to start well, live well and age well, both physically and mentally.

The BCF will build on the existing plan and will align with “Age Well” priorities of the Wandsworth Health and Care Plan 2019-21. Whilst focusing on older people, the BCF also supports younger adults with complex needs, including those with physical disabilities and mental ill health. The BCF will continue to support and facilitate the strategic direction in Wandsworth, to meet the requirements of the NHS Long Term Plan and set out in the vision of the SWL Health and Care Partnership to deliver integrated services to give people the care they have told us they want.

The Wandsworth Health and Care Plan 2019-21 has been developed alongside local health and care plans of the other boroughs in the South West London Health and Care Partnership. It describes the vision, priorities and actions to meet the health and care needs of local people in the borough, in themes of Start Well, Live Well and Age Well. The plan is one element of work being undertaken by health and social care partners in Wandsworth to improve health and wellbeing. The priorities within the Wandsworth Health and Care Plan are focused on areas where, over the next two years, we can have the greatest impact by working collectively to prevent ill health, keep people well and support them to stay independent.

In response to the South West London (SWL) Sustainability and Transformation Plans (2016) there was a recognition that a local approach works best for planning and it was agreed that local health and care plans would be developed across the six boroughs in SWLHealth and Care Partnership. Wandsworth’s Health and Care Plan has been developed in partnership with the Local Authority, Wandsworth CCG, NHS Providers, Healthwatch and representatives from the voluntary and community sector with consultation and engagement from local people in the borough.

Wandsworth Health and Care Plan is informed by the borough’s Joint Strategic Needs Assessment (JSNA) outlining the key challenges and pressures across health and social care for the whole population of the borough. The plan reflects the whole life cycle and sets out priorities for Start Well, Live Well and Age Well acknowledging that there is transition between these stages. Wandsworth Health and Care Plan reflects the key priorities for improving health and wellbeing for the local population, and where we can have the biggest impact by working differently across health, social care and the voluntary sector.

The six borough plans will form an overall SWL Health and Care Partnerships Plan and will form part of the SWL response to NHS England in relation to achieving priorities set in the NHS Long Term Plan.

Wandsworth is part of a complex system with WBC and WCCG working across different geographies. Wandsworth Council has been part of a Shared Staffing Arrangement (SSA) with Richmond Council since 2016 and Wandsworth CCG have shared Local Delivery Unit with Merton CCG. NHS Community Services are largely provided by Central London Community Healthcare, which also provide community services in Merton. Wandsworth has a large acute hospital in the borough, St George's NHS Trust with 65% of the boroughs acute admissions but has a significant flow of people into acute trusts outside of the borough, including Chelsea and Westminster Hospital (12%) and Kingston Hospital (8%) and all other hospitals (15%). Working across CCG and Council geographies offers benefits to how we engage with acute Trusts in and outside the borough, for example working across Wandsworth and Merton on aligned discharge pathways from St George's Hospital, and developing closer relationship and improving pathways from Kingston Hospital. There will be further opportunities through SWL on how we engage with acute hospitals across the system.

The BCF Plan and Health and Care Plan need to be set in the context of the wider strategic landscape for health and care integration for adults in the borough. This is supported by other joint plans, including:

- Wandsworth Joint Health and Wellbeing Strategy 2015-2020
- SWL Primary Care Strategy for 2019 and beyond
- St George's Hospital Strategy 2019-2024
- Carers and Young Carers Strategy 2017-2020

4.2 Integrated Services at Borough Level

The Wandsworth Health and Care Plan broadly sets out the high-level approach to integrated care in the borough. WCCG and WBC are committed to joint commissioning opportunities where this will deliver efficiencies and better outcomes for local people. Wandsworth has established joint commissioning initiatives between the CCG and the Council which will continue in 2019-20 and support the BCF.

As a vibrant and well-connected borough with many community assets Wandsworth is recognised as a great place to live and work. Wandsworth has a large number of working age adults and a population that is more affluent than the general national population. However, Wandsworth also has pockets of deprivation throughout the borough and there are inequalities with small populations at either end of the age spectrum who are deprived and have significant health issues. Wandsworth has projected the number of over 65's to increase 44% by 2035 (from 2015) and a third of people over 65 in the borough current live alone.

Our joint commissioning initiatives are focused on:

- The enhanced care pathway providing multi agency proactive care for people living in their own home and successfully reducing unnecessary admission into hospital over the last 3 years.
- Improved falls prevention services; upscaling the falls expertise working more closely with the voluntary and community services and with emergency services to prevent unnecessary admissions.
- Increasing the number of carers identified through working more closely with GPs and hospitals and continuing to work with local groups.

Following the publication of the NHS Long Term Plan and the GP Contract Reforms, a new Primary Care Network Contract went live on 1st July 2019. In Wandsworth, practices formed themselves into 9 Primary Care Networks (PCNs). These are broadly geographically arranged across Wandsworth CCG. The PCNs will work with local community teams around a population of approximately 30,000 – 50,000 people, which are small enough to provide personal care and large enough to have an impact through deeper collaboration between practices and other health and social care partners. Primary Care Networks will be the foundation of Integrated Care Systems and enable the provision of proactive, accessible, coordinated and more integrated primary and community that will improve outcomes for patients.

The seven national network service specifications are set out below. The first five will start by April 2020 and the remaining two will start by 2021:

(i) Structured Medications Review and optimisation

(ii) Enhanced Health in Care Homes, to implement the vanguard model

(iii) Anticipatory Care requirements for high need patients typically experiencing several long-term conditions, joint with community services

(iv) Personalised Care, to implement the NHS Comprehensive Model

(v) Supporting Early Cancer Diagnosis

(vi) CVD Prevention and Diagnosis

(vii) Tackling Neighbourhood Inequalities

Wandsworth has an active and well-developed voluntary sector with over 900 voluntary sector organisations offering a diverse range of services. Support for the voluntary sector is delivered through Wandsworth Care Alliance's (WCA) Voluntary Sector Co-ordination Project. Wandsworth recognised the potential within the voluntary sector to play an active part in addressing the health and wellbeing challenges that we face and the WCA represents the voluntary sector, in a

partnership capacity, on the Wandsworth Transformation Group and the Health and Wellbeing Board.

In Wandsworth over 10,000 older people live alone and over 20% of older people are on low incomes. Isolation in older age often disproportionately affects people living in more deprived areas or who are on low incomes. Tackling Isolation for Older People is a key priority of the HCP. Isolation in older age is an important focus as it is a preventative cause of both physical and mental health problems, including depression, dementia and cardiovascular disease.

Through the Health and Care Plan, Wandsworth has made a commitment to improve the preventative services offer provided by the voluntary sector with a focus on intergenerational activities. Improved coordination of services will be achieved through the commissioning of an enhanced Voluntary Sector Coordination Programme, supporting the provision of face to face social prescribing services and through the current digital social prescribing service called the Wandsworth Wellbeing Hub.

Social Prescribing

We will be working with emerging Primary Care Networks (PCN) to ensure positive learning from existing social prescribing models is built upon to deliver the best outcomes.

Social Prescribing is a means of enabling clinicians to refer people to a range of local, non-clinical services to improve their health and wellbeing. Recognising that people's health is determined by a range of social, economic and environmental factors, Social Prescribing seeks to address people's needs in a holistic way by facilitating access to the right support, in the right place, at the right time.

The new GP PCN contracts provide new funding for Social Prescribing Link Workers. Clients referred to the Link Workers will receive 1:1 support through a series of consultations, including connecting them to other agencies in the community, which can help to address their needs.

The CCG is working with emerging Primary Care Networks to ensure that positive learning from existing Social Prescribing models is built upon to deliver the best outcomes.

This will include supplementing the funding allocated through the GP PCN contract to ensure an effective and sustainable Social Prescribing model is delivered across the Borough.

4.3 Integrated Care around the Person

In Wandsworth our vision is that we want people to remain as healthy as they can for as long as they can. We are focused on prevention, joining up care where it is

appropriate to deliver a better service, and supporting and developing resilience in individuals and local communities.

During 2018-19, Wandsworth has been in consultation with local people and key stakeholders on what their priorities are for the local health and care system. Reflecting on evidence from the Joint Strategic Needs Assessment (JSNA) and informed by wide consultation with residents, staff and stakeholders, the priorities for the Wandsworth Health and Care Plan have been developed. The Health and Care Plan has been developed across the whole life course of "Start Well, Live Well and Age Well" and the BCF will predominately support 'Age Well' priorities.

From our engagement residents have told us:

- People with long term conditions want more guidance and support with managing their conditions
- Better identification and support for carers
- People want better support after discharge from a hospital setting
- Services are currently disjointed, and all services need to work better together

Through the BCF schemes and delivery of the Health and Care Plan we want to join up health and social care services to provide a better service to residents. The priorities for "Age Well" are **Joined Up Health and Social Care, Dementia** and **Isolation.** There is also a priority on supporting unpaid **Carers** across the whole life course.

Through 2017-19 BCF Schemes there have been developments on integrating services around the person, which have now become embedded and are areas of strength in Wandsworth including the Enhanced Care Pathway, Reablement Services, Falls Services, and Carer Services.

<u>Enhanced Care Pathway/Complex Case Management</u>

A key focus of the of the 2017-19 Plan was the Enhanced Care Pathway (ECP) which is the proactive integrated health and social care planning for people with the most complex needs. The ECP cohort has been identified each year through a risk stratification model, and people identified have been reviewed by their GP and an Enhanced Care Plan is developed, with input from the multi-disciplinary team (MDT) which includes health and social care representation.

The ECP has been effective in reducing the number of hospital admissions for the most vulnerable people in the borough. The investment and focus for Enhanced Care Pathway will remain integral to the BCF Plan this year. Developments of the ECP this year include a review of the ECP patient criteria, providing more guidance to GP practices on how to identify ECP caseload. This includes people with a high clinical frailty index; frequent falls and/or A&E attendances; more than 4 unplanned visits for the same long-term condition by the GP in the last six months. The criteria have also incorporated social risk factors including people receiving an intense package of care; socially isolated; and where there are high carer support needs.

There have also been developments in relation to sharing the EPCs between the GP and MDT through EMIS systems. The care plan templates have also been updated to include a Comprehensive Geriatric Assessment (CGA) and there are plans to standardise care plans across different cohorts.

Through the Health and Care Plan we have committed to improve the coordination of community services for people with the most complex health and social care needs, including support for their carers. Wandsworth has a dedicated social care team that works alongside Wandsworth's Community Adult Health Service (CAHS) providing timely, joined up approach to health and social care, enabling holistic care delivery for people with complex health and social care needs.

Plans are in place to review the referral pathways for the integrated social care team to focus more on supporting people and their carers with complex needs who would benefit from coordinated case management. This will include referrals from Enhanced Care Pathway, as well as MDT referrals from CAHS.

Reablement

An area of focus of the 2017-19 Plan was to increase the responsiveness and capacity of reablement and improve discharge pathways into reablement and intermediate care services. There are two main community reablement services in the borough, the Council's in-house Enablement service, Keeping Independent Through Enablement (KITE) and CLCH's Maximising Independence Service, which now includes the Quick Start, rapid response home care service commissioned by the CCG.

Since the 2017-19 Plan, there have been improvements in how KITE and Maximising Independence Teams work together to improve discharge pathways. A single referral pathway for KITE and Maximising Independence has been developed and embedded for patients being discharged from St George's Hospital. This has streamlined referrals into reablement services, reducing duplication of multiple referrals and assessments, and lack of coordination of community reablement services provided to people once they were discharged from hospital.
Building on this joint working there are plans to further integrate the delivery of Reablement/Intermediate Care Services in Wandsworth and a Reablement Review and Redesign programme is being developed. The overarching aim of the programme is to build a health and social care system based on the principles of prevention and strengths-based approaches, which supports residents to live as independently as possible.

Wandsworth, like other boroughs, is facing growing pressures on local services because of increasing numbers of people requiring health and social care support. To ensure we can meet these challenges and offer sustainable services for the longer term, we need to find innovative solutions across the health and care system. Prevention and integration, where appropriate, are key to meeting these challenges and form the basis of the Wandsworth Health and Care Plan.

In 2018, the Council engaged Institute of Public Care (IPC) to undertake a high-level review of the current model against best practice and identify key design

characteristics and learning from other local authorities. The final report identified areas of good practice and areas for improvement, including:

- The in-house KITE (Keeping Independent through Enablement) service delivered excellent outcomes but does not have the capacity to meet current demand.
- Good partnership working already exists between social care and community health staff, however the current system is overly complex and relies too much on staff relationships.
- Clearly defined roles and responsibilities and eligibility criteria across health and care would improve communications and reduce unnecessary delays and hand offs.

The aim of the project is to improve access to intermediate care and reablement services, with better coordination between health and social care services. The expected outcomes as follows:

- Prevent, reduce and delay long-term care and support needs
- Promote independence and reduce dependency on services
- Reduce pressure on budgets
- Improve user experience
- Avoid unnecessary hospital admission and readmission
- Reduce average length of stay in hospital where appropriate

<u>Falls Prevention Service</u>

During the last two year, WCCG and WBC have been working with providers, the community and voluntary sector and the public to review how falls prevention is delivered. This is in response to concerns that the data shows a high number of unplanned hospital admissions due to injuries from falls for people over 65 in the borough.

Following a Public Health review of the Falls Prevention Service, it was jointly agreed to upscale the number of people assessing and advising on falls across the health and care system. This includes training people who work or volunteer in community groups and centres aimed at older people.

The current falls service is to be refocused in three ways to:

- Create a rapid response service that will either prevent a conveyance to A&E or prevent a Non-Elective Admissions if conveyance is deemed necessary.
- Extend the geriatric clinic to a more multidisciplinary or holistic service for older people with a significant falls risk. The service will outreach into the community, such as day centres and care homes providing training on reducing fall risks.
- Provide more accessible strength, balance and healthy bones classes with a social aspect within it. By making it more local and fun, it is anticipated that more people will join and remain active for longer.

Carer Services

Wandsworth Carers Centre (WCC) is commissioned by health and social services through the BCF, to provide support to unpaid adult carers. The core services include:

1. Advice, information and informal advocacy
2. Peer support
3. Respite and unplanned replacement care
4. Back care and therapies
5. Health and social care liaison and training

WCC is well established across the health and social care system and the wider community. Service users who access the service reported high levels of satisfaction and the shared view is that more carers could benefit from accessing the service. A revised specification for procurement in 2019-20 includes monthly carers' surgeries where carers can access one-to-one information, advice and support at their GP practice or local hospital and carer awareness training sessions open to all health and social care staff.

Disabled Facilities Grant (DFG)

Under the provisions of the Housing Grants, Construction and Regeneration Act 1996, the Council provides mandatory means tested Disabled Facilities Grants to assist residents with the cost of providing adaptations to dwellings or common parts of buildings containing flats where the adaptation is considered 'necessary and appropriate' and 'reasonable and practical'. The Regulatory Reform Order 2002 (RRO) provides local authorities a broader freedom and opportunity to address living conditions in their area including to provide, directly or indirectly, assistance to adapt or improve living accommodation and repair living accommodation.

The RRO (2002) allows local authorities to create assistance schemes using the DFG funding which help people to meet their needs without going through the full DFG process. Additional funding under the BCF has expanded the scope of help available to include discretionary DFG schemes. This widening of funding enables more people to remain independent and prevents the need for care and support for longer.

The BCF has created new opportunities for the Council to develop and fund joint commissioning plans with Clinical Commissioning Groups to meet the needs of residents across care groups. The Discretionary DFG and Housing Assistance Policy supports the development of these plans by providing the policy context for how commissioning partners will use the funding available to develop a range of DFG funded services. The broad priorities of the policy are to improve outcomes for disabled and older people, reduce admissions or re-admissions through prevention, help people remain independent for as long as possible, reduce care costs where possible and help facilitate more efficient discharge from hospital.

More specifically, the funding for discretionary DFGs sits within the BCF and funding for services is prioritised and targeted at initiatives which:

- Reduce or eliminating hospital admissions;
- Allow speedier discharge from hospital;
- Consider the long-term needs of individuals and reductions in associated treatment and social care costs; and
- Provide for works, adaptions or provision of equipment that is not provided by any other service.

Wandsworth Council implemented a Discretionary DFG and Housing Assistance Policy in 2018. The policy sets out how the discretionary funding can be used, and it includes the local agreed approach for funding in the following areas:

- Speeding up the delivery of adaptations: additional staff and/or training
- Funding adaptations over the maximum mandatory DFG limit
- Relocation funding
- Hospital Discharge Grants
- Fast Track non-means tested assistance
- Preventative Outreach and independence assistance
- Telecare and telehealth services
- Adaptation of temporary accommodation
- Provision of interim placements (for people awaiting adaptations)

Adaptations provided via Mandatory DFG are managed by the Council's Home Improvement Agency while equipment and services provided via the Discretionary DFG policy are delivered across a wider range of services including Social Services and Hospital Discharge teams.

The outcomes achieved by the Mandatory DFG and the Discretionary DFG initiatives are monitored by the CCG, Social Care and the Housing and Regeneration Department as the Local Housing Authority Spend and activity is reported to the BCF Board.

The DFG Lead in the WBC's Housing Department has been involved in BCF Planning and is a core member of the BCF Programme Board.

5.0 Metrics

All BCF plans must include ambitions for each of the four metrics and plans for achieving these are a condition of access to the fund. Expectations for reducing or maintaining Delayed Transfers of Care (DToCs) will continue to be set centrally for each Health and Wellbeing Board area.

5.1 Non-Elective Admissions

A key focus of the BCF is to reduce non-elective admissions to hospital. In Wandsworth, non-elective admissions have increased by 1600 admissions between 17-18 and 18-19. There has been a shift in activity from 2 + LOS to 0-1 which is promising, but the number of admissions continues to grow year on year. Please see the table below with the breakdown by hospital and over 3 years.

Trust Name	Adms 16-17	%	Adms 17-18	%	Adms 18-19	%
St George's University Hospitals NHS Foundation Trust	14,671	66%	15,205	65%	16,170	65%
Chelsea and Westminster Hospital NHS Foundation Trust	2,625	12%	2,743	12%	2,918	12%
Kingston Hospital NHS Foundation Trust	1,540	7%	1,768	8%	1,997	8%
Others	3,463	16%	3,590	15%	3,840	15%
Total	**22,299**		**23,306**		**24,925**	

Figure 3: Table showing non-elective admissions between 2017 – 2019

There is continued work with St George's Hospital to improve the Referral to Treatment (RTT) trajectory through capacity modelling and better data validation. This provides patients with more timely access to specialist services. In addition to initiatives described in the High Impact Change Model, key initiatives to reduce Non-Elective Admissions in Wandsworth include enhanced care planning and rapid response.

The 'Enhanced Care Planning' initiative commenced in 2016 and continues to provide a proactive response to avoid hospital admissions for the 500 people most at risk of a NEL admission. Risk stratification identifies the patients and a multi-disciplinary team drawn from across the health and social care system agree a care plan with the patient and/or carer/family. This work since 2016 has shown a 41% reduction in Non-Elective Admissions for this patient cohort.

Rapid Response is a multi-organisational team including 111, London Ambulance Service, Social Care, Community Adult Health Services, Primary Care, Voluntary Sector and private agencies. The aim is to prevent the scaling up of urgent response and needs from avoiding the attendance of ambulance crew; to attending ambulance crew avoiding the need to convey and to conveyed patients avoiding the need to be admitted. The team will also help to reduce length of stay by providing temporary care when a health and/or social care services are not available straight away.

<u>Winter Planning</u>

The approach to winter planning will refine, optimise and improve the successful approach taken in 2018/19 through building upon lessons learned and reflective dialogue with key stakeholders. The A&E Delivery Board (AEDB), which has members from all parts of the system, will continue to lead on the Urgent Care

elements whilst the SWL Urgent and Emergency Care Transformation and Delivery Board will retain responsibility for the delivery and assurance of plans as well as being the point of escalation in the governance structure.

Each AEBD has carried out Winter Reviews in April/May and the learning factored into ongoing work streams and operational processes as well as plans for next winter. Issues that occur in winter are often featured in less pronounced forms all year round so, any opportunities for improvement will be considered for implementation well ahead of next winter.

The NHS Improvement (NHSI) demand and capacity model was shared and used widely across SWL last year and the expectation is that this work be repeated for this winter, however there were limitations with using this model for services outside the acute providers.

Following the cycle from previous years, the AEDB will start developing their strategies for winter with sessions scheduled to support fully integrated plans by September/October. These draft plans will then be shared at the SWL Urgent and Emergency Care Forum to share good practice, encourage consistency and work through issues and risks that have an impact across SWL.

5.2 Delayed Transfers of Care

Wandsworth has been set a Delay Transfer of Care (DToC) target for 2019-20 of **13** delayed transfers of care per day (daily delays) from hospital. This includes people who are delayed for reasons attributable to the NHS, social care or both. Whilst a daily target has been set, performance will be monitored on a monthly basis.

Wandsworth has consistently remained in the top Quartile performance of London benchmarking for DTOCs for more than three years. The BCF has contributed to Wandsworth maintaining performance both in acute and non-acute (including mental health) settings. Over the two-year period of the 2017-19 BCF Plan, DTOC's across health and social care improved by 27.4%.

This has been a key priority for Wandsworth health and care system and focus on DTOC's have been driven through the BCF and Older People's Programme Board and the Emergency Care Delivery Board. Success has been achieved through a shared commitment to improve patient experience and reduce unnecessary delays in discharge from hospital settings. This has been supported by improved partnership working across CCG, Adult Social Care, Community Adult Health Services, voluntary sector and the acute hospitals as well as learning from Multi-Agency Discharge Events (MADE) and implementation of the High Impact Change Model.

The most significant decrease has been of non-acute delays in the Mental Health Trust, with a 53.4% improvement (reduction from 1517 days delayed in March 2017 to 810 days delayed in March 2019). This has been achieved through joint working with the Mental Health Trust, Adult Social Services and WCCG including the

implementation of a weekly DTOC meeting and agreement of DTOC validation process.

The main acute provider for Wandsworth patients is St George's Hospital and for 2018-19, 27% of all DToCs were at St George's Hospital. Acute Hospital Trusts outside of the borough boundaries made up 29.9% of DToCs. There were a significant proportion DToCs at Queen Mary's Hospital (21.1%) which is a non-acute community hospital setting. This will be an area of focus for 2019-20, as well as continuing to improve and maintain performance in acute hospital settings.

The main reasons for health and social care delays in 2018-19 are listed below, with the percentage of total days delay attributable to Social Care and the NHS respectively:

Social Care delays

- Awaiting Residential/Nursing Care – 58.1%
- Awaiting Home Care – 31%

NHS delays

- Awaiting further NHS non acute care – 29.7%
- Awaiting Residential/Nursing Care – 17.7%
- Patient/Family Choice – 13.5%

Plans to reduce DToCs at St George's Hospital are being driven through the Wandsworth and Merton Emergency Care Delivery Board. A Transfer of Care Bureau has been established at St George's Hospital and is represented by the acute trust, Adult Social Services and NHS Community Providers. There is a social work team co-located in the hospital, and there are link workers assigned to the four highest referring wards. This is being reviewed, and consideration will be given to expanding link workers across the hospital to enable earlier identification of people who need social care support before a formal referral is made.

St George's Hospital is also leading on the development of a Homeless Pathway which will aim to improve the multi-agency coordination for patients who are of no fixed abode. This will improve admission avoidance pathways from A&E as well as improving discharge pathways for people where there are often complexities that result in a delayed discharge.

Schemes

Most of the BCF schemes will have an influence on the level of DTOCs and reducing length of stay in hospital, with reablement and intermediate care services being key to ensuring that the right support is available to help people on their discharge from hospital. The Winter Pressures Grant funding will be used to support social services to maintain social care DToC performance during seasonal winter pressures. This will include additional capacity in home care and reablement services to ensure that community services are available for people to return home in a timely way. Additional funding for residential and nursing home placements, will also help to

reduce the time that people have unnecessary delays in hospital while waiting to be discharged to a care home setting.

5.3 Care Home Admissions

Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care.

During 2017-19, Wandsworth has made significant improvements with reducing rates of permanent admissions in care homes. This is reflected in a more stretching target for 2019-20 for 122 placements, compared to a target of 134 in 2018-19.

		18/19 Plan	19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	432	392
	Numerator	**134**	**122**
	Denominator	31,004	31,132

Wandsworth Adult Social Services has a strong focus on 'Promoting Independence', which is supported by a shift to strength-based assessments and support planning with individuals. This practice sees a focus on the individual's assets, as well as family and personal networks and connection with the wider community. The overall priority is for residents to be independent, resilient, healthy, active and physically and mentally well.

When people become less independent or unwell, we want to ensure they can access care and support at the right time and in the right place. We will do this by supporting people at home, or in a home like setting, wherever possible and enabling them to access personal and community networks before introducing reliance on statutory services.

Wandsworth's enablement and intermediate care services, including access to 24hr enablement from hospital, have been successful in supporting people with complex needs to return home from hospital. It is recognised that making long term care decisions during an un-planned hospital admission, when people are often in crisis, should be avoided unless there is no other option. In some occasions, people will access bed-based services including intermediate care or step-down beds in local nursing homes to continue with their recovery and rehabilitation prior to making decisions about their long-term care needs.

Extra Care Housing provision in the borough has also been key in reducing residential care admissions. Extra care or supportive living offers people the opportunity to live in their own flat, with care staff on site, and for some people can be a viable alternative to moving into a care home setting.

Needs Analysis and forecasts projecting demand to 2035 for accommodation with care and support ranging from independent living options, such as supported living and extra care to care home provision, have been undertaken. These provide an understanding and overview of existing provision and predicted need across all client groups including older persons, mental health, learning disability and physical disability and sensory needs in line with demographic growth and service use trends. They form part of a robust evidence base to ensure we plan, commission and develop the right accommodation options in a cost effective and sustainable manner working closely with Housing.

Our aim is to avoid care home admissions (although there will be a need for an increase in specialist residential and nursing care in response to increasing numbers with dementia) and to provide increased support in individuals' own homes and develop more extra care and supported living provision, encouraging people to live as independently as possible.

5.4 Reablement

There is evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their needs for ongoing support and dependence on public services.

This measure seeks to demonstrate the effectiveness of reablement services by determining whether an individual remains at home 91 days following their discharge from hospital. This measure is complimented by locally monitored performance on people who leave the service with a reduced need or have no needs for council provided services.

		18/19 Plan	19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	93.3%	91.3%
	Numerator	277	95
	Denominator	297	104

There has been a change in data used for this measure since the 2017 plan, and this accounts for the appeared reduction in number of people who will receive Reablement this year. This measure previously included data from NHS Intermediate Care services and following a change in the provider and provision of NHS Community Intermediate Care Services in 2017, the data now only includes the Council's In-House reablement service.

The 2019-20 target has been set on the outturn of WBC's performance in 2018-19 and is reflective of ASCOF reporting. We are developing a future model for an integrated reablement service across health and social care and we are working on having more robust data available.

6.0 High Impact Change Model

National condition four requires health and social care partners in all areas to work together to agree a clear plan for managing transfers of care and to continue to embed the High Impact Change Model (HICM). The High Impact Change Model identifies eight system changes which will have the greatest impact on reducing delayed discharges.

1. Early Discharge Planning
2. Systems to monitor patient flow
3. Multi-disciplinary discharge teams
4. Home First, Discharge to Assess
5. Seven-day services
6. Trusted Assessors
7. Focus on Choice
8. Enhancing Health in Care Homes

In Wandsworth, we are "established" or "mature" across all areas of the HICM. There are three broad areas of focus for 2019-20 that will enable the HICM to be embedded and matured. These will be completed by strategies being developed at SWL level which include long term conditions which includes a focus on digital technologies, prevention and end of life care.

Please find a summary below:

1. Early Discharge Planning - Established; including a Transfer of Care Bureau (TOCB) and agreed cross agency pathways.
2. Systems to Monitor Patient Flow – Established; there is digital patient tracking in all hospitals.
3. MDT Discharge Teams – Mature; SW hospital and community teams work together in the TOCB.
4. Home First – Established; Mature in CHC pathways and in progress with rehab/reablement.

5. 5. Seven Day Service – Established; SW and rehab and reablement teams are 7 day working and now need to receive referrals at weekend.
6. Trusted Assessors – Established; the CHC focus and interim step-down beds to be developed work with A and E.
7. Focus on Choice – Established; the policy revised and next is to roll out additional training.
8. Enhancing Health in Care homes – Established; a rapid response nurse practitioner service; bespoke training and developing GP care planning in care homes recruiting additional therapists and nurses.

Complex Patients and non-standard pathways

Health and social care colleagues are working together to identify cohorts where the current commissioned pathways do not meet all the patient's needs. For example, for people who have developed delirium or who will leave hospital temporarily unable to weight-bear. So far, a process has been agreed for these exceptional circumstances. This was tested through case reviews and further improvements identified. The next step will be to ensure these patient needs are included into the service redesign of the delivery of intermediate care services. Intermediate care services in the borough are evolving to provide more home-based health and social care. This includes a review of intermediate care bed usage along with the development of a Rapid Response service which will prevent conveyances to hospital, reduce admissions and facilitate discharges home to reduce length of stay in hospital. The team will provide up to seven-day package of care and then be discharged or referred on for further longer-term management.

A new choice policy has been implemented by St George's Hospital and training for hospital staff is planned, this should help with improving discharge and reduce the number of bed days for some people. There are now established escalation frameworks in place where all partners are committed to ensuring that people receive the care, they need in the right care setting. In development are frameworks to identify people with long stays in hospital who often have the most complex needs, to ensure they achieve the best outcomes and wellbeing.

Reablement

Health and social care partners are working together to design an integrated, urgent, short-term rehabilitation and reablement service. The vision is to provide an integrated approach to intermediate care services which is person centred and encompasses physical, mental health and social care needs. The focus will be on the two areas below:

- Crisis response to avoid unnecessary hospital admissions and include the delivery of traditionally acute clinical interventions for people that can be safely delivered at home
- Short term rehabilitation and reablement – home and/or community bed-based interventions which aim to allow the person to remain at home and live as independently as possible. i.e. promote recovery, rehabilitation and reablement.

Enhanced health care in care homes

Since the 2017-19 BCF Plan, Wandsworth has been developing programmes that support enhanced health in care homes. There is increased proactive care with increased GP leadership in multi-disciplinary teams within care homes as well as expansion of community in-reach nursing and therapy team. The team provides a mix of crisis support along with proactive preventative care and training. As well as the introduction of a pharmacist who visits to conduct medication reviews for patients. This has reduced the number of London Ambulance Service (LAS) conveyances, non-elective admissions and length of stay. The quality of care is improving which is evidenced by increased resident satisfaction. There are some concerns around the availability of therapies, and this is being reviewed.

A Joint Intelligence Group across health and social care meets monthly and enable various stakeholders working with care homes to quality assure the level of care at each home. A dataset has been developed that provides a holistic view on a range of quality indicators to enable improved quality monitoring. The group is then able to identify areas in which homes may require support and develop a plan.

A pilot in the use of Coordinate my Care (CMC) is helping to avoid unplanned admissions. CMC is a care planning tool that can be shared electronically with all healthcare providers working with an individual, it was initially established to support people in their end of life care but has been successfully implemented across care homes in some areas. Electronic data systems are not always used in the care homes as some clinicians still prefer to use paper notes. This influences how other services such as LAS and community-based health and social professionals perform as they cannot access key information.

7.0 Programme Governance

Programme Governance:

The BCF is a jointly developed and agreed approach and plan between CCGs and local authorities and the governance for the plan reflects this. As such governance for the plan is incorporated within existing joint structures. This allows oversight of delivery of the BCF plan in terms of ongoing delivery but also allows the consideration of the BCF's role in supporting and enabling the broader integration agenda for Wandsworth.

Wandsworth Health and Wellbeing Board have ownership of the BCF and is responsible for signing off BCF Plans.

Wandsworth Transformation Group is a group of senior leaders across WCCG, NHS Providers, WBC and Voluntary Sector setting the strategic direction for health and social care integration in Wandsworth, including providing the leadership for the Health and Care Plan.

Wandsworth BCF Programme Board has responsibility for responsible for determining and providing leadership and oversight of the BCF plan and other associated programmes of work between WBC and WCCG. There is joint membership from WCCG and WBC

Emergency Care Delivery Board - The Wandsworth and Merton Emergency Care Delivery Board is where executive partners across the health and social care system across Merton and Wandsworth undertake the regular planning of urgent care service delivery, planning for the capacity required to ensure delivery; overseeing the co-ordination and integration of services to support the delivery of effective, efficient, high quality accessible urgent and emergency services to the population and measuring performance and initiating and completing corrective action as necessary.

8.0 Approval of Agreed Plans

BCF Plans will be approved by NHS England following a joint NHS and local government assurance process at regional level. In addition to the national conditions to set the four-national metrics, NHS England is also placing the following requirements for approval of BCF Plans

I. All funding agreed as part of the BCF Plan must be transferred into one or more pooled funds established under Section 75 of the NHS Act 2006
II. That all plans are approved by NHS England in consultation with the Department of Health and Social Care (DHSC) and Ministry of Housing, Communities and Local Government (MHCLG)

NHS England will approve plans for spend from the CCG minimum in consultation with DHSC and MHCLG as part of overall approval of BCF Plans. The DFG, iBCF and Winter Pressures grants are subject to grant conditions set out in the grant determinations made under Section 31 of the Local Government Act 2003.

9.0 Appendix

9.1 Financial Summary

BETTER CARE FUND 2018/19 to 2019/20: BUDGETS/SPEND

	Total Annual Budget and Spend 2018/19	Total Annual Budget DRAFT 2019/20
	£	£
Services commissioned by the CCG (paid by the CCG)		
Integrated falls (inc LA contribution £362,650)	895,960	921,072
Quick Start (Rapid Response) service	612,000	628,524
Enhanced Care Pathway – community health and social care	12,398,224	12,620,998
Management costs	104,552	104,552
Telehealth (previously telecare) (CCG lead commissioner)	0	50,000
Care Homes Enhanced Care in Care Homes (MCP contract)	0	488,000
	14,010,736	14,813,145
Services commissioned by the LA (paid by the CCG)		
Integrated home care	661,960	847,034[1]
Enhanced Care Pathway – community health and social care	23,026	23,026
Integrated Carers Service	578,949	610,849
Meeting entitlements of carers under the Care Act	221,451	221,451
Social care staffing	765,000	865,000[2]
Social care purchased services, including respite	2,807,775	2,807,775
Mental Health community services	500,000	500,000
Occupational Therapy Equipment	70,000	70,000
Telecare Services	0	0
Telehealth (previously telecare) service commissioned directly by the CCG	50,000	0
Preventative and support services for older people	700,000	738,570
Preventative community services	500,000	500,000
Management costs	200,899	235,411[3]
	7,079,060	7,419,116
Disabled Facilities Grant (paid by LA)		
Major adaptations	1,007,499	1,087,177
Equipment and Minor Adaptations	300,000	323,700
Better at Home Improvement Scheme (Handy Man and Key Safe)	90,000	97,110
Hospital Discharge Grant	40,000	43,160
	1,437,499	1,551,147
Winter Pressures (paid by LA)		

[1] Additional from NHS E Funding £284k
[2] Additional from NHS E Funding £284k
[3] Additional from NHS E Funding £284k

Winter Pressures Grant	0	1,297,456
	0	1,297,456
iBCF (paid by LA)		
Meeting Adult Social care:		
Strengthening statutory social care functions	445,000	445,000
Housing with preventative support (Mental health)	150,000	150,000
Support transition arrangements (Children to Adult)	500,000	500,000
Protection of adult social care	5,439,623	7,588,334
Transfer of care from hospital:		
Increased demand for adult social care services	1,494,000	2,881,000
Preventative services offer (Voluntary sector support)	948,000	948,000
Whole system improvement with health service partners	211,000	211,000
Invest in carers, admission avoidance	350,000	0
Maintain investment in intermediate care	300,000	300,000
Increase capacity in enablement services	300,000	300,000
Accelerate initiatives to accelerate for out of hospital care	280,000	0
Ensuring stability of the social care provider market:		
Maintain stability & capacity in social care provider market	1,465,000	1,865,000
	11,882,623	15,188,334
Total	**34,409,918**	**40,269,199**

Summary:		
Services commissioned by the CCG	14,010,736	14,813,145
LA contribution to F&B service	-362,650	-362,650
Services commissioned by the Council (paid by the CCG)	7,079,060	7,419,116
CCG Minimum Contribution	20,727,146	21,869,611
Services commissioned by the Council	1,437,499	1,551,147
LA contribution to F&B service	362,650	362,650
Winter Pressures	0	1,297,456
iBCF	11,882,623	15,188,334
LA Contribution	13,682,772	18,399,587
	34,409,918	**40,269,199**