Lewisham Better Care Fund/Improved Better Care Fund Plan 2021/22

Executive Summary

The continued ambition of Lewisham Health and Care Partners is to create a strong, sustainable, and accessible health and care system across the borough which supports people of all ages to maintain and improve their physical and mental wellbeing; to live independently; and which enables people to access high quality care when needed. A key element of this aim is to deliver care in our communities which is proactive, joined up, cost-effective, and prevents ill-health and promotes wellbeing. In addition, across all parts of the system, partners are committed to addressing the existing health and care inequalities which have been exacerbated by Covid19.

During 2021/22, the BCF will continue to fund activity which supports the LHCP's agreed key priority areas and the recovery of the local health and care system. Reflecting on the activity that took place during 2020/21, this year's BCF will support the stabilisation and recovery of services as well as support further integration and transformation work, building on the positive changes implemented across the system during that time.

In reviewing the BCF for 2021/22, partners agreed that there should be minimal change to the BCF allocations, retaining the schemes and levels of funding that were in place in 2020/21. Accordingly, those services which were funded from the BCF in 2020/21 will continue to receive funding through the BCF in 2021/22.

The BCF continues to provide resources for many key services which report into the Care at Home Alliance and the Mental Health Alliance. The focus of the Alliance work is to oversee activity which maintains independence and wellbeing in the community, supports admission avoidance and avoids crisis, and which improves hospital discharge. The BCF will also continue to support the enablers to system transformation including the borough's population health management system, which has been instrumental in providing better understanding the health and care needs of our communities, creating new insights on our population needs, enabling more accurate modelling of services and pathways and enabling us to drill down to target areas of inequality and high need.

In summary, the 2021/22 plan will continue to fund activity in the following areas:

- Prevention and Early Action
- Community based care and Neighbourhood Networks
- Enhanced Care and Support
- Population Health and IT

Lewisham Context

Lewisham has a population of 305,300 people. The borough is densely populated and has the 6th highest rate of household overcrowding in London. Nearly 10% of households in the borough are classed as overcrowded. Although the borough has a relatively young population profile, about 70% of the borough's population is of working age (16-64), whilst older residents, aged 65+, make up about 10%.

Lewisham is within the 20% most deprived Local Authorities in England (Indices for Multiple Deprivation,2019, DCLG). Within London, Lewisham is ranked the 7th most deprived borough (DCLG, 2019). Whilst Lewisham was less deprived in 2019 compared to 2015, concentrations of deprivation in the north and south of the borough remain comparatively high (Indices for Multiple Deprivation,2019, DCLG) .

Lewisham has an ethnically diverse population. By 2031 it is forecast that the overall White and Black and Minority Ethnic population of Lewisham will be 50/50 (Ethnic Group Population Projections GLA). The percentage of 0-19s of Black and Minority Ethnic heritage has remained at or marginally above 65% since 2011. By 2031 the proportion of BME residents aged 0-19 is projected to reach 67% (2016 Round Ethnic Group Population Projections, GLA).

Lewisham Health and Wellbeing Board

The Lewisham Health and Wellbeing Board is responsible for agreeing the Better Care Fund plan and, in September 2021, a report was presented to members outlining the Better Care Fund planning arrangements for 21/22 – see following link. https://councilmeetings.lewisham.gov.uk/documents/s86180/BCF%20Plan%202021-22%20-%20HWB%20September%202021%20FINAL%202.pdf

The report provided members of the Health and Wellbeing Board with an update on the development of Lewisham's Better Care Fund (BCF) plan for 2021/22, which also includes activity funded by the Improved Better Care Fund (IBCF). Members were asked to note the current position and agreed to receive the BCF 2021/22 plan for formal sign off at their next meeting in December 2021.

Partnership Working in Lewisham

Lewisham has a strong history of partnership working. Health and care is delivered and supported by a wide range of organisations and partners working together across the borough. Since the start of the pandemic, partners have continued to show the value of these strong relationships as evidenced by the joint working between our statutory services, our voluntary and community sector, and with the communities we serve.

Members of the Lewisham Health and Care Partnership (LHCP) includes representatives from:

Lewisham and Greenwich NHS Trust (LGT)

London Borough of Lewisham (LBL)

NHS South East London (Lewisham) Clinical Commissioning Group (SELCCG)

One Health Lewisham (Pan-Lewisham GP Federation)

South London and Maudsley NHS Foundation Trust (SLaM)

Primary Care Networks

Voluntary and Community Sector

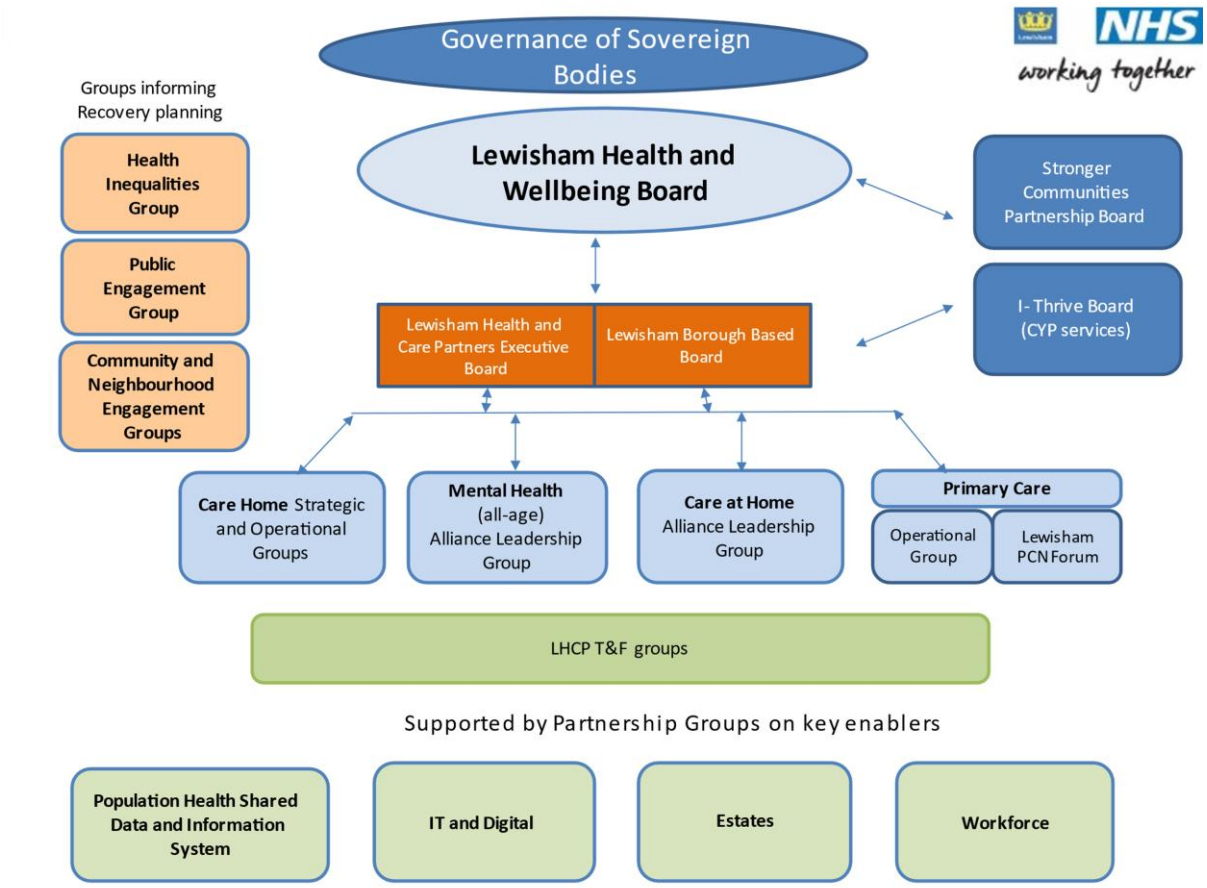
Since the beginning of 2020, the LHCP and the Lewisham Borough Based Board (LBBB) have held monthly joint meetings to ensure strategies and planning are aligned, to identify and address system barriers and challenges, and to share key information. The alignment of the LHCP and LBBB meetings enabled further representation from primary care and Healthwatch and introduced a lay member to the partnership. Throughout 2021/22 these boards continue to provide shared system wide leadership, set the strategic direction for integration and transformation of health and care, and provide a collective view on the priorities for a system wide focus.

As set out in its terms of reference, members of the LHCP Executive Board work collaboratively on the development and delivery of health and care across the whole system to promote and deliver integrated and holistic care and are also responsible for the delivery of One Public Estate (OPE). To ensure that the strategic direction is coherent and is adopted by all parts of the system, members engage with their respective governing bodies and the local political leadership to keep them appropriately engaged, informed and able to influence and participate.

LHCP continue to recognise the importance of housing in the maintenance and support of health and wellbeing. This is evidenced by the continued close working with housing partners to support hospital discharge for example, addressing hoarding, providing deep cleans and securing housing tenure. Voluntary and community partners who work with housing also support tenants with rent arrears and tenancy issues.

To further ensure alignment of activities across the system, the LHCP Executive Board has established several sub-committees and steering groups as shown below. These include partnership groups with responsibility for the Population Health Management System, Estates, Workforce and IT. These groups work closely with the two main partnership alliances for *Care at Home* and *Mental Health*.

The structure of Lewisham Health and Care Boards is shown below:



Members of the Lewisham Health and Care Partnership also ensure that key reorganisation or redesign plans developed by individual partner organisations, such as the Council's review of adult social care or the redevelopment of estates, are shared with board members to ensure coherence with the overall direction of travel.

BCF S75 Agreement Management Group

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 regularly assessed by the BCF S75 Agreement Management Group, comprising of senior representatives from SEL CCG (Lewisham) and the London Borough of Lewisham. The Board meets regularly to maintain 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.

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 2021/22 and the S75 Agreement will be updated once the BCF Plan has been formally agreed. A contingency fund of £342k

has been earmarked within the expenditure plan which will be utilised if necessary to mitigate the financial risk associated with emergency activity above plan. Similarly, a contingency fund of £161k has been allocated from the IBCF to mitigate against unforeseen adult social care demand. 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.

Lewisham's approach to integration

The Lewisham Health and Care Partnership Executive Board provides shared leadership in setting the strategic direction for health and care developments. The Board oversees the changes required to achieve better health and care outcomes and to reduce inequalities across Lewisham. In 2021/22, this activity is focused on the following priority areas:

<table>
<tr><td colspan="5">Addressing Inequalities
addressing inequalities and disparities in risks and outcomes, including a specific focus on our BAME communities and staff.</td></tr>
<tr><td>Care Homes
supporting care homes locally including co-ordinated support and safeguarding of all residents and staff</td><td>Prevention
restarting services reduced or put on hold during lockdown with a focus on addressing inequalities</td><td>Planned Care
including proactive immunisations, cancer screening, Long Term Conditions support and management, postnatal and health checks</td><td>Building Community Resilience
recognising individual strength, knowledge and skills to ensure people have more control and a greater voice</td><td rowspan="2">Children, Young People & Families
catch-up immunisations, screening and weight management, mental health support and support to schools
implementation of the i-Thrive model across early help and emotional health services to develop a common language and enable better access to services, creating improved family resilience</td></tr>
<tr><td>Frailty
understanding and mapping mild, moderate and severe frailty, links to other conditions, and how best to provide more responsive care</td><td>Diabetes
including patients with undiagnosed diabetes, at risk of developing diabetes and with gestational diabetes</td><td>Respiratory
integrated respiratory community hubs, review of Lung Education Exercise Programme (LEEP), and implementation of multi-disciplinary working for respiratory patients</td><td>Mental Health
Front Door & Rapid Crisis Response, Community Support, Rehabilitation & Complex Care, including addressing inequalities and improving outcomes for BAME communities</td></tr>
<tr><td colspan="4">Safeguarding our communities and those who support them
mitigating and managing the risks of a "second surge" of Covid-19 in Lewisham, including Test and Trace, Shielding, "Covid-19 Secure" services</td></tr>
</table>

In 2019/20, LHCP established two provider alliances which report into the LHCP and LBBB: the Care at Home alliance and the Mental Health alliance. The former brings together local health and care organisations to develop integrated provider arrangements to deliver care and support for adults in their own homes, improving the co-ordination, quality and accessibility of that care and support. Similarly, the Mental Health Alliance seeks to provide working age adults with a personalised approach to their treatment, care and support needs, based on the identification of assets and strengths, and facilitating the achievement of personal goals. The group's remit was expanded during 2020/21 to include Children's Mental Health and Older Adult Mental Health.

The BCF schemes agreed for 2020/21 contribute to the alliances' plans and the priority areas identified by the LHCP. The schemes underpin LHCP's vision for community based care which is:

> **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, 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. This includes raising awareness of the range of health and care services available and increasing access to community health services and early intervention support.
>
> **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.

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 Unplanned Care Board with representatives from acute, community and social care.

Health Inequalities

Lewisham's Health and Wellbeing Board, supported by health and care partners, remains committed to tackling health inequalities, particularly the health inequalities of Black, Asian and Minority Ethnic communities who are at greater risk from health conditions such as diabetes, hypertension and stroke.

Life Expectancy - For male residents, life expectancy is significantly lower than the national average (ONS, 2017-19). There are big variations in life expectancy throughout the borough: men in Crofton Park ward can expect to live for 6 years longer than those in New Cross ward, and women in Perry Vale ward can be expected to live 8.5 years more than women in New Cross ward.

Cardiovascular and respiratory diseases - The rate of premature death from cardiovascular and respiratory diseases in Lewisham are higher than the average for London and England.

Smoking and Obesity (adults) - Smoking and obesity contribute significantly to premature mortality and morbidity in Lewisham. These health risks are also strongly linked with poor COVID-19 outcomes. Lewisham has a higher proportion of smokers and higher levels of adult obesity than most areas in London.

Diabetes - Diabetes is also a known risk factor for COVID-19 outcomes. Nearly 1 in 10 people in Lewisham are estimated to have diabetes (T1 & T2, including those currently undiagnosed). 58% of our population with type 2 diabetes are estimated to be of ethnic minority origin.

Mental Health – Lewisham is one of the most ethnically diverse areas of the country, with 46% of the total population from BAME heritage. This percentage differs with age as over 65% of 0–19-year-olds are from BAME heritage. In Lewisham, there is an overrepresentation of people from BAME heritage in crisis acute adult mental health services, with an underrepresentation in Primary Care Mental Health Services and IAPT.

Long term conditions - 14.5% of residents are living with a long-term condition which limits their daily activities (Proxy question for disability 2011 Census)

The COVID-19 pandemic highlighted and exacerbated the health inequalities across the population (socio-economic, ethnic, socially excluded and vulnerable). Since March 2020, Lewisham Health and Care Partners have recognised the direct impact of COVID-19 on both physical and mental health.

Consequently, Lewisham is working in partnership with public health teams across South East London and colleagues in Kings Health Partnership on an in depth analysis of inequalities across SEL. An evidence review of interventions known to effectively tackle inequalities is also being undertaken. This will provide a detailed profile of the impact of COVID-19 and a menu of options to incorporate into recovery plans. The BCF schemes will also be reviewed to consider those options.

Lewisham Borough and Birmingham City Councils are also undertaking ground-breaking work into the health inequalities of African & Caribbean communities. The

programme, which will conclude in February/March 2021, consists of a series of reviews which aim to explore in-depth the inequalities experienced by these ethnic groups and their drivers. The review topics include mental health and wellbeing and chronic health, amongst others. The aim is to find approaches to break the decades of inequality in sustainable ways that will lead to better futures for local citizens.

The pandemic also highlighted the need for and the effectiveness of targeted listening and working with disadvantaged individuals and communities to co-create community centred approaches that use lived experience expertise and community assets to develop and deliver sustainable approaches.

To further support Lewisham's focus on reducing health inequalities, a Health Inequalities Toolkit and Health Inequalities Summit are being developed. The Health Inequalities Toolkit will provide a data overview of existing health inequalities Lewisham. The aim of this toolkit is to present data in a user-friendly format that can be used by community members and inform data insights for the joint work with Birmingham. Health Inequalities Toolkit_270821.pdf (lewisham.gov.uk)

Funding Contributions

In 2021/22 the financial contribution to the BCF from the CCG is £24,580,557. The financial contribution from the Council in 2021/22 is £773,989, in addition to the DFG contribution of £1,518,970. The IBCF grant to Lewisham Council has been pooled into the BCF and totals £14,502,373. The total BCF pooled budget for 2021/22 is £41,375,889.

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

The table below shows the areas of expenditure within the BCF and IBCF plan for 2021/22

Scheme and ref numbers	Areas of Expenditure	2021/22
Integrated Care Planning and Navigation -1,7,14,31,41	Telephone Triage, Single Point of Access, Transition planning, additional Winter Capacity for care planning	£5,247,028
Community Based Schemes - 2,10,12,13,19,36	Extended primary care and urgent care access, Medicine Optimisation and Enablement	£11,071,754
Assistive Technologies – 3,40	Equipment and Telecare	£996,082
Prevention and Early Intervention	Community Falls Service Sail Connections	£1,151,529

-4,5,6,44,47	Self-Management support Social Prescribing	
DFG -11	Adaptations to the home	£1,518,970
Residential placements -15,26,30	Extra Care Provision Transition support Maintaining level of mental health provision	£4,082,162
Personalised Care at Home – 8,9	Neighbourhood Community Teams	£4,188,174
High Impact Change Model for Managing Transfer of Care - 16,17,18,27,33,34,48,49	Social Care Delivery Hospital Discharge Provision Continuing Health Care Assessments Home First and D2A Trusted assessors	£4,402,507
Enablers for integration - 21,22,23,42	Population Health System Connect Care Integration programme and Alliance resource	£1,194,306
Carers services - 24	Advice, information and support	£558,456
Contingency (BCF/IBCF) - 25,37	To meet activity above plan	£502,972
Housing Related - 28,29	Learning disability supported accommodation	£164,000
Home Care or Domiciliary care - 32,35,38,39	Demographic growth Protection of current level of packages of care Local Care Market Stability	£5,397,949
Care Act Implementation - 45	Deprivation of Liberty Safeguards support	£900,000
Total BCF/IBCF		£41,375,889

NOTE: Schemes 20, 43 and 46 which appeared in the 19/20 plan have been deleted. These schemes totalled just under £180k and provided initial resources to support the development of the Waldron as a neighbourhood hub (£60k), and resources to support the development of the provider alliances (£120k) which have now been established and which are now supported by Lewisham's system transformation team and integrated commissioning team. This funding has been reallocated across other schemes.

Metrics

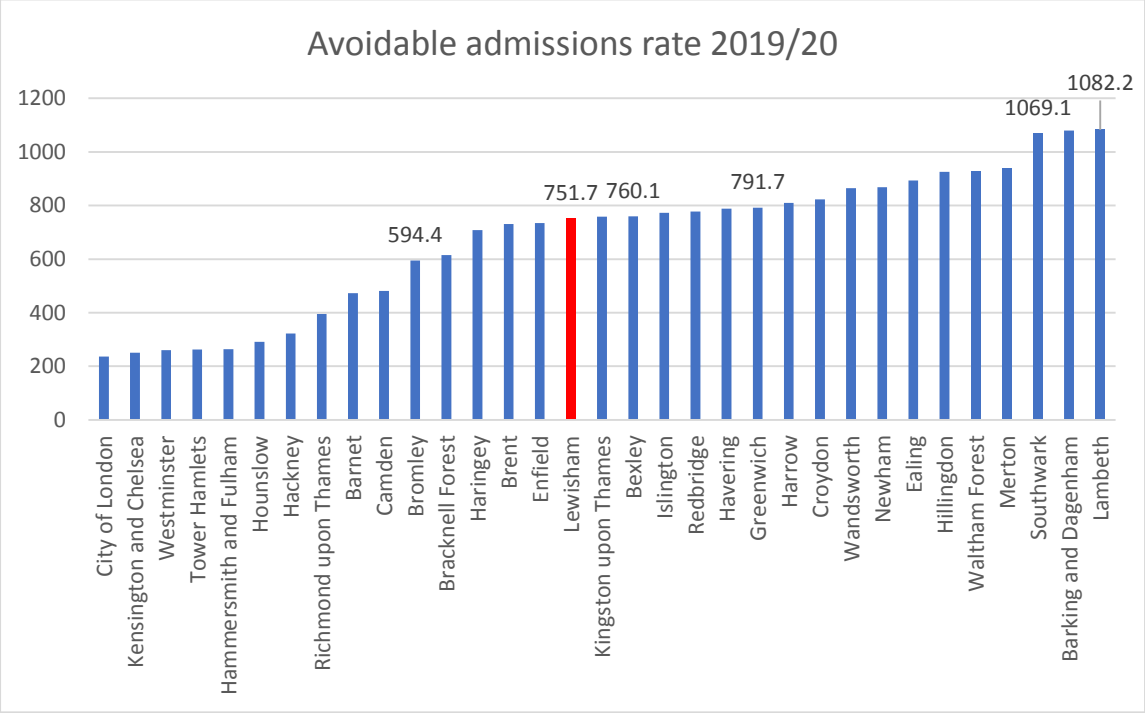
The Delayed Transfers of Care metric was suspended in March 2020 and for 2021/22 has been replaced with two new metrics:

1. reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days
2. improving the proportion of people discharged home using data on discharge to their usual place of residence

In addition, the BCF reports against previous metrics for admission avoidance, residential admissions and re-enablement.

21-22 plans for Metrics

<u>Avoidable admissions</u>



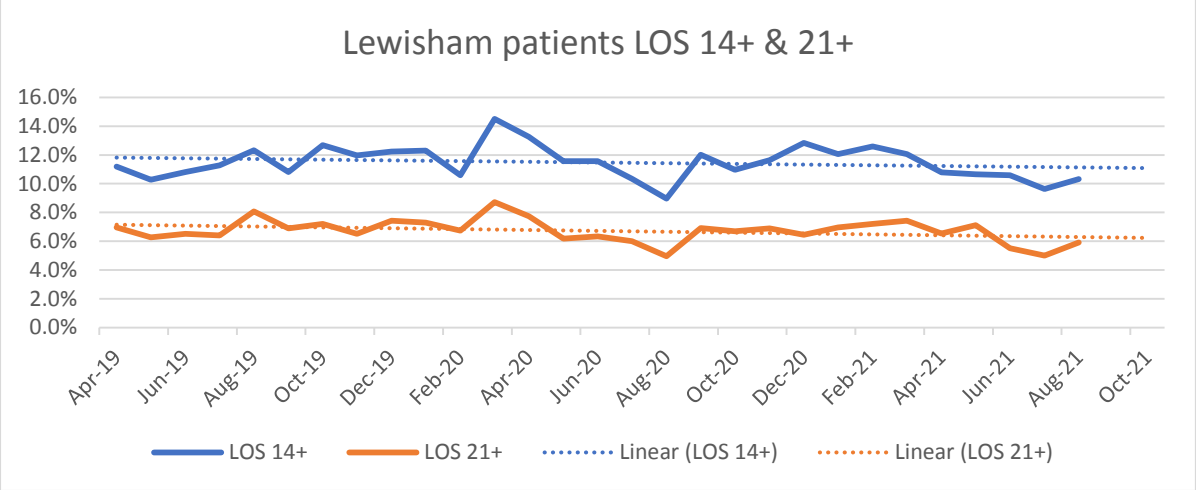
Lewisham's BCF plan uses data from 2019/20 which has made it difficult to assess a predicted reduction for 2021/22. The 2020/21 data will be reviewed as soon as possible.

In terms of local challenges, there are increased attendances to A&E following the COVID spikes, in part caused by high numbers of NHS 111 referrals to A&E. Use of 111 is almost double this year compared to last, and the algorithm used by 111 results in high numbers attending A&E, with proportionately higher numbers being admitted as a result. This issue is being addressed at regional and national levels. Lewisham's Urgent Community Response service (UCR) is continuing to expand. However started from a small baseline which led initially to fewer early interventions in the community than other neighbouring boroughs which have more well-established UCRs. Locally, due to COVID, a focus on developing a more proactive and comprehensive Frailty pathway had to be put on hold, although this work has now re-started. However, this

work is being taken forward initially as a pilot which therefore will pro-actively target only small numbers of people with frailty until the model is fully tested.

Through the local Discharge Improvement Plan and implementation of the EHCH work, there is a range of targeted work being undertaken locally to reduce avoidable admissions. This includes a focus on reducing admissions from care homes and the community through closer working links between the GP Home Visiting Service and the UCR to ensure that appropriate referrals are made swiftly to the UCR. In addition, early work is in place to improve step-up referrals to the Enablement team, and additional capacity has been provided for therapies, to ensure that there is earlier intervention from a therapist in the community when needed. Given this work, a reduction from 751 in 2019/20 to 735 for 2021/22 is proposed. This is a reduction of 16 (or 2%) since 2020 which is considered realistic.

Lengths of Stay (LOS)



- Actuals for Lewisham for 2021/22 Q1 & 2 for 21+ LOS was an average of 6.0%. This position is a major improvement on the same period in the previous two years, which were respectively 6.9% (19/20) and 6.4% (20/21).
- Actuals for Lewisham for 2021/22 Q1 & 2 for 14+ LOS was an average of 10.5%. This position is a major improvement on the same period in the previous two years, which were respectively 11.1% (19/20) and 11.3% (20/21).

Expected pressures on the system includes unusually high ED attendances for this time of year. COVID rates are increasing nationally, and we also expect severe winter weather.

Lewisham has particularly long length of stay compared to other neighbouring hospitals as it is a stroke hospital, with challenges in discharging long-stay patients with serious neurological conditions to other specialist centres.

However, there is focused work ongoing to improve flow both within the hospital and in the community, which includes:

- Ward-based pilot to improve pre-discharge planning (currently expanded from one ward to two)
- Recruitment of ward-based navigators expected by December
- Discharge Improvement plan being delivered, with improved processes for discharge implemented
- Community capacity bolstered (enablement & therapies) and further expansion of Enhanced Care provision
- Weekly Length of Stay escalation meetings with senior leadership.

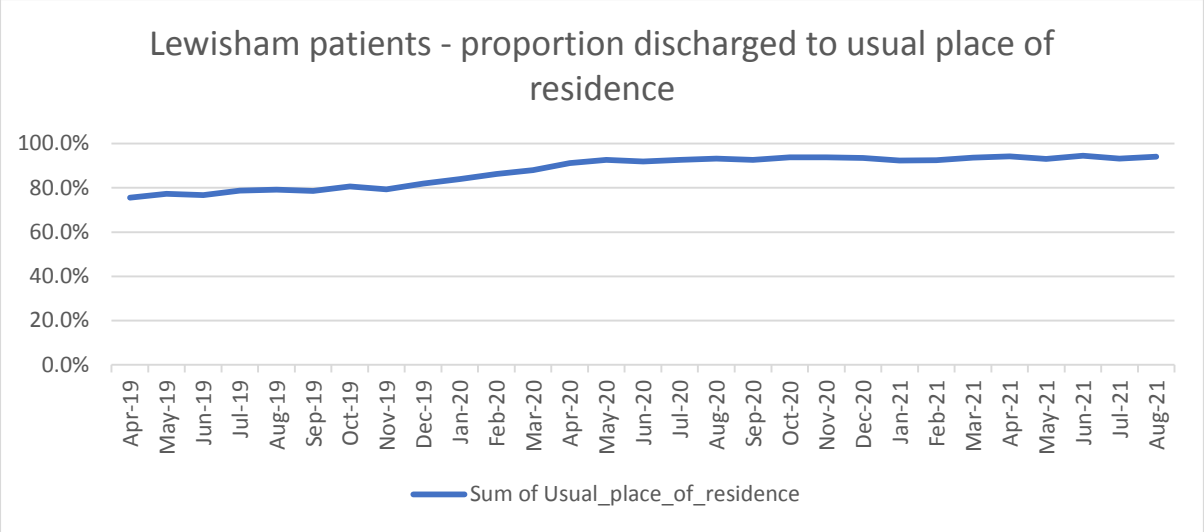
The expected additional winter pressures will be mitigated by the improvement activity already underway. Given the last 18 months' of improvement, we can expect a continued gradual improvement in performance.

The forecasts proposed by the BCF team for Lewisham in Q3&4 for 21+ LOS are 6.1% and 6.0%. This appears achievable based on good progress made in reducing LOS 21+ over the last two years. While this still puts Lewisham above national and regional averages, it is an improvement on previous years and has been agreed by Lewisham and Greenwich NHS Trust based on ongoing activity being undertaken to reduce LOS.

The forecasts proposed by the BCF team for Lewisham in Q3&4 for 14+ LOS are 10.9% and 10.8%. This appears achievable based on the good progress made in reducing LOS 14+ over the last two years. This puts Lewisham in a better position than national and regional averages. It is an improvement on previous years and has been agreed by Lewisham and Greenwich NHS Trust based on ongoing activity being undertaken to reduce LOS.

Plans for reducing LOS have been agreed by Lewisham and Greenwich NHS Trust and HWB partners. These plans have been developed and led by the Care at Home Alliance Leadership Group and the Unplanned Care Board. Both these boards include representation from all Lewisham health and care system partners.

Discharge to normal place of residence



Actuals for Lewisham's last two quarters show averages of 80.5% and 92.8% .

Work is ongoing to improve patients being discharged to their usual place of residence and includes:

- Screening of all Pathway 3 discharges
- Community capacity bolstered (enablement & therapies) and further expansion of Enhanced Care provision

An improvement can be expected given the local focus on discharge processes currently taking place. The latest month's performance given is 94%. Lewisham has a higher proportion of care home residents than many other boroughs. Some level of improvement is achievable but the baseline position means many patients will be discharged back to their existing care home via Pathway 3. An improvement of 0.5% given the impact of ongoing improvement work is considered reasonable and a target of 94.5% has been agreed by Lewisham and Greenwich NHS Trust in agreement with HWB partners.

Number of Care Home admissions per 100,000

Due to COVID, high numbers of people entered care homes in 2020/21, and therefore Lewisham has started in a worse position for 2021/22 than expected. As set out above, work is ongoing to reduce the number of people entering care homes and investment this year is being focused on providing more intensive care packages to help people return home and remain more independent, and on increasing the use of step-down facilities from hospital. The Council has set a target of 671/100,000 for

2021/22 in agreement with HWB partners. This is a reduction on 2020/21, and is considered a challenging target, but work is being undertaken to support delivery of this, including:

- Screening of all Pathway 3 discharges
- Community capacity bolstered (enablement & therapies) and further expansion of Enhanced Care provision
- Expansion of Urgent Community Response (UCR) service
- Closer links between GP Home Visiting service and the UCR
- Remote monitoring systems in place
- Step-up pathway developed to enablement/therapies service

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital

Following COVID, Lewisham's plans are to increase discharges supported by enablement/rehab during 2021/22. Work is underway to grow and transform the services to support more complex discharges.

The target set by the Council in agreement with HWB partners is to achieve 80% for 2021/22.

Ongoing work to monitor the effectiveness of Lewisham's Enablement team shows that there is an increasing improvement throughout the year in older people remaining at home after an Enablement episode. Further work is ongoing to improve patient outcomes following enablement still further, and the Council and HWB partners are therefore confident that this target is both stretching but achievable.

Lewisham's plans for 2021/22 against the metrics are shown below:

Metric		20-21 Actual	21-22 Plan	Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions		751.7	735.0	Lewisham has seen significant investment in community support to improve admission avoidance, including new referral pathways from community to enablement teams, Urgent Community Response service expansion, and work with therapies to better support the enablement service. However, this must be set against unusually high ED attendances currently, a proportion of which convert to admissions.

		21-22 Q3 Plan	21-22 Q4 Plan	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	Proportion of inpatients resident for 14 days or more Proportion of inpatients resident for 21 days or more	10.9% 6.1%	10.8% 6.0%	Work is ongoing to improve flow both within and outside the hospital. This includes: a ward-based pilot to improve pre-planning for discharge, recruitment of ward-based care navigators expected by December, bolstering of community capacity including support to enablement and investment in therapies. A weekly LOS escalation meeting takes place with senior representation to ensure that any issues preventing discharge of long-stay patients is managed.
			21-22 Plan	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence			94.5%	The BCF funds an extensive range of services which support people to be discharged home safely including the provision of equipment, enablement and therapies support, and intermediate care provision. Additional screening of all Pathway 3 discharges is taking place and additional Enhanced Care provision has been put in place. Lewisham has a higher proportion of care home residents than many other Boroughs. Some level of improvement is achievable, but the baseline position means many patients will be discharged back to their existing care home via Pathway 3.
		20-21 Actual	21-22 Plan	
Long-term support needs of older people (age		998	671	Due to COVID, high numbers of people entered care homes in 2020/21. In 2021/22 Lewisham is using more step-down facilities and providing more

65 and over) met by admission to residential and nursing care homes, per 100,000 population				intensive care packages to help people return home and remain more independent.
		19-20 Actual	21-22 Plan	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services		70%	80%	Following COVID, Lewisham's plans are to increase discharges supported by enablement/rehab during 2021/22. Work is underway to grow and transform the services to support more complex discharges.

Joint commissioning in Lewisham

Lewisham has an integrated commissioning team across the CCG and LA governed by section 75 agreements. The team is based within the local authority and covers the following commissioning areas:

Complex care and learning disability – including residential and nursing care, Day care, LD supported living and continuing health care;

Community care and support - including the Community Health Contract, end of life, carers support, community equipment and home care;

Prevention and inclusion – including supporting accommodation pathways for children and young people, vulnerable adults and mental health. This also includes most aspects of public health commissioning including sexual health, substance misuse, obesity and health checks;

Mental Health - including working age adults and older adults, voluntary sector commissioning and the development and delivery of the all age mental health alliance.

The integrated commissioning team work collaboratively with statutory, independent sector and voluntary and community sector providers to deliver high quality, evidence based, outcome focused services which meet the needs of our residents delivering value for money for the health and care system

Supporting Discharge

In 2021/22, the BCF is supporting safe and timely discharge and the continued implementation of Home First by ensuring there is 7-day working within the Hospital Transfer of Care Hub (TOCH), and staff available for post-discharge home visits and assessments. The BCF continues to fund Trusted Assessors working to enable faster and safer discharges to care homes, social worker presence in the TOCH to improve discharge planning from the point of admission, and enablement support for up to 6 weeks following discharge.

The Discharge delivery model, including ongoing improvement work, is agreed between the Trust, Council and CCG, and led by a steering group chaired by the local Discharge Lead, who is the Borough DASS. The improvement work being implemented includes developing a regular engagement forum with users and carers, enhancing care provision and enablement to provide services at home for patients with more complex needs, and improving communication between post-discharge teams.

Lewisham is the pilot site for a D2A self-assessment, an approach which is due to be adopted across all London Boroughs. This self-assessment has taken place with the participation of hospital and community-based teams involved in patient discharge to identify where further improvement activity can be delivered.

The Discharge Improvement work supported by the Lewisham system transformation team is linking with ECIST ward-level improvement work at University Hospital Lewisham, and is closely aligned with the improvement work supported by Newton Europe for the Borough Council.

The aim of all this work is to improve patient experience, reduce length of stay (LoS), avoid unplanned admissions, improve discharges to care homes and improve enablement outcomes.

Through proactive management with weekly escalation meetings to senior leadership, length of stay at UHL is reducing year on year and further improvements are expected.

BCF-funded schemes including the Disabled Facilities Grant, the provision of equipment, Falls service and the Lewisham Integrated Medication Optimisation Service (LIMOS) also continue to support timely and effective discharge and keep people safe at home.

Lewisham has historically high rates of care home placements. This was further exacerbated by Covid and high numbers of people entered residential/nursing care in 20/21. Lewisham has placed extra focus on Pathway 3 discharges, with early discharge planning taking place at ward level and will be providing increased investment in care navigators on the wards from December 2021. A further review of Pathway 3 discharges is currently in hand to establish what more could be done to reduce admissions to care homes as well as providing better support to care homes to reduce hospital admissions.

In further support of Home First delivery, Lewisham has increased the number of discharges which are supported by Enablement/Rehabilitation services and has trialled an Enhanced Care service to provide wrap-around 24-hr care at home following discharge. This service provides enhanced care to people with complex needs allowing valuable recuperation time while they settle back into their own homes. Work is also underway to transform and grow the current enablement service to facilitate more complex discharges home, for patients who might otherwise have required care home provision. This team is also increasingly delivering step-up interventions to keep people safe at home. Finally, the implementation of the Urgent Community Response service in Lewisham, launched last year, provides a safety-net for deteriorating patients in the community. This includes providing multi-disciplinary support for recently discharged patients, reducing the risk of re-admission.

Disabled Facilities Grant (DFG) and wider services

Lewisham Council's contribution to the BCF includes the DFG allocation of £1,518,970 in 2020/21. 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.

In 2020/2021, 67 major adaptations were completed. 60 customers (90%) who received adaptations said they were satisfied with the service and that their quality of life and well-being had improved. £1.1m was spent in FY 2020/2021.

This expenditure has resulted in reduced costs to the health and care system by:

- supporting older elderly, disabled people and their carers to manage their health and wellbeing and remain independent at home,
- delaying and avoiding moves into residential care,
- reducing demand for NHS services and reducing people delayed in hospital while awaiting home adaptations,
- helping in the prevention of high cost acute incidents, such as falls in the home.

During 2021/22, Housing and Adult Social Care will continue to work closely together. The Housing Improvement and Assistance Team has jointly created a triage system with Adult Social Care to ensure that straightforward adaptions are referred to Trusted Assessors to be carried out quickly and effectively.

The DFG funds a Health and Housing coordinator post who has continued to forge stronger links between housing adaptions delivery and the hospital. The coordinator links into hospital discharge, falls and dementia pathways. The role also provides links with the voluntary sector to mobilise resources in delivering joined-up support for older people. This includes links to Green Gym, Lewisham and Southwark Age UK and other social prescribing activity.

The DFG also funds Lewisham's hoarding service. Due to the extent of the hoarding issues in Lewisham the housing team and hoarding officer continue to work closely

together. The DFG also funds hoarding clearances and supports services for residents in the borough who have been referred by the Hoarding Officer or the Health and Housing Coordinator to address their hoarding issues.

Lewisham's early intervention approach helps to identify a patient's housing and other needs and provides holistic, collaborative and innovative interventions to address the root causes. Community support and assistance is ongoing to meet a person's identified needs, reducing readmission to hospital as well as tackling any health or social inequalities identified.

The Housing Improvement and Assistance Team are strengthening their relationships with housing partners to ensure suitable adaptable properties are identified early on. A steering group has been created between Adult Social Care, Housing, and Housing Improvement and Assistance Team to identify adaptable properties as well as influencing development partners to build more fully accessible properties to combat a rising shortage of accessible and adaptable properties.

Energy Efficiency and Fuel Poverty has also been a key aspect in the housing support offered. Surveyors /Trusted Assessors carry out an HHSRS inspection to all DFG applicants' properties to identify any Category 1 or 2 hazards that require repairing.

The Housing Improvement and Assistance Team is currently working in partnership with South London Energy Partnership Team to meet the needs of Lewisham's vulnerable resident applicants who have no heating or boiler for example. They are also working in partnership with Foundations Warm and Adapted Homes scheme and Surveyors are currently undertaking NEA level 2 certification in Energy advice and fuel poverty which, on completion, will enable them to advise clients on energy efficiency and fuel poverty measures that can be taken to improve their property.

For those who have no boiler, officers are looking at the possibility of installing heat pumps instead of conventional boilers to cut carbon emission footprints of the properties.

The Housing Improvement and Assistance Team is also working with Adult Social Care to progress the incorporation of smart technology into recommendations and designs. This would allow disabled and visually impaired applicants to live more independently within their homes.

Conclusion

Although the schemes funded through the Better Care Fund and Improved Better Care Fund in 2021/22 have not changed significantly from those that received funding in 2020/2021, all schemes have been reviewed to ensure that they continue to support and deliver against the LHCP's priority areas and contribute to the achievement of the BCF metrics.