Lewisham Better Care Fund/Improved Better Care Fund Plan 2023/24 and 2024/25

1. Executive Summary

1.1 Lewisham Health and Care Partners (LHCP) are committed to achieving a sustainable and accessible health and care system through which people can maintain and improve their physical and mental wellbeing, be supported to live independently and have access to high quality care when needed.

1.2 The schemes within the BCF plan continue to align with the aims of Lewisham's current Health and Wellbeing strategy:

- *To improve health – by providing a wide range of support and opportunities to help adults and children to keep fit and healthy and reduce preventable ill health.*
- *To improve care – by ensuring that services and support are of high quality and accessible to all those who need them, so that they can regain their best health and wellbeing and maintain their independence for as long as possible.*
- *To improve efficiency – by improving the way services are delivered; streamlining pathways; integrating services, ensuring that services provide good quality and value for money.*

and contribute significantly to the achievement of Lewisham Health and Care Partners' vision to make Community Based Care:

- *Proactive and Preventative – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need on the support, activities and opportunities available to maintain their own health and wellbeing and to manage their health and care more effectively;*
- *Accessible – By improving delivery and timely access when needed to planned and urgent health and care services in the right setting in the community, which meet the needs of our diverse population and address inequalities.*
- *Co-ordinated – so that people receive personalised health and care services which are coordinated around them, delivered closer to home, and which integrate physical and mental health and care services, helping them to live independently for as long as possible.*

1.3 During 2023/24, partners will continue to prioritise the integration of primary and community based care across the borough at a neighbourhood level and to identify and address inequalities in access, experience and outcomes.

1.4 The contribution of the BCF schemes to these priorities and overall aims has been significant in maintaining the activity and services which support prevention and early action. This includes augmenting our neighbourhood and multi-disciplinary working and delivering enhanced care and support. With the addition of Winter, Discharge and Disabled Facilities Grant funding, partners have worked together to develop plans which strengthen the provision to avoid admission to hospital, to facilitate timely discharge from hospital and to maintain people's independence at home.

1.5. A review of the schemes funded in 2022/23 has confirmed continued alignment of the schemes with the BCF conditions and the local health and care partnership's priorities. There has therefore been minimal change to the BCF schemes for 2023/24 and broadly retaining the levels of funding, with uplifts as appropriate, that were in place previously.

1.6 The BCF also continues to fund several enablers to system transformation including the borough's population health management system, which through the analysis of our integrated data provides better understanding of the health and care needs of our communities and creates new insights on our population needs. The integrated data enables more accurate modelling of services and pathways and allows us to drill down to target areas of inequality and high need.

2. Lewisham Context

Our Population

2.1 Lewisham currently has a population of 300,600. It is the 14th largest borough in London by population size and the 6th largest in Inner London. In the next five years our population is likely to rise to over 310,000 and to over 320,000 by 2032. 52.5% of the population are female; 23.5% are 0-19 years of age; 9.5% are aged 65 or over; and 67% are 20-64 years of age. The population of very young children aged 0 – 4 is larger in Lewisham than in England. We have a significantly younger population compared with national averages, with more people aged between 25 and 44. There is a smaller population of those aged 65+. However, it is thought our population growth won't be evenly spread across the ages and we will see an increase in the older population and a slight decrease in the younger population and working age population. Almost half (48.3%) of our population are from an ethnic minority community. Between 2011 and 2031 it has been projected that the size of the population of children and young people 0-19 in ethnic minorities will grow much faster than the rate of children from white ethnic groups

Health outcomes for our population

2.2 For female residents, Lewisham life expectancy (83.2 years) now exceeds the national average (83.1). However, for male residents, life expectancy is significantly lower (78.8) than the national average (79.4). The main cause of death in Lewisham is cancer (28%), followed by circulatory disease and respiratory problems. Lewisham has lower average mental health scores than London or England. Just over 8% of adults in Lewisham have a recorded diagnosis of depression. This is higher in than in London (7.1%). According to the 2020/2021 ONS Annual Population Survey, 29% of

Lewisham residents age 16+ reported high anxiety levels, compared to the London average of 24%, and 24% across England. We are seeing an increase in the complexity of need and those needing care and the number of people living with multiple health conditions is increasing.

Inequalities in our borough

2.3 Lewisham is the 63rd most deprived local authority in England and within the 20% most deprived local authorities in the country. Bellingham, Downham, Rushey Green and New Cross are the most deprived local wards in the borough. Lewisham's Black and Minority Ethnic communities are at greater risk from health conditions such as diabetes, hypertension and stroke. In addition, Black, Asian and Minority Ethnic populations have higher prevalence rates of some mental health conditions, including psychotic disorder and Post-Traumatic Stress Disorder (PTSD), and experience inequalities in access to services. In the borough, we also see late presentations of lung and colorectal cancers. Those in poorer health were disproportionately impacted by Covid. For some services, including the uptake of preventative healthcare such as health checks, immunisations and certain cancer screening, Lewisham is still to return to pre-pandemic levels. This is concerning in Lewisham, which even prior to COVID-19 was already seeing lower uptake and long-standing health inequalities such as notable differences in life expectancy depending on the area of the borough a resident lived.

2.4 In addition to existing data and evidence, it was recognised that Lewisham needed to better understand health inequalities, the reasons why they exist and to identify opportunities for action. Accordingly, the Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) set out to urgently reveal and explore the background to health inequalities experienced by Lewisham's Black African and Black Caribbean communities. Our response to the recommendations arising from the BLACHIR report can be found at section 10 of this plan.

3. Governance

Lewisham Health and Wellbeing Board

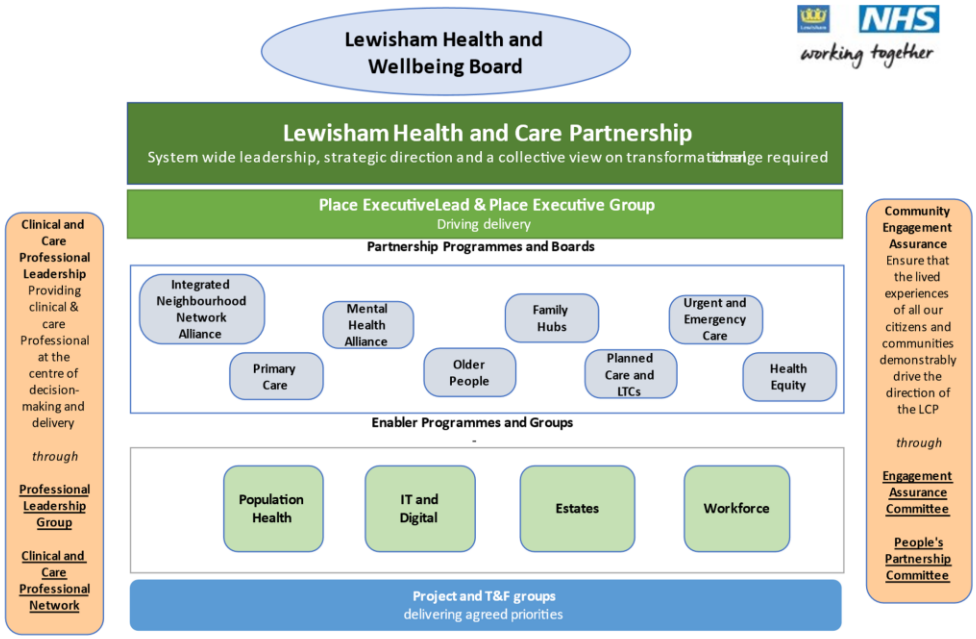
3.1 The Lewisham Health and Wellbeing Board is responsible for agreeing the Better Care Fund plan. The Plan will be presented to members of the Health and Wellbeing Board for formal approval on 18 July 2023.

The Local Health and Care Partnership (LHCP)

3.2 Lewisham has a strong history of partnership working. Lewisham's Health and Care Partnership brings together representatives from local organisations including the voluntary and community sector who are committed to working together to ensure that the people of Lewisham live happier and healthier lives. The partnership provides shared system wide leadership, sets the strategic direction for the transformation and integration of health and care, and provides a collective view on the priorities for a system wide focus. The Core members of the board are:

Local Care Partnership Place Executive Lead	Director of Public Health, LBL
Executive Director for Community Services (DASS), LBL	SLAM – Executive organisational representative
Executive Director for Children & Young People, LBL	LGT – Executive organisational representative
Healthwatch representative	Social care provider representative
Primary Care x 2 representatives (of which 1 is representative from PCNs)	VCSE representation x 2
Community/public representative	Clinical & Care Professional Lead
One Health Lewisham – Executive organisational representative	

3.3 The relationship between the Health and Wellbeing Board and the Lewisham Health and Care Partnership is shown in the governance structure below.



3.4 During 22/23, a review of Lewisham's programmes and partnership boards took place. Several new boards were established, and Terms of Reference updated where necessary. Reporting into the new statutory local care partnership –the Lewisham Health and Care Partnership - these programmes and boards co-ordinate the activity needed to meet BCF, local and national objectives and deliver the recommendations of the Fuller Stocktake.

3.5 Reporting into the LHCP, the Place Executive Group, which oversees delivery across the partnership, is further support by a new joint programme management approach. This offers a dynamic function which offers resource for project and programme management and delivery to all LHCP partners and provides LHCP with the assurance that high quality programmes are being delivered effectively and to

time/budget within Lewisham, relaying this assurance up the line to NHS England and others as required.

BCF S75 Agreement Management Group

3.6 In addition to the overarching governance arrangements shown above, the BCF arrangements are underpinned by pooled funding arrangements and governed by a section 75 agreement. Progress against planned BCF activity is assessed by the BCF S75 Agreement Management Group, comprising of senior representatives from SEL ICB (Lewisham) and the London Borough of Lewisham. The Board maintains an overview of BCF spend and monitors progress within scheme activity. The Group is responsible for establishing the overall controls which govern new investments and agrees variations to BCF/IBCF expenditure if necessary.

3.7 The BCF S75 Agreement Management Group receives finance reports showing expected spend against budget. Overspends require approval and are identified in advance via finance reports. Agreed financial risk management arrangements are set out in schedule 3 of the BCF S75 Agreement. The overarching principles governing these arrangements will remain in place for 2023/24 and 2024/25 and the S75 Agreement will be updated once the BCF Plan has been formally agreed. A contingency fund of c£400k has been earmarked within the expenditure plan which will be utilised if necessary to mitigate the financial risk associated with emergency activity above plan. Use of the contingency fund will be governed by the BCF S75 Agreement Management Group in accordance with schedule 3 of the BCF S75 Agreement.

3.8 The s75 Management Group ensures that the Better Care Fund and Improved Better Care Fund activity is aligned with other funded programme activity and that the contribution of the BCF/IBCF is maximised and achieves agreed objectives.

4. Lewisham's approach to integration

4.1 For many years, Lewisham's Health and Care Partners have provided shared system wide leadership and have set the strategic direction for integration and transformation to achieve the improvements required in health and care across Lewisham. The LHCP's Strategic Board receives regular reports on planned service improvement and integration activity to achieve better health and care outcomes and address health and care inequalities.

4.2 During our integration journey, our joint working has delivered agreed priorities for collaborative action underpinned by joint programme plans; established neighbourhood networks bringing together social care and community health teams on the same locality footprint to work alongside our primary care networks; and ensured strong health and care representation on our partnership alliances and programme boards.

4.3 In Spring 2023, partners approved Lewisham's Local Care Plan which sets out the direction of travel we will take together as a partnership and outlines the priority areas on which the partnership will focus over the next 1 – 5 years. The LHCP will use the priority areas to judge the success of its partnership working and to assess

how well it has achieved the improvement in health and care outcomes to which it has committed.

4.4 Our approach to integration sits alongside our approach to stakeholder engagement and Lewisham Health and Care Partners have engaged with stakeholders on service redesign, programmes and projects.

4.5 To further support delivery and to ensure our integrated services are co-designed, Lewisham has committed to a new model of engagement. The model will:

- Support local people to exercise power and contribute as equal partners.
- Build trust by acting on feedback and developing deeper relationships with local people.
- Reduce barriers to engagement (for example language barriers, resource barriers and cultural barriers).
- Work together to achieve more with what we have.

4.6 Our LHCP People's Partnership sits alongside and feeds into the broader structures of the Lewisham Health and Care Partnership (LHCP) bringing patient and citizen voices and lived experience into supporting our planning and delivery.

4.7 Though this engagement, stakeholders have reinforced our focus on the following:

1. The need to develop a truly integrated way of working across the local system and within neighbourhoods.
2. The need to take a broad lens to access and inequality to better understand what the drivers are and how to address them.

4.8 Partners recognise that the way in which they work together is critical to their success. LHCP members have therefore signed up to a set of guiding principles and shared behaviours. These principles guide the delivery of our plans and ensure that across the partnership, we are open and transparent, collaborative and constructive, and supportive to others in everything we do.

5. Joint/collaborative commissioning for adults

5.1 Lewisham has a long-established Adult Integrated Commissioning Team across the ICB (Lewisham) and local authority governed by section 75 agreements. The team is based within the local authority and covers the following areas:

- Adult Mental Health, Community Health Services and Autism
- Community Care and Support
- Complex Care, Continuing Health Care, Learning Disabilities
- Prevention, Inclusion and Public Health

5.2 As part of the Integrated Care System, the integrated commissioning team continues to work collaboratively with statutory, independent and voluntary and community sector providers. Working together they support the LHCP's aim to develop and deliver high quality, evidence based, outcome focused services which

meet the needs of our residents, and which deliver value for money for the whole health and care system. The team plays an important role in highlighting and challenging inequalities, giving particular focus on equalities assessments and analysis and operationalising the outcomes of the BLACHIR* report locally.

**For more information on BLACHIR see section 10.*

6. Funding Contributions

6.1 In 2023/24 the financial contribution to the BCF from SEL ICB (Lewisham) is £27,441,822 and in 24/25 will be £28,995,029. The financial contribution from the Council in 2023/24 and in 2024/25 is £773,989, in addition to the DFG contribution of £1,518,970 in both years. The IBCF grant to Lewisham Council has been pooled into the BCF and totals £14,941,703 in 2023/24 and in 2024/25.

6.2 The local authority discharge funding in 2023/24 is £2,094,804 and in the following year is indicatively £3,477,374. The ICB discharge funding allocated to Lewisham for 2023/24 is £1,590,552 and in 2024/25 will indicatively be £2,814,975 based on a weighted population split of current notified ICB core service allocations, which may change as part of 2024/25 planning. The total BCF pooled budget for 2023/24 is £48,361,839 and in 2024/25 will be £52,522,040 on this basis.

6.3 The financial contributions to the BCF have been agreed by the ICB and Council and agreed through the ICB's and Council's formal budget setting processes.

7. Implementing the BCF Policy Objectives

7.1 As in previous years, the BCF funding continues to support the achievement of the BCF Policy Objectives to:

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

7.2 The table below shows the schemes that receive funding from the BCF/IBCF and the expenditure allocated to those schemes for 2023/24. In aligning the BCF/IBCF schemes to the BCF objectives for 2023/24, the schemes also significantly contribute to the delivery of LHCP's vision for community-based care as set out earlier in this document.

Schemes	Areas of Expenditure	2023/24
Integrated Care Planning	Telephone Triage, Single Point of Access, Transition planning, Trusted Assessors, additional Winter Capacity for care planning	£5,824,617
Community Based Schemes	C'ty secondary Mental Health, Community Rehab and enablement, Medicine Optimisation	£10,489,784

Assistive Technologies	Equipment and Telecare	£2,031,828
Bed based intermediate care services	Intermediate care with reablement	£110,000
Prevention and Early Intervention	Community Falls Service Sail Connections Self-Management support Social Prescribing	£1,271,901
DFG	Adaptations to the home	£1,518,970
Residential placements	Extra Care Provision Transition support Maintaining level of mental health provision Residential care	£4,183,474
Personalised Care at Home	Neighbourhood Community Teams Primary care in community settings	£5,335,285
Home based intermediate care services	Reablement at home	£300,000
High Impact Change Model for Managing Transfer of Care	Social Care Delivery Hospital Discharge Provision Continuing Health Care Assessments Development of alternative care Home First and D2A Trusted assessors Discharge Support	£4,810,778
Enablers for integration	Population Health System Connect Care Integration programme and Alliance resource Contingency	£2,042,757
Carers services	Advice, information, and support	£623,363
Housing Related	Learning disability supported accommodation	£164,000
Home Care or Domiciliary care	Demographic growth Protection of current level of packages of care Market stability	£7,202,777
Care Act Implementation	Deprivation of Liberty Safeguards support	£900,000
Workforce recruitment and retention	Hospital discharge provision Arranging care	£1,552,306
Total BCF/IBCF/Discharge Fund		£48,361,839

7.3 Following the formation of the statutory local care partnership, which brought together representatives from local organisations and groups, the focus on the BCF objectives has been further strengthened by a re-scoping of our partnership programmes and the establishment of an integrated programme management approach. This integrated programme management approach provides Lewisham Health and Care Partners with the assurance that our partnership objectives are being delivered effectively and to time and budget.

7.4 In identifying their priorities for 23/24 and future years, LHC partners have committed to strengthening the integration of primary and community-based care and to working together in collaboration and with the communities they serve. Through our partnership work we want teams to work as close to the individual as possible and for services to be built around those individuals through integrated multi-disciplinary approaches with organisational barriers no longer getting in the way.

7.5 Sitting alongside our existing boards, including the Mental Health Alliance and the Urgent and Emergency Care Board, three new partnership boards have been established which oversee the work to deliver the partnership priorities and the BCF objectives. Through our **Integrated Neighbourhood Network Alliance (INNA) programme** we are building on existing work across the partnership to improve the delivery and integration of community-based care at a neighbourhood level and strengthening the model, infrastructure and approach required to deliver integrated neighbourhood working. The INNA programme brings together local partners from health and care as well as the voluntary and community sector. This work closely interfaces with two other key areas of work: **the Older People's Programme** which is developing the model of care for older people with an emphasis on proactive care; and the **Long Term Condition Management Group** to improve the management of care for people living with a long term condition and increase the ability of patients to self-manage and their access to the most appropriate services in a timely and safe manner.

7.6 The INNA programme ensures that staff in our neighbourhood services, funded by the BCF, work effectively together to deliver the following outcomes:

- Integrated and coordinated neighbourhood teams
- Personalised health and care services coordinated around population needs
- Improved local awareness of services available
- Established social prescribing networks that support the needs of the population
- Improved and timely referrals between services
- Effective multidisciplinary working/teams in place following best practice

7.7 Similarly, those involved in the Older People's Programme are establishing a model of care for older people which specifically addresses: Proactive Care, Admission Avoidance, Integrated Discharge and Intermediate Care for this cohort. The outcomes will contribute to:

- A reduction in unplanned admissions and attendances for Older People; and
- An increased proportion of Older Adults remaining at Home, resulting in a reduction in people moving into care homes

7.8 The BCF resourcing of community-based care services, in particular those services which interface with the hospital, including preventative services, urgent care and discharge services, will continue to be closely monitored to assess capacity, demand and effectiveness. The BCF funding which is available to respond to Winter pressures is overseen by a joint Urgent and Emergency Programme Board with representatives from acute, community and social care. Similarly, a partnership approach has been adopted to develop and agree the discharge funding plan.

7.9 The BCF continues to fund Lewisham's voluntary and community sector which supports residents to improve their health, wellbeing and social welfare by connecting them to community services run by local organisations. Through their work, the voluntary and community sector organisations address wider factors contributing to a person's health and wellbeing including social, mental, physical, financial, and environmental factors and aim to help people to live as well as possible. Social Prescribing is now well embedded in Primary Care and is provides proactive preventative support to maintain health and wellbeing. In addition to the work that the VCS undertakes in support of admission avoidance, we continue to fund the voluntary and community sector to support timely discharge from hospital. This includes continuation of funding to Age UK's Take Home and Settle service to reduce the likelihood of any deterioration once patients get home.

7.10 To further promote independence, in 2023/24, funding from the BCF will continue to support Lewisham's Assistive Technology provision (LinkLine) to help people to stay safely in their own homes. We are seeing an increase in referrals for this provision as we continue to build the use of assistive technology into preventative approaches including the planning for both admission avoidance and hospital discharge.

Population Health Management

7.11 Our focus on delivering the right care in the right place, and on keeping people safe and independent at home, is underpinned by good data analysis provided by Lewisham's integrated Population Health and Care Management system. This system, part funded by the BCF, brings together data feeds from partners across Lewisham including:

- Acute Trust data
- Community data
- Mental health data
- Primary care data

7.12 Using this integrated data, we can support individuals by identifying those who we believe are at risk of a particular illness or condition, or who appear to have a disease or condition but have not yet been diagnosed. This was evidenced to good effect in the Lewisham Frailty pilot which tested a model of proactive care for people aged over 65 with a moderate or severe frailty to provide better support for them to live well at home and to better identify and meet their health and care needs. These patients received a home visit with a comprehensive geriatric assessment and had their needs reviewed at a multi-disciplinary team meeting.

7.13 Our integrated data system is also used to support the planning of services by analysing the population more widely. Recently this has looked at the 'Vital 5' health characteristics which have the most direct impact on people's lives and wellbeing. By analysing how these affect the population in Lewisham, we can make evidence-based decisions and plan which services we and our partners across the borough should focus on for our population, now and in the future.

Lewisham's Home First approach

7.14 In Lewisham, system partners have been running a Home First improvement programme since May 2022. This approach has been co-designed by frontline staff, with patient input and includes representatives from primary care, acute, community health and adult social care. At present the programme is focusing on acute hospital discharges so has not yet included mental health practitioners although we are currently seeking a dementia specialist to advise acute discharge teams.

The programme focuses on three key areas:

(i) A one team approach: working seamlessly across organisational boundaries with residents in the centre

(ii) Embedding a Home First Ethos: we believe home is the best place for people to be enabled and to receive ongoing care

(iii) Early identification: working together to proactively identify people who will require ongoing care once discharged.

7.15 With support of the funding from the BCF/IBCF, to date the programme has reduced discharges to care homes by 30% over the last year, improved resident outcomes from our ICB by 30%, significantly improved staff satisfaction, and reduced 21+ length of stay by 10%. It is now in year two of delivery with improvement activity focused on therapies and care homes. As the number of discharges to care homes is relatively small, this significant improvement is not visible in the Discharge to Usual Place of Residence metrics.

Use of Additional Discharge Funding

7.16 The additional Discharge Funding is being used to improve the ability of adult social care and community health services to respond effectively to meet hospital discharge demand. Investment in 2023/24 will fund Trusted Assessors, Brokerage and Social work posts adding much needed capacity to teams and providing longer-term security and stability. This additional capacity also ensures that teams retain knowledge and system understanding and can plan activity in a systematic way.

7.17 These posts all support delivery of the High Impact Change Model including Trusted Assessment, Discharge 2 Assess capacity and MDT working. Further investment is directed at packages of care, residential placements and pathway 2 discharges to secure availability of step-down beds and meet the increasingly complex requirements of some people when they are discharged; including a growing number of double-handed discharges and people requiring 1:1 care. This work ensures that home is the primary discharge location. Finally, investment is being put into securing additional therapies resource to support the double-handed discharges into a person's own home and to ensure that everyone who has the ability to benefit from reablement is given the chance to do so. These investments are part of the Home First approach in Lewisham and will help to meet the ministerial priority of continuing to reduce delayed discharges for Lewisham and bring about sustained improvements in outcomes for people discharged.

Rationale for Capacity and Demand Plan

7.18 The Capacity and Demand plan uses 22/23 SitRep discharge data from SEL acute providers to provide a projection of anticipated demand for 23/24 for pathways 1,2 & 3 for hospital discharge. Pathway 0 discharge support from the voluntary sector is the Take Home and Settle service which directly supports discharges. While last year we reported on a wider range of vol sector services, many of these contributed to a wider range of outcomes in addition to hospital discharge so this year following consultation we have agreed to take these numbers out.

7.19 The discharge numbers for Lewisham patients are split across the Trusts based on the SitRep data.

7.20 SitRep returns do not currently include MH data and we are therefore seeking to develop our understanding of MH demand and capacity separately in discussion with SLaM.

7.21 The community demand projection is based on service-level data using actuals from the first three months of this year. Referrals into enablement from the community have more than doubled since last year but the number of referrals remains relatively low and therefore manageable within current capacity.

7.22 During the winter of 22/23, care home capacity was under severe strain which significantly affected timely discharges to care homes., We developed a number of approaches to mitigate against this including: (i) Winter Pressures funding to provide additional staff in the brokerage team – agreement has been given to fund these posts recurrently through the Discharge Fund which will provide longer term security; (ii) The Home First programme, alongside other improvement work has been focusing on ensuring as many people as possible can go home with appropriate support. Interventions including MDT reviews of patients prior to discharge, weekly ward rounds to proactively identify complex cases, the piloting of an MDT therapy-led team to re-able people with more complex needs requiring double-handed packages of care, have resulted in a reduction in new care home placements from hospital by 30%. The therapy-led MDT team is now being funded from the new Discharge Fund element of the BCF.

7.23 Care Home placements are now being made more quickly, thus reducing the number of delayed discharges, although this could also be as a result of reduced demand from those people privately seeking placements.

7.24 Intermediate bedded care has also seen a major change in terms of demand since last year. This outstripped capacity on average by 10% last year, creating waits in hospital. Part of the Home First programme has been to improve LOS and patient outcomes at the intermediate bedded unit, Brymore, and LOS has now reduced from an average of 82 days to 30. This faster flow through the Intermediate Care Bedded Unit has led to regular vacancies in the Unit as well as improved functional outcomes for the patients, and capacity now adequately meets demand for this service.

7.25 Referral patterns increased marginally in winter months but across the year are relatively stable.

8. Supporting Unpaid Carers

8.1 Data from the Office for National Statistics shows 19,957 people in Lewisham were looking after someone without being paid when the census was carried out in March 2021. Of these, 9,890 people were providing more than 20 hours of unpaid care a week in 2021, including 5,133 people doing so for more than 50 hours a week.

8.2 With the BCF funding, Lewisham has recently procured a Maximising Wellbeing of Unpaid Carer service. This service, which has been developed and procured in collaboration with unpaid carers, will maximise the wellbeing of unpaid carers by identifying, valuing and supporting them. The service will support them in their caring role by enabling them to:

- Have access to information, advice and guidance
- Have access to joined up services
- Have a life of their own
- Have support to stay mentally and physically well
- Promote their financial wellbeing.
- Have a voice about services for their cared-for person and for themselves

8.3 The new service has seven core elements and will go live in July 2023. These elements include:

- Lewisham Unpaid Carer Hub and Spoke model
- Unpaid Carer Primary Care Coordinator
- Young Carer Schools Facilitator
- Championing Unpaid Carers Lead
- Wellbeing Carer Coordinators
- Unpaid Carer Activities Coordinator
- Access to Specialist Wellbeing coaches

9. Disabled Facilities Grant (DFG) and wider services

9.1 The suitability and quality of a home can have a substantial impact on people's lives. The Council, as a member of the LHCP, recognises that there are many households who are unable to maintain their homes because of age, disability or lack of resources.
The link between poor health and poor housing conditions is well known and addressing housing conditions can help people improve their health and wellbeing.

9.2 In funding adaptations to homes and assisting residents with their access and mobility in their homes, the DFG plays an important part in helping people to live independently for as long as possible. Lewisham Council's contribution to the BCF includes the DFG allocation of £1,518,970 in both 2023/24 and 2024/25.

9.3 Lewisham is undertaking an end-to-end process review to bring our HIA processes in line with the updated DFG delivery guidance. Lewisham's revised

Housing Improvement Policy was also approved by the Council's Housing Select Committee in June 2023. Last financial year (22/23) the Council was underspent on its DFG allocation by just under £200k, due to a combination of staffing and supply-chain issues.

9.4 To improve out outturn in 2023/24, Lewisham has revised its policy to increase our means-testing threshold, maximise eligibility and introduced a new hospital prevention and discharge grant. The aforementioned process review is expected to drive significantly improved outcomes in terms of spend. This will be completed by the middle of this financial year (2023/24).

9.5 Lewisham is also building on its existing Health and Housing Coordinator programme, having recently recruited a new sickle cell and long-term conditions lead, which will help to eliminate health and social inequalities and bridge the gap between health and housing. Through our internal and external partnership working we aim to maximise the supply of adaptable properties through the empty homes route, the landlord DFG route, as well as scoping a project to fund adaptations through the DFG to a bank of properties for PRS discharge.

9.6 This work is expected to drive efficiencies, increase referrals and numbers of completed adaptations. However the impacts of inflation, supply chain issues and staffing challenges will continue to be a challenge. Therefore, while Lewisham expects to spend its full allocation this year and the equivalent amount in 24/25 the expected outputs in terms of numbers of adaptations have been adjusted accordingly.

9.7 As a result, Lewisham is confident in being able to spend its full allocation in 2023/24 and in subsequent financial years delivering 65 adaptations per year.

10. Equality and health inequalities

10.1 The Birmingham and Lewisham African Caribbean Health Inequalities Review (BLACHIR) has been a two year partnership between Lewisham Council and Birmingham City Council, to gather insights on health inequalities within Black African and Caribbean communities in Birmingham and Lewisham.

10.2 Seven key themes have been outlined alongside 39 opportunities for action. The seven key themes are:

- Fairness, inclusion and respect
- Trust and transparency
- Better data
- Early interventions
- Health checks and campaigns
- Healthier behaviours
- Health literacy

10.3 The 39 opportunities for action are practical opportunities for action to address systemic inequalities with the ambition of breaking decades of inequality in sustainable ways that will lead to a better future for residents. All 39 of these opportunities for

action have been mapped to current or planned activity across the Lewisham Health and Care Partnership providing ownership and a clear plan as to how they will be implemented to reduce health inequalities in Lewisham.

10.4 A detailed implementation process has been co-developed and formally initiated at a wider stakeholder engagement event as part of the BLACHIR report launch in June 2022. The Lewisham Health Inequalities and Health Equity Programme 2022 – 24, approved by the Lewisham Health and Wellbeing Board in March 2022, is the vehicle for delivery of the opportunities for action identified in the BLACHIR report.

10.5 The Lewisham Health Inequalities and Health Equity Programme 2022-24 aims to strengthen local health & wellbeing partnerships across the system and communities to enable equitable access, experience and outcomes for Lewisham residents, particularly those from Black and other racially minoritised communities.

10.6 The key objectives of the Programme are:

- System leadership, understanding, action and accountability for health equity
- Empowered communities at the heart of decision making and delivery
- Identifying and scaling-up what works
- Establish foundation for new Lewisham Health and Wellbeing Strategy
- Prioritisation and implementation of specific opportunities for action from BLACHIR

10.7 The Programme has eight concurrent and intersecting workstreams:

1) Equitable preventative, community and acute physical and mental health services
   Aim: To design, test and scale up new models of service provision that achieve equitable access, experience and outcomes for all
2) Health Equity Teams
   Aim: To create place-based teams to provide leadership for system change and community-led action
3) Community Development
   Aim: To develop infrastructure to empower communities and delivery community-led service design and delivery
4) Community of Practice
   Aim: To share synergies across Health Equity Teams, workforces and communities
5) Workforce Toolbox
   Aim: To increase awareness and capacity for health equity within practice
6) Maximising Data
   Aim: To maximise the use of data, including Population Health platform, to understand and take action on health inequalities
7) Evaluation
   Aim: To evaluate within and across programme to identify what does and doesn't work towards achieving vision
8) Programme Enablement and Oversight
   Aim: To support, coordinate and oversee the Programme across Lewisham.

10.8 Within these workstreams, in particular workstreams one, two and three, are multiple, targeted projects aimed at addressing a number of specific health inequalities that the local population face. Over the last year the Programme, and the projects

within it, have been established, co-designed, initiated and progressed into their current delivery phase. As such, the outcomes achieved will be monitored and reported on over the next year with a full academic evaluation to be completed in the first half of 2024.

10.9 The Programme adopts a keen focus on data as seen in workstream six which underpins the entirety of the Programme. As part of our internal monitoring, we require project leads to report how they are effectively adopting population health management approaches and tools such as the Core20PLUS5. All projects within the Programme engage in these approaches and tools and use them to inform their project design and delivery to reduce health inequalities in Lewisham.

10.10 Where appropriate, the services and activity funded by the BCF/IBCF will implement this approach and be reviewed to monitor impact, particularly on how activity is addressing health inequalities.

11. Conclusion

11.1 The schemes funded through the Better Care Fund and Improved Better Care Fund in 2023/24 and planned spend for 2024/25 have not changed significantly from those which received funding in 2022/23. However, all schemes, including those now funded via the Additional Discharge Funding, continue to support and deliver against the BCF objectives, the priority areas identified by Lewisham Health and Care Partners, and contribute to the achievement of better health and care outcomes overall.