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Merton Council
Health and Wellbeing Board

Date: **24 June 2014**

Time: **13:00**

Venue: **Committee rooms B, C & D - Merton Civic Centre, London Road, Morden SM4 5DX**

Merton Civic Centre, London Road, Morden, Surrey SM4 5DX

Future meeting dates

30 September and 25 November*. Further dates to these will be set in due course

* Please note that the start time for 25 November meeting will be slightly earlier commencing at **12.30**

This is a public meeting – members of the public are very welcome to attend.

Requests to speak will be considered by the Chair. If you would like to speak, please contact democratic.services@merton.gov.uk by midday on the day before the meeting.

For more information about the work of this Board, please contact Clarissa Larsen, on 020 8545 4871 or e-mail democratic.services@merton.gov.uk

Press enquiries: press@merton.gov.uk or telephone 020 8545 3483 or 4093.

Note on declarations of interest

Members are advised to declare any Disclosable Pecuniary Interest in any matter to be considered at the meeting. If a pecuniary interest is declared they should withdraw from the meeting room during the whole of the consideration of that mater and must not participate in any vote on that matter. If members consider they should not participate because of a non-pecuniary interest which may give rise to a perception of bias, they should declare this, .withdraw and not participate in consideration of the item. For further advice please speak with the Assistant Director of Corporate Governance.

Health and Wellbeing Board Membership

Merton Councillors

- Caroline Cooper-Marbiah (Chair)
- Gilli Lewis-Lavender
- Maxi Martin

Council Officers (non-voting)

- Director of Community and Housing
- Director of Children, Schools and Families
- Director of Public Health

Statutory representatives

- Four representatives of Merton Clinical Commissioning Group
- Barbara Price, Chair of Healthwatch

Non statutory representatives

- One representative of Merton Voluntary Services Council
- One representative of the Community Engagement Network

Quorum

Any 3 of the whole number.

Voting

3 (1 vote per councillor)
4 Merton Clinical Commissioning Group (1 vote per CCG member)
1 vote Chair of Healthwatch
1 vote Merton Voluntary Services Council
1 vote Community Engagement Network

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HEALTH AND WELLBEING BOARD
25 MARCH 2014

(13.00 - 14.50)

PRESENT Councillors Linda Kirby (in the Chair), Margaret Brierly, Maxi Martin,

LBM - Dr Kay Eilbert, Simon Williams and Paul Ballatt (for Yvette Stanley)

Merton Clinical Commissioning Group - Eleanor Brown, Adam Doyle and Dr Geoffrey Hollier

MSVC – Ian Beever

ALSO PRESENT NHS England – Owen Richards (for Penny Emerit)
Johan van Wijgerden

LBM – Chris Lee, Clarissa Larsen and Lynne Hartley

1. DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 1)

No declarations were made.

2. APOLOGIES FOR ABSENCE (Agenda Item 2)

Apologies were received from Penny Emerit (Owen richards attended on her behalf), Melanie Monaghan, Barbara Price and Yvette Stanley (Paul Ballatt attended on her behalf).

3. MINUTES OF THE MEETING HELD ON 28 JANUARY 2014 (Agenda Item 3)

RESOLVED: That the minutes of the meeting held on 28 January 2014 are agreed as a correct record.

4. MATTERS ARISING FROM THE MINUTES (Agenda Item 4)

None.

ORDER OF THE AGENDA

With the agreement of the meeting the Chair varied the order of the agenda to allow items 6, 9, 10 and 11 to be taken as the next items of business.

5. CHILDHOOD IMMUNISATIONS REPORT (Agenda Item 6)

Johan van Wijgerden introduced the report and confirmed that work was being done to separate out the data for Sutton and Merton. Asked about the provision of information for ethnic groups he said that leaflets in different languages are available from health visitors, GP surgeries and on the website.

Councillor Maxi Martin offered to distribute leaflets through a women's group at the Baitul Futuh Mosque and asked for leaflets in Urdu to be sent to her.

Dr Kay Eilbert advised that, together with MVSC, the Council will be starting a community outreach project which will focus on such issues and will concentrate on the East of the borough.

Eleanor Brown suggested that the role of health visitors be extended to include giving vaccinations, as is done in some parts of the country. Johan van Wijgerden agreed to raise this with the Head of Early Years and Immunisation. He confirmed that there are plans to use children's centres for vaccinations which are expected to be in place in 3–4 months' time. He also agreed to report back the concern that work to provide data for Merton only should be expedited.

Report RECEIVED.

6. BETTER CARE FUND PLAN (Agenda Item 9)

Reason for urgency: The Chair approved the submission of the report as a matter of urgency as it is a requirement that the Better Care Fund strategic plan is agreed by the Health and Wellbeing Board.

Introducing the report Simon Williams advised that the submission had been approved by Cabinet subject to the Board's approval.

RESOLVED: That the Better Care Fund Submission, as attached to the report, is approved and submitted to NHS England and the Local Government Association.

7. SECTION 75 PARTNERSHIP AGREEMENT FOR MENTAL HEALTH SERVICES (Agenda Item 10)

Simon Williams introduced the report and advised that Cabinet had approved the agreement subject to the approval of the Board.

Asked about performance management Simon Williams advised that arrangements similar to the current practice of quarterly meetings with the Mental Health trust would be set up.

RESOLVED: That the Board
(1) agree the Section 75 agreement and all attached schedules; and
(2) authorise the Director of Community and Housing to join the Chief Executive of the Trust to oversee the operation of the agreement.

8. IMPLICATIONS AND IMPACT OF CARE BILL (Agenda Item 11)

Reason for urgency: The Chair approved the submission of the report as a matter of urgency as it provides the latest available information on the impact and implications of the Care Bill which are significant to the Health and Wellbeing Board.

Simon Williams gave an overview of the report and advised that the redesign programme would be brought to the Board at a later stage.

Eleanor Brown reported that a briefing was being provided for commissioning managers and Ian Beever advised that Simon Williams would address the INVOLVE Network.

The Chair drew attention to widespread concerns about underfunding and the resulting implications.

RESOLVED: That the report is noted.

9. CHILDREN AND FAMILIES BILL (Agenda Item 5)

Introducing the report Paul Ballatt advised that the Bill had received Royal Assent in the previous week and that Merton is working towards starting the key elements in autumn.

RESOLVED: That the Board
(1) note the contents of the report; and
(2) agree to receive a further update on progress in implementing the requirements of the new legislation in due course.

10. MCCG OPERATING PLAN (Agenda Item 7)

Adam Doyle gave a presentation which updated the version printed on the agenda and advised that regular updates would be brought to the Board.

Eleanor Brown suggested that the negative responses to the GP survey might be because it was carried by means of a questionnaire, and those who had a poor experience might be more likely to reply. She agreed to follow up on the Chair's request for data allowing comparison between the east and west of the borough. Ian Beever advised that Healthwatch had found that consistency, rather than geographical location, was an issue. Healthwatch would be looking at these inconsistencies over the next year. He further advised that MVSC will be carrying out a pilot project at a Cricket Green practice to help them with information management and that they will also be working with Health Champions.

11. CALL TO ACTION (Agenda Item 8)

Eleanor Brown provided a verbal update on the Call to Action programme, advising that it had involved approximately 200 people.

The full report would be published in April. It would be sent out to all groups who had been contacted and would be available on the website.

The report was NOTED.

12. MERTON MENTAL HEALTH REVIEW (Agenda Item 12)

Dr Kay Eilbert introduced the report.

RESOLVED: That the Board –
(1) agrees that, once the draft Adult Mental Health Needs Assessment is reviewed and agreed by the Merton Mental health Task and Finish Group, it is made available to the Board and to the public; and
(2) notes that the next two stages of the review (Prioritisation Activity and Strategy development) commenced on 13/03/14.

13. EAST MERTON LOCAL CARE CENTRE (Agenda Item 13)

Dr Kay Eilbert introduced the report.

Adam Doyle added that the task and finish group have drafted the strategic outline case which it has been agreed will go to the CCG Governing Body, after which the business case and Project Initiation Document will be prepared. In answer to questions he confirmed that work previously undertaken would be used to support the case and that all financial models of delivery are being considered, including the capital receipt from the existing building.

Paul Ballatt was given an assurance that Children's Services would be engaged in the project.

East Merton Model of Care will be a standing item on the Board's agenda.

RESOLVED: That the Board notes the progress on the development of a Model of Care for East Merton that ensures early detection of disease when it can be cured or managed closest to home, either in primary or community care.

14. HEALTH AND WELLBEING STRATEGY MONITORING OF DELIVERY PRIORITY 2 AND 4 (Agenda Item 14)

Introducing the reports Dr Kay Eilbert advised that the Health and Wellbeing Strategy would be simplified for the next refresh.

Chris Lee circulated a revised version of the delivery plan for priority theme 4. He drew attention to progress made, including the significant reduction in worklessness and progress in community safety.

Asked why the impact of domestic violence was not shown Chris Lee advised that the current objective was to increase the level of reporting. Kay Eilbert undertook to look at this in the refresh.

Councillor Maxi Martin said that a volunteer day would be held at the Baitul Futuh Mosque on 4 June as many of the women had expressed interest in volunteering.

On the question of health issues related to the high street Eleanor Brown and Kay Eilbert agreed to jointly write to Lord Ara Darzi drawing attention to the legislative constraints on authorities trying to control the number of licensed premises and betting shops in their areas.

RESOLVED: That the Board notes the progress on the development and delivery of the Health and Wellbeing strategy Priority 2: Supporting People to Improve their Wellbeing and Priority 4: Improving Wellbeing, Resilience and Connectedness.

15. PHARMACEUTICAL NEEDS ASSESSMENT (Agenda Item 15)

RESOLVED: That the Board –
(1) notes that it has new statutory duties relating to the Pharmaceutrical Needs Assessment(PNA);
(2) notes that following a competitive procurement exercise, joint with Sutton Council, that Primary Care Commissioning has been appointed to produce Merton's PNA;
(3) notes that the PNA process will take up to 12 months, which includes a duty to consult with a number of interested parties for a minimum of 60 days; and
(4) agrees to receive regular updates on the progress of the PNA.

16. VOLUNTARY SECTOR STOCKTAKE 2013 (Agenda Item 16)

Ian Beever introduced the report and advised that it will be included as part of the induction for Merton councillors following the May elections. He further advised the Board that the Volunteer Centre Merton will be merging with the MVSC at the end of June.

RESOLVED: That the Board note that in order to steer their way forward to manage change, the research highlights the voluntary sector will need –
(a) support and information to understand the changing policy, legislative and funding environment in which they operate
(b) support to fundraise from public bodies, trusts and importantly unrestricted funds
(c) support to work collaboratively to maximise opportunities for contracts and funding
(d) support to maximise the financial capital in the borough through volunteering and local business networks.

17. EAST MERTON COMMUNITY HEALTH AND WELLBEING FUND UPDATE (Agenda Item 17)

RESOLVED: To note the progress in the delivery of the Merton Community Health and Wellbeing Fund in East Merton.

18. FUTURE MEETINGS (Agenda Item)

The Board noted the dates of future meetings.

Concerns raised by Councillor Maxi Martin about the issues of female genital mutilation and the higher incidences of still births among African, Asian and Pakistani populations were also noted. It was agreed not to add these issues to the Board's work programme at this point as future agenda were fully committed.

MERTON 2015

Children & Families Board

Children & Families Act
- work in progress
May 2014

http://intranet/merton2015

merton

Work strands & related activity

- C&F Act
- Assessment framework
- Education, Health and Care Planning
- The Local Offer
- Personal Budgets
- Preparation for adulthood
- Related activity
- Review and alignment of children's service commissioning CSF/CCG/PH
- Structures (CSC, Edn, Healths)
- Early Help commissioning
- Continuous improvement activity

Role of the new service

- Provide a 0-25 service across a continuum from signposting, to direct intervention to access to commissioned services
- Provide an integrated health, education and social care service based around the needs of the C/YP and their family.
- Be the joint access point for consideration of assessment, planning and review of single ECH plans
- Host the health navigation and oversight team
- Operate across the health, social care and education regulatory regimes.

This means

- Delivering statutory integrated assessment leading to an ECH Plan
- Delivering statutory children's social care functions for children with disabilities.
- Overseeing the contributions of the wider education, social care & health network to single or MA assessments & joint/single agency planning outside the ECH framework.
- Providing/securing timely, proportionate & personalised interventions based on assessed need
- Ensuring plans are reviewed & securing continuity and good transitioning

Eligibility criteria

- Children & YP 0-25 who have a need for a co-ordinated response from education, health & care services to achieve life outcomes; **and**
- A significantly greater difficulty in learning than others of the same age and who will need access to educational resources over and above that which is normally/universally available; **or**
- A disability/health condition which stops or hinders them from using educational facilities of a kind generally provided for others of the same age.

Our core offer

- A single agency assessment informed by other agencies of a MA assessment
- A named lead professional/case manager/ and or key worker
- Co-ordinated support via a plan (single or MA)
- Sign posting or access to services based on assessed need

Merton's Children's Trust Values

Our CT values will shape our approach to implementing the Children & Families Act

Keeping our C&YP at the heart of our services

- Fewest transition points
- Best practice single and MA assessment, planning and review
- C&YP engaged in their assessment, planning and review
- Clarity regarding lead professional, case holder, key worker and team around the child
- Supporting YP's resilience and independence and good preparation for adulthood

Equality, equity & valuing diversity

- Clear eligibility criteria
- Offering a continuum of services to meet a continuum of need
- Using evidence based approaches
- Ensuring robust QA and making the maximum difference to outcomes

Local accountability & partnership working – parents and carers

- Having parents and carers on the C&F Board
- Facilitating their engagement in service development and review
- Ensuring parents and carers engaged at all stages of assessing, planning and reviewing needs
- Providing direct support to parents

Local accountability & partnership working – commissioners and deliverers

- Aligning commissioning activity and driving value out of shared contracts (CCG; CSF; ASC; PH)
- Integrated service delivery
- Working to deliver a joined up local offer and to support needs being met in universal settings with:
  - colleges, schools and education settings, employment & training, and health, care providers
- Robust safeguarding and QA throughout

Striving for Continuous improvement

- Harnessing the broadest talents and expertise
- Seeking out good and best practice
- Using evidence based programmes
- Maintaining our focus on impact and outcomes
- Being ambitious for our C&YP
- Ensuring all our services meet national standards and are rated good or better by CQC/Ofsted

Promoting a learning culture

- Supporting our staff in maintaining professional competencies and expertise
- Developing generic competencies
- Actively supporting parents and carers develop their skills and expertise
- Actively supporting YP with developing skills for independence and pathways to adulthood

Listening to and valuing Children &Young People

- Involving YP in assessing their needs and planning their future services and pathways
- Involving young people in shaping services
- Involving YP in quality assuring the services they receive
- Ensuring the voice of the child is recorded and use all the tools at our disposal to ensure YP can actively feed in their views

Committee: Health and Wellbeing Board

Date: 24 June 2014

Agenda item:

Wards: All

Subject: Young Carers Memorandum of Understanding

Lead officer: Yvette Stanley, Director of Children, Schools and Families

Lead member: Councillor Maxi Martin, Cabinet Member for Children Schools and Families

Forward Plan reference number:

Contact officer: Yvette Stanley, Director of Children, Schools and Families

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Recommendations:

That the Health and Wellbeing Board:

A. Agrees the Young Carers MoU for signature by the Director of Children, Schools and Families and the Director of Community and Housing.

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1. Purpose of report and executive summary

To seek the agreement of the Health and Wellbeing Board to 'Working Together to Support Young Carers and Their Families' a template for a local memorandum of Understanding between Directors for Children's Services and Adult Social Services.

2. DETAILS

Appendix 1 of this report includes the full Memorandum of Understanding (MoU) to support young carers and their families.

Members of the Health and Wellbeing Board are asked to consider this report and agree that the Director of Children, Schools and Families and the Director of Community and Housing sign up to the MoU.

3. ALTERNATIVE OPTIONS

None for the purpose of this report.

4. CONSULTATION UNDERTAKEN OR PROPOSED

None for the purpose of this report.

5. TIMETABLE

N/A

6. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report.

7. LEGAL AND STATUTORY IMPLICATIONS

None for the purpose of this report.

8. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

None for the purpose of this report.

9. CRIME AND DISORDER IMPLICATIONS

None for the purpose of this report.

10. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None for the purpose of this report.

11. APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1 Working Together to Support Young Carers and Their Families – A Template for a Local Memorandum of Understanding August 2012.

12. BACKGROUND PAPERS

None for the purpose of this report.

WORKING TOGETHER TO SUPPORT

YOUNG CARERS AND THEIR FAMILIES

A Template for a Local Memorandum of Understanding [MoU]

between Statutory Directors for

Children's Services and Adult Social Services

August 2012

About this Paper

There is a considerable amount of guidance and practice material to guide local policy and practice when working with young carers and their families. New materials are appearing all the time and increasingly there is local evidence based material that can be used to review and support local action.

The template in this paper is intended to be a resource and not a prescription. The intention is to promote working together between Adult's and Children's social care services and offer an enhanced basis for working in partnership with health and third sector partners. The final local text may be varied to reflect local circumstances. Additional areas may be included where this is considered appropriate. Any areas covered by existing local policies may be omitted or simply referenced. The content reflects the cross government strategic vision and priorities set out ***Recognised, Valued and Supported***[1] [See: **Appendix B**] intended to inform national and local progress.

Nothing in this updated paper seeks to amend or replace existing statutory or accepted best practice guidance on any of the issues the template seeks to cover. Should any conflict or apparent difference in interpretation arise, or if further statutory guidance is issued, the expectation is that the statutory guidance would take precedence. Statutory Directors should obtain further information or legal advice, as necessary.

Whilst every attempt has been made to ensure accuracy and promote best practice, the content of this document does not represent a formal statement of the law or Government policy. The Associations cannot accept any responsibility for loss or liability occasioned as a result of people acting or not acting on any information contained in this paper.

The content of the template applies in all situations irrespective of age, disability, gender, race, cultural or religious beliefs and sexual orientation. All references to *children* in this paper include *young people*.

About Our Organisations

The Association of Directors of Adult Social Services [ADASS]

Principal Office: Local Government House, Smith Square, London SW1P 3HZ
Tel: 0207 072 7433 E-mail: adasscarers@warwickshire.gov.uk or team@adass.org.uk. Registered Charity No: 299154 – England

The Association of Directors of Children's Services Ltd [ADCS]

Registered Office: 3rd Floor, The Triangle, Exchange Square, Manchester M4 3TR. Tel: 0161 838 5757 E- mail: info@adcs.org.uk Registered in England and Wales Company No: 06801922

The Children's Society

Church of England Children's Society ,Company No. 40004-C England
Charity Registration No. 221124 .Registered Office: Edward Rudolf House, Margery Street, London WC1X 0JL ,VAT Registration No. 626649317
Subsidiary Companies: The Children's Society (Services) Ltd Company No. 4545124, The Children's Society (Trading) Ltd Company No. 885496

Acknowledgements

The development of this paper has been made possible by funding from The Children's Society, the Department of Health in support of progressing the priorities within the national strategy for carers, the invaluable contributions of colleagues within both Associations, the ADASS Carers Policy Network, the support and advice of the Department for Education [DfE] and the contribution of participants within the DfE funded *Prevention Through Partnership Programme* [2011-12].

CONTENTS

JOINT FOREWORD

The first model local Memorandum of Understanding [MoU] was published jointly by ADCS and ADASS in December 2009[2]. A summary version was prepared in partnership with The Children's Society in 2010. Quite a few Councils have developed their local agreements. The updated template contained in this paper reflects this and the experience flowing from the Department for Education [DfE] funded *Prevention through Partnership Programme*[3] led by The Children's Society. In addition, we have some new resources, which we have worked on, that support the need for working together to support young carers and their families:

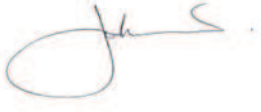
- ***Signposts 2011***[4]
- ***Young Carers Personalisation And Whole Family Approaches 2011*** [5]
- ***Whole Family Pathway 2012*** [6]

Our starting point for everything continues to be that children and young people who are carers have the same rights as all children and young people. We should be pursuing the same opportunities for them. They should be able to learn, achieve, develop friendships and enjoy positive, healthy childhoods just like other children. Where services are working with families we should try to ensure that the needs of dependent children in the family, including those who may be assisting with caring, are recognised. This means taking account of their hopes, aspirations, strengths and achievements and the need for advice and support for all the family. Continued caring by children and supporting others in a family can be an appropriate part of this where this does not have an adverse affect on well-being.

Young carers and families are experts on their own lives. It falls to professionals across all sectors to include them in shaping the personalised and integrated responses that best suit their needs. We remain clear, however, that the approaches we outline apply no matter how competent or willing a young carer may appear to be. They apply equally whether care needs arise as a result of mental or physical illness or disability, substance misuse and whether a parent or a sibling is the focus of support. The updated template offers a clear framework which professionals can use to develop and provide personalised and joined up support for young carers and their families. It is expected that it will apply equally when working in partnership with colleagues in health and the third sectors.

Where one person holds both statutory roles the memorandum template approach may still be relevant for use by their operational leads for adult's and children's social care within the organisation. This is consistent with our view that the template is principally about how we work together and the professional culture we expect to inform it. In updating the template we are clear that early local adopters of the 2009 model do **not** need to review or amend their local agreement until its agreed review date unless, of course, they wish to do so.

Finally, it is especially pleasing that this updated template is a jointly agreed one between our three organisations. It is a reflection of the shared commitment we hold. Widespread adoption and use of the template can help us all to build upon local delivery of national policies, support local progress and better achieve the outcomes we are working towards.



Clair Pyper
ADCS LEAD
YOUNG CARERS

Jenny Frank
PROGRAMME MANAGER
THE CHILDREN'S SOCIETY

Joe Blott
ADASS LEAD
CARERS

Working Together To Support Young Carers And Their Families

A Memorandum of Understanding

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Kate Kenally
Director of Adult Social Care and Interim Director of Children's Services

Commencement Date: January 2013

Review Date: November 2015

WORKING TOGETHER TO SUPPORT YOUNG CARERS AND THEIR FAMILIES

WHAT WE ARE AIMING TO DO LOCALLY – A JOINT STATEMENT OF INTENT

Young carers tell us that they value their caring roles and are often proud of the contribution they are able to make in their families. All too often, however, children and young people become carers because someone in their family has significant unmet care needs arising from ill health, disability, mental health needs or substance misuse. In some cases young carers have stepped into the breach, sometimes assuming a level of responsibility that no child should be expected to take on. This can have consequent knock-on effects on schooling and other key areas of their lives.

Putting People First [7] emphasised that care services should be delivered in ways which sustain families, avoid the need to take on inappropriate caring roles and prevent further inappropriate caring. This policy aim, which is also reflected within the current national strategy for carers, is interdependent with the principle of integrated working.

Making it Real [2011] [8] was prepared by the Think Local Act Personal Partnership [TLAP] and sets out a framework for taking forward personalised, community based support.

Positive for Youth, 2012 [9]***,*** the cross-Government policy for young people aged 13-19 offers us real insights and encouragement on how we can work together in partnership to support families and improve outcomes for young people; especially, those who are vulnerable.

We have committed to working together locally. We will do this across systems, in partnership with health and local carers' organisations and within the resources available. We will work in partnership with parents and young carers to ensure:

- Children have a sense of belonging within supportive relationships where parents feel supported in their parenting role.
- Risks to independence, safety and welfare are recognised and responded to. We ensure safety of those who are vulnerable and at risk of significant harm and do so in ways that are personalised, proportionate and risk based.
- Integrated, earlier and more effective responses to young carers and their families are adopted using approaches such as the "***whole family pathway***".
- There are no "wrong doors". Young carers are identified, assessed and their families are supported in ways that prevent excessive or inappropriate caring and support parenting roles regardless of which service is contacted first.
- No care or support package for a parent or sibling relies on excessive or inappropriate caring by a young carer to make it sustainable.
- Young carers are encouraged to have strong ambitions and good opportunities to realise their potential and to have the same access to education, career choices and broader opportunities as their peers.
- Transition to adulthood is supported. The challenges faced by young adult carers [18-24] around education, training, employment and independence are responded to.
- All young carers and their families feel empowered. Increasingly they see themselves and are seen as partners in shaping what we do.
- We learn from and build on their experience and outcomes.

MEMORANDUM OF UNDERSTANDING

EMPOWERMENT

1. Young Carers: A Shared Understanding

We are agreed that the term "young carer" should be taken to include children and young people under 18 who provide regular and ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances.

The term does not apply to the everyday and occasional help around the home that may often be expected of or given by children in families and is part of community and family cohesion. The key features for us are that:

"***caring responsibilities are important and relied upon within the family in maintaining the health, safety or day to day well-being of the person receiving support or care and/or the wider family."***

We will continue to work together to develop a shared and more detailed understanding of the different types and levels of caring in our area. Our main focus, however, will be to ensure we develop better ways of identifying where caring by children risks becoming excessive and/or inappropriate and putting in place the support that prevents this happening.

The central issues for us are recognition, adverse impact, empowerment and support, including emotional support and accountability. Timely assessment and early intervention can prevent a child undertaking inappropriate levels of care. We start from the belief that:

"a young carer becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical well being or educational achievement and life chances" [10]

The young carers involved in the *Whole Family Regional Conferences*[11] facilitated by The Children's Society provided powerful testimony about joint working and support services for young carers. They want to be seen as just like other children and young people. At the same time they are very clear that timely and effective support for young carers and their families can make a real difference to the impacts they experience by:

- reducing marginalisation, isolation and anxiety
- managing feelings of stigma or shame
- meeting additional needs
- keeping together as a family – being a family
- enabling them to keep up with school work
- improving school attendance and achievement
- enabling young carers to continue in education post 16 and gain employment
- recognising what it means to be a "young carer"
- responding to concerns around self identification and what happens next

2. Promoting Awareness and Recognition

We have heard key messages[12] that:

- Without early identification young people's disclosure tends to happen at crisis points.
- Young people appreciate professionals who give them space to build trust as well as the choice to talk, what to tell and at what pace.
- Young people's repeated experiences of disrupted relationships with professionals may result in resignation and lack of engagement.

We will keep local practice under review and where appropriate refine it to ensure that it:

- promotes positive images of adults with long term conditions/disabilities that encourage families to seek information, assistance and spot children with caring responsibilities;
- provides appropriate and accessible information for families about services that support parenting capacity, independence and well being;
- enables access to self directed support; including direct payments to meet the needs of parents where appropriate;
- reaches out to families to offer support that avoids inappropriate forms of caring developing or continuing;
- reflects principles of partnership working with communities, in particular, the need for sensitivity to cultural needs;
- supports schools in their key role of identifying children with additional support needs and early intervention and support of young carers;
- identifies "hard to reach" groups/families and creates opportunities to meet their needs;
- recognises that care needs can vary significantly and ensures local processes offer emergency advice and support where usual care arrangements risk breaking down; and,
- engages with local young carers' projects for early support and *whole family* working.

Awareness is the key to recognition. Indicators of the impact of caring on children can include:

- Problems at school, not completing homework, absenteeism, lateness and inability to take part in after school activities.
- Social Isolation from other children their age, feeling that no one else can understand his or her experience.
- Lack of free time for play, sports and leisure activities.
- Emerging behavioural problems, in some cases including youth offending activity.
- Emotional impacts, such as worry, depression, self-harm.
- Physical impacts, such as tiredness, fatigue, back injury.
- Lack of aspirations and career opportunities.
- Increased independence and maturity for their age.

- Advanced life skills such as a caring attitude or being a good listener.
- Increased knowledge of disability and illness.

Not all children who have ill or disabled parents or siblings take on caring roles or do so in ways that cause difficulties. Circumstances will vary. What is important is that we work closely with the family and the young person so that reasonable steps can be taken to pre-empt likely problems and any emerging difficulties affecting well-being can be identified at an early stage.

Adult Social Services**,** in addition to assessing parental social care needs, have a key role in identifying young carers, as they will often be the first point of contact. At the point of assessing the cared-for person, adult services will ask whether the person they are assessing has children and, if they do, what impact they feel their situation has on them.

SIGNPOSTS [ADCS/ADASS 2011] contains valuable evidence to inform practice on working together to improve outcomes for young carers in families affected by enduring parental mental illness or substance misuse. It is a useful resource for local professionals in identifying and supporting young carers. It offers points for discussion that we can use to support progress.

3. Schools, Academies and Colleges

Schools, Academies and Colleges will be encouraged to identify young carers at an early stage; promote and co-ordinate their support of young carers; and, liaise with other agencies as appropriate with the outcomes we are seeking. School nurses also have a role to play here. We will encourage schools and academies to:

- Have a named staff member with lead responsibility for young carers and to recognise this role within continuing professional development.
- Have in place a policy to encourage practice that identifies and supports young carers such as adapting school arrangements if needed, provision for personal tutors and private discussions and access to local young carers' projects.
- Promote open communication with families that supports parenting capacity and encourages the sharing of information.
- Ensure school policies such as those for enrolment, attendance, bullying, behaviour and keeping safe afford recognition to young carers.
- Incorporate into individual pupil plans recognition and support for the positive aspects of the young carer's role, as well as providing the personalised support necessary to enable young carers to attend and enjoy school.
- Consider scope for school staff to adopt lead professional roles within locally agreed assessment arrangements or ***CAF*** [13].
- Consider the role of school nurses in supporting improved health outcomes and reduce inequalities of family/child experience[14].

4. Promoting Health and Wellbeing

Health professionals are also likely to be among the people that a family turns to for help with an illness or disability. Whether they work in a hospital or community, with adults or children, they may be the only person who is able to ask the right questions to find out that a child is taking on caring responsibilities. Additionally, we will encourage GP surgeries to have registers identifying carers and young carers and consider use of e-learning resources[15].

Child and adolescent mental health services should be used as appropriate to support the emotional well being of young carers who are seriously troubled by their caring role. Integrated working across health, adult social care, children's services and third sector partners and through local partnership arrangements and the local ***Health and Wellbeing Board*** [16] will be used to develop a strategic and operational framework that identifies young carers and their needs. This would be done with a view to:

- Promoting and sustaining healthy lifestyles and diets
- Encouraging regular exercise
- Ensuring good oral health
- Raising awareness and reducing risks of substance misuse
- Offering smoking cessation support to young carers interested in giving up.
- Raising awareness of maintaining emotional well being and reducing personal stress
- Enabling young people to assess risks about lifting and handling and provide information, advice and support to remove or reduce risk of injury as necessary
- Promoting safe procedures for control of medication that do not involve young carers.

5. Equality & Diversity

As with abuse or neglect, inappropriate caring responsibilities adversely impacting on wellbeing, cannot be condoned on gender, religious or cultural grounds. We will ensure that appropriate people are readily available to provide advice on such matters. We will tackle barriers to effective communication and take up of support.

When considering translation services we will consult with families as to who could fill this role appropriately. Where appropriate and possible, bi-lingual advocates will be used and account taken of any relevant factors around faith, gender or locality. We are agreed it is not good practice to expect young carers to interpret for their families, particularly when it involves someone with an illness. We will discourage this. We expect interpreters to be used and will reinforce this in staff guidance as appropriate. There may be occasions, however, where a family express a strong preference for an adult family member to be the interpreter. Where all are in agreement and the requirements and responsibilities of the role are understood this can be considered.

We will keep under review and encourage staff awareness around gender issues and assumptions that can impact upon both male and female young carers

6. Information for Empowerment

Together with our partners, we will work towards a position where, if not already in place, information and advocacy services are available to all young carers and their families offering information, advice, advocacy, representation and support. This includes, where appropriate, peer support through local young carers' projects or parenting groups. We will encourage local use of the following general principles when people act as advocates for young carers and/or their families:

- Advocates should be the individuals' person of choice and can be informal as well as professional advocates. Peer advocacy may be appropriate in some situations.
- Advocates should work for the best interests of the individual and their family.

- Advocates should be alert to the potential for conflicts of interests within families and potential needs for separate advocates in some situations.

- Advocates should value and respect young carers and their families as individuals and challenge all types of unlawful discrimination.

- Advocates should work to make sure that everyone understands what is happening to them, can make their views known and exercise, where possible, appropriate choices when decisions are being made.

- Advocates should help young carers and their families to raise issues and concerns about things with which they are unhappy. This includes complaints.

- Advocates must understand requirements regarding safeguarding and know what to do if they become aware of abuse or neglect or risk of it occurring.

7. Information Sharing

Effective and timely information sharing between our agencies and with our partners is critical to empowerment, the provision of early intervention and preventative work, supporting transitions and, for safeguarding and promoting the welfare of young carers. Within the framework of existing local information sharing protocols our aim is to ensure specific recognition of the position of young carers. This will cover their identification and support. Local arrangements for information sharing under this protocol will be consistent with national guidance. All practitioners should follow the seven "golden rules" that are in place:

- Remember that Data Protection legislation is not a barrier to sharing information

- Be open and honest about why, what, how and with whom information could be shared,

- Seek advice if in any doubt

- Share information with consent where appropriate

- Consider the child's safety and welfare

- Gather and keep secure information that is necessary, proportionate, relevant, accurate, and timely

- Keep a record of decisions and what, if any, information has been shared and with whom.

8. Transition to Adulthood

We will build on local experience and make use of the findings of ***Young Carers Pathfinders***[17] and other research[18] to deliver our commitment on transition to adulthood and for support of young adult carers. We will:

- Raise professional awareness of the risks and challenges faced by young carers around low aspirations, negative experiences of learning and support and the impacts of disadvantage and consequences of caring responsibilities on take up of education, training and employment.

- Aim to have one organisation/named professional who takes responsibility for the holistic needs of a young adult carer's; support on transition issues, moving from dependence to independence; improving resilience and opportunities to take up education, training and employment whilst recognising needs around continuing to care.

ASSESSMENT

9. Introduction

We are agreed that the key to ensuring better support and outcomes for young carers is effective assessment. If a referral is made about a parent with a disability, dependency or illness, agencies should always consider whether there is a child in the family who is providing personal care or practical support. In doing so, practitioners will be expected to consider, preferably within a ***whole family approach***, the impact of the disability or illness on each child within the family; including whether any of them are or could be providing care or support that is relied upon, is impacting on wellbeing and where a review of adult care needs is indicated.

Concerns may arise in many different contexts and their nature will vary. Our local approach will make appropriate use of partnership and integrated working. For young carers and their families this includes:

- **Assessment** – ensuring all assessments are timely, transparent and proportionate within the locally agreed *Assessment Framework or CAF* which is consistently understood and applied. [See Below].
- **Early intervention** – early or identification of situations before they become critical
- **Reviewing or referring for review** the adult social care needs of a parent where children with caring responsibilities that are relied upon within the family are identified.
- **Personalising Support –** using the potential of personalised care and self-directed support planning to meet care and support needs.[19]
- **Recording** – making sure information is in one place with the consent of the child or parent consistent with established principles for obtaining informed consent.
- **Sharing information** – so that all agencies involved know what the issues are, what is intended and so that young carers and families do not have to repeat things to us. [See above]
- **Joint Decisions,** using, as appropriate, *Team around the Child* and *Team Around the Family* for assessments and evidence based decisions for support
- **Lead Professionals** – acting as the point of contact for young carers and their families to make connections, build trust, bring things together and help them stay that way.
- **Ensuring child safety** [See: p 15]
- **Effective professional supervision and regular reviews –** seeing assessment as a continuing process to ensure a clear direction of travel and inform future plans.

10. Empowering and Proportionate

The local approach to working with families will be empowering, holistic, inclusive, proportionate, integrated, child centred, rooted in child development, focus on strengths as well as difficulties and have a clear focus outcomes. We will:

- Consider the family as a whole, acknowledge parents' strengths, promote resilience and beware of undermining parenting capacity.
- Work with colleagues from all sectors including with the voluntary sector where appropriate.

- Ensure that the assessment process is appropriate to age and understanding and specific to their needs as a young carer.
- Recognise that families may be fearful of acknowledging children's caring roles.
- Ascertain if the illness/disability is stable, changing or episodic.
- Maintain a focus on positive outcomes for the young person and their family when working with other departments/agencies.
- Respond to young carers' needs for emotional support and counselling.
- Consider the family's housing needs and access to benefits.
- Be sensitive to cultural perceptions and needs around disability, illness and caring consistent with a child's fundamental right to a safe and secure childhood.
- Recognise there may be differences of view between children and parents about appropriate levels of care and that such differences may not be acknowledged.
- Take account of the young carers wishes regarding education, employment and recreational activities

The resolution of any tensions requires good quality joint work between adult and children's social services as well as co-operation from schools and health care workers. This work should include direct work with the young carer to understand his/her views. The young person who is a primary carer of his or her parent or sibling may have a good understanding of the family's functioning and needs. These should be incorporated into any assessment.[16]

This memorandum also provides a framework to ensure that any lead professional, adult or children's services, should have access to and hold multi-agency information and assess the whole family regularly. Consideration will be given to who is deemed to be an appropriate lead professional having regard to all the circumstances of the assessment.

We will encourage professionals to ask certain questions either as part of their assessment, or during professional supervision, or at review to inform judgements about what is in the "best interests" of the young carer and their family. These questions might well include:

- Is a child undertaking (or at risk of undertaking) caring tasks likely to impact on them?
- Why is a child undertaking care and support tasks that are relied upon?
- What is the impact of caring on the child's development, health and well-being?
- What additional personalised services or support may be needed to ensure the parental care needs are met or to sustain a family unit and to prevent a child taking on or continuing to hold inappropriate caring responsibilities?
- What is the parental capacity to respond to needs? Do they need support in their parenting role or in developing their parenting capacity?
- What can be done to help the whole family or to maximise the broader support which others in the family are able to provide and to promote resilience?
- How might we build resilience and family strengths and manage risks along the way?
- Do the impacts on the child indicate that it would be appropriate to engage the locally agreed framework for assessment of *Children in Need and their Families* or under the Carers and Disabled Children Act 2000[20?]

- Are there any additional needs falling within the locally agreed ***Assessment Framework*** **for Children** [See: endnote 13]?

Keeping the Family in Mind [21] offers some timely reminders from children and young people for professionals coming into contact with parents with enduring mental health needs. We will encourage professional awareness of these, as appropriate, along with the principles of successful front line family services[22].

11. Whole Family Working

A ***whole family*** approach will be embedded into local assessments. We will ensure that:

- The primary responsibility for responding to the needs of young carers derives from the person in need of care and support. This means that whichever service identifies there is a young carer in the family, whether it is children's or adults' social care services or health, it is responsible for referring or assessing the needs of that young carer within that family context.
- Practitioners seek advice and support where necessary from colleagues, whether it is children's or adults' social services or a partner agency, to support discharge of our joint and separate responsibilities towards young carers and their families.
- Practitioners are aware of the prejudices and stereotypes that may exist around cultures, and disability, or about adults who misuse drugs/alcohol or have mental health needs in terms of their parenting capacity and competence.
- Practitioners reach their conclusions on the basis of the evidence of their observation of both parents and children; including any young carers.

12. Focused on Change and Outcomes

Providing an assessment only for the child will not necessarily resolve the situation that has caused their referral. All adult social care and children's assessments should ascertain **why** the child is caring, the **extent** of the reliance and caring responsibility and **what** needs to change. This is essential to prevent children from undertaking inappropriate levels of care and being relied on to assume levels of responsibility which impact adversely on their own well-being.

Timely assessments of both the person who needs care and the whole family could prevent a child undertaking inappropriate levels of care in the first place. When a referral is made about a parent with a disability, substance dependency or illness, we have committed to finding out whether there is a child in the family who is providing personal care or practical help. In doing so, professionals will also be expected to consider, within a ***whole family*** approach, the impact of the disability or illness on any child within the family; including, whether any of them are or could be providing some form of care or not. Similar considerations apply if there is a child with a disability within a family.

Such assessments should not only identify regular individual personal care needs (including safeguarding), but should also consider the range of parenting, caring and family tasks that are needed when care workers are not present and mean a child is relied upon to carry them out.

13. Joint Assessment

Joint assessment by adult, child and family and health staff will be expected where this is appropriate. Access to specialist advice and support should be available as needed. Finally, we should never ignore any aspect of a situation that indicates there are concerns about children's and/or vulnerable adults' safety and they require protection from harm.

SAFEGUARDING

14. Children at Risk of Harm

Safeguarding[23] is part of a continuum where prevention and early intervention can help young carers and their families work through the challenges they face. Safeguarding is about keeping children safe from harm and abuse and is an important part of integrated working.

By working together in an integrated way professionals place the child at the centre of all activities and are better able to identify holistic needs earlier and improve outcomes. We accept a joint responsibility to work in partnership with others to identify and respond to any young carers who are suffering, or likely to suffer, significant harm and to protect them from this harm. We will do this in ways that keep children safe and:

- focus on working together, early intervention and prevention;
- reflect practice guidance;
- do not stigmatise families or risk increasing the number of hidden young carers; and,
- do not discourage young carers and their families from seeking information and advice, or an assessment and provision of services.

Local single and multi-agency policies and procedures set out clearly the local arrangements for safeguarding children at risk of significant harm and/or promoting their welfare. We will:

- State clearly the responsibilities of staff under local safeguarding children procedures to make referrals where children are considered to be suffering or likely to suffer significant harm and emphasise the principle that safeguarding is everyone's business.
- Ensure all staff and volunteers across all sectors have undertaken appropriate training in recognising harm, reporting concerns about a child's welfare and safety and confirming referrals they have made to children's social care within 48 hours.
- Ensure all staff and volunteers across all sectors have undertaken appropriate training in relation to mental health and substance misuse issues.
- Make sure our arrangements for young carers and their families reflect any requirements of local multi-agency and single agency policies for safeguarding children and seek inclusion as necessary.

15. Adults at Risk of Harm

The Vision for Adult Social Care[24] identifies seven key principles for building up a modern system of social care. They are: prevention, personalisation, partnership, plurality, protection, productivity and people. Protection is defined as ensuring that:

"there are sensible safeguards against risk of abuse or neglect. Risk is no longer an excuse to limit people's freedom".

We are agreed that we have a joint leadership responsibility to:

- Ensure awareness of safeguarding adults' policy and practice; the ability to recognise and respond to safeguarding adults' concerns; and to promote confidence and consistency in using local multi-agency procedures by staff in across all agencies.
- Apply the agreed principles of adult safeguarding and secure consistency with local multi-agency policies and procedures in respect of adults who are vulnerable and more at risk of harm in line with the following[25]:

- **Empowerment:** presumption of person led decisions and informed consent.

- **Protection**: support and representation for those in greatest need.

- **Prevention:** it is better to take action before harm occurs.

- **Proportionality:** proportional and least intrusive response appropriate to the risk presented.

- **Partnership:** local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting abuse and neglect.

- **Accountability:** accountability and transparency in delivering safeguarding; including learning from experience and outcomes

16. Local Safeguarding Boards

Local Safeguarding Children and Adults Boards have been made aware of the general issues surrounding young carers and the intention to adopt this Memorandum of Understanding. This has been done to ensure consistency with local multi-agency policies and procedures.

It is also intended to raise awareness of the way in which safeguarding work forms part of a continuum of locally agreed person-centred and proportionate risk-based responses. We can all use these to ensure that those adults and children at risk of harm are kept safe and their welfare is promoted.

ACCOUNTABILITY

17. Funding Responsibilities

The internal allocations of funding by the Council should not become a barrier to timely and appropriate support for young carers and their families. We recognise that disputes about where funding responsibility lies can be deeply damaging to families. They were one of the concerns voiced by families and young carers in national consultations on the National Carers Strategy. We will act to ensure that staff have a clear understanding of joint and separate responsibilities to support parenting roles, respond to needs and reduce the need for inappropriate caring by young carers. The following general principles apply to the expected *whole family* and joint approach to meeting needs and arranging support:

- Adult social care is responsible for commissioning care and support services for adults to reduce or prevent inappropriate caring responsibilities by young carers.
- Children's social care is responsible for commissioning services to respond to specific needs of the child or young person; including, those relating to the impact of their caring role on them.
- Shared responsibility exists between us for commissioning services that would support or sustain adults in their parenting role having regard to the individual circumstances.

18. Preventing Disagreements

We believe that the inclusive, *whole family* approach to which we are committed should mean significant disagreements between local adult and children's services will be rare. Two potential areas suggest themselves and are:

- disagreements about whether the need relates to the young carer or the adult or sibling who is supported by him or her; and/or,
- disagreements about respective responsibilities or thresholds for adults or children.

We intend to reduce the risk of disagreements by:

- ensuring that staff are appropriately trained and supported in understanding and in the exercising of joint and separate responsibilities towards young carers and those they support;
- being as clear as we can about our joint and separate responsibilities;
- ensuring young carers and parents have access to information and advocacy services to support them in the exercise of their rights; and,
- ensuring that effective arrangements for consultation, communication and feedback to young carers and those they support are available and acted upon.

How such issues are resolved is a matter for us as the Statutory Directors to determine within the context of our corporate responsibilities within the Council. The following general principles will be used to inform action and decision-making:

- Disagreements about funding responsibilities must <u>not</u> get in the way of responding in a timely manner to situations where it is evident that inappropriate caring responsibilities are being undertaken and relied upon.
- Disagreements about funding must <u>not</u> be allowed to become a problem for the young carer or the person supported and must not be argued about in front of them.

- Disagreements about responsibilities must not leave the needs of family members unmet because they seem to fall between internal administrative boundaries.

- Dispute resolution procedures relating to the joint and separate responsibilities of Statutory Directors for young carers and the people they support will be put in place.

- Both Statutory Directors have final operational responsibility for ensuring that any disagreements about funding are resolved in a reasoned, timely and appropriate manner with better outcomes for young carers being a primary consideration.

19. Audit and Reasonable Assurance

We intend to put in place arrangements for periodic audit and the provision of reasonable assurance to the Council, partners, young carers, their families and the community on how this memorandum of understanding [MoU] works in specific areas or as a whole.

These audit arrangements will be located within wider Council processes for the management of risk and provision of reasonable assurance. The information arising from these audits will be used to inform performance priorities for development and delivery of the key processes and outcomes that the memorandum has been designed to help secure.

Information on audit and assurance will be shared within local partnership arrangements.

20. Learning and Development

We will ensure that our programmes for learning and development reflect the need for joint and separate training to underpin the organisational, policy and practice principles adopted for working with young carers and their families.

Feedback from young carers and their families will be used to inform our programmes.

21. Local Partnerships

We are agreed that successful local partnerships depend on the building of constructive relationships and a shared vision around what we are trying to do. We will use the opportunities for working together to identify key priorities for commissioning and the best use of available resources designed to secure the outcomes for well-being we have identified and agreed.

APPENDIX B

RECOGNISED VALUED AND SUPPORTED

- THE CURRENT NATIONAL POLICY CONTEXT FOR CARERS

Recognised, Valued and Supported [2010] set out the Coalition Government's broad approach and priorities in England with a view to securing the best possible outcomes for carers and those they support.

The five key outcomes within the 2008 strategy[26] continue to inform the overall framework:

- Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.
- Carers will be able to have a life of their own alongside their caring role.
- Carers will be supported so that they are not forced into financial hardship by their caring role.
- Carers will be supported to stay mentally and physically well and treated with dignity.
- Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive and to enjoy positive childhoods.

The Coalition Government identified four key priority areas flowing from consultation responses and discussions with the Standing Commission on Carers. They are:

- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages.
- Enabling those with caring responsibilities to fulfil their educational and employment potential.
- Personalised support both for carers and those they support, enabling them to have a family and community life.
- Supporting carers to remain mentally and physically well.

The priority areas were recognised to be overlapping and that "… addressing any one of them adequately will require attention to all of them."

Source: Recognised, Valued and supported: next steps for the carers strategy [2010]

Shared Pathway – please note:

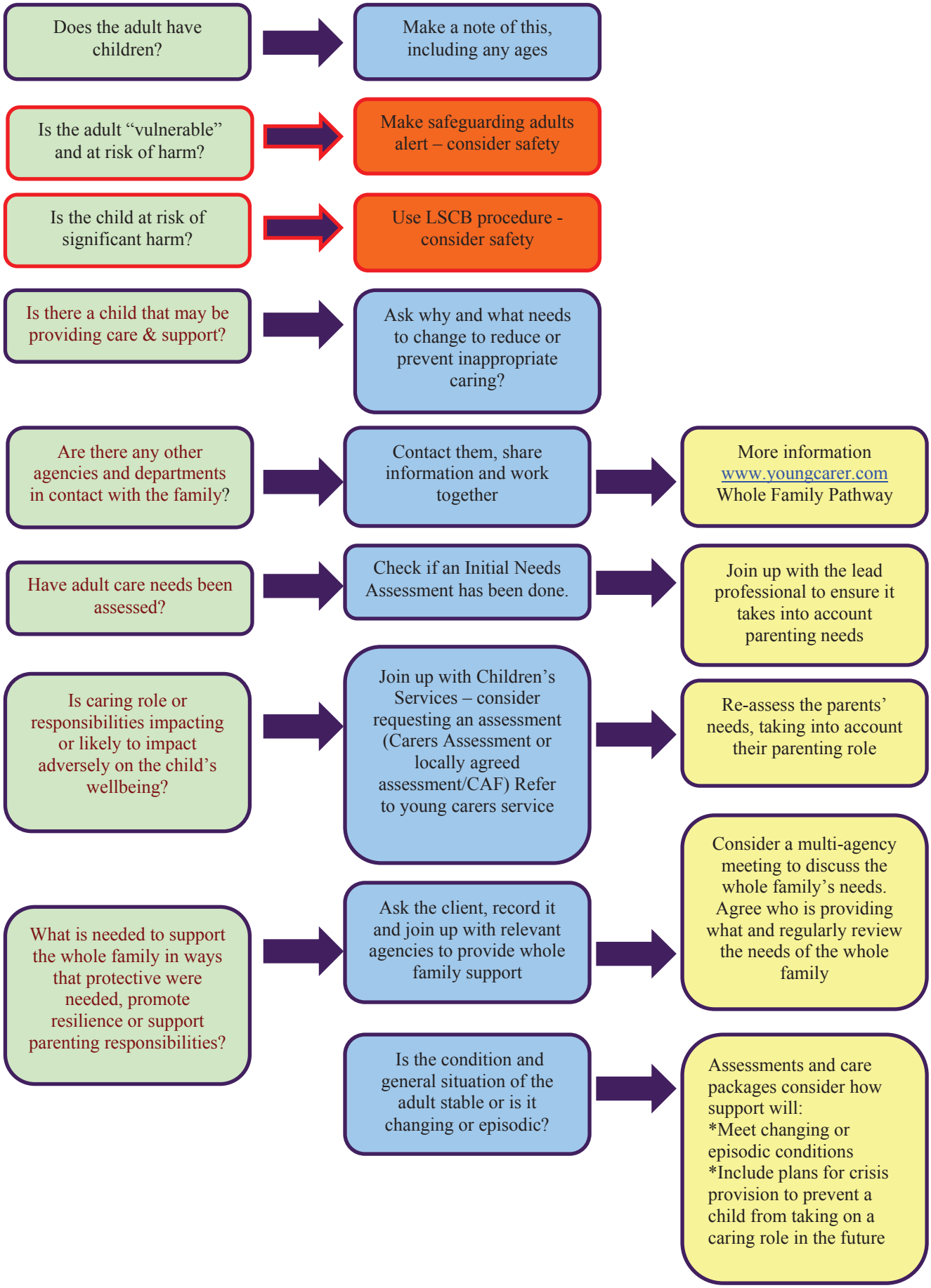
The following *two pages* indicating a shared pathway are models only.

This shared pathway will be updated by Barnet Adults and Children's Service to reflect Barnet's working practice and will be incorporated into this memorandum in January 2013.

(note inserted November 2012)

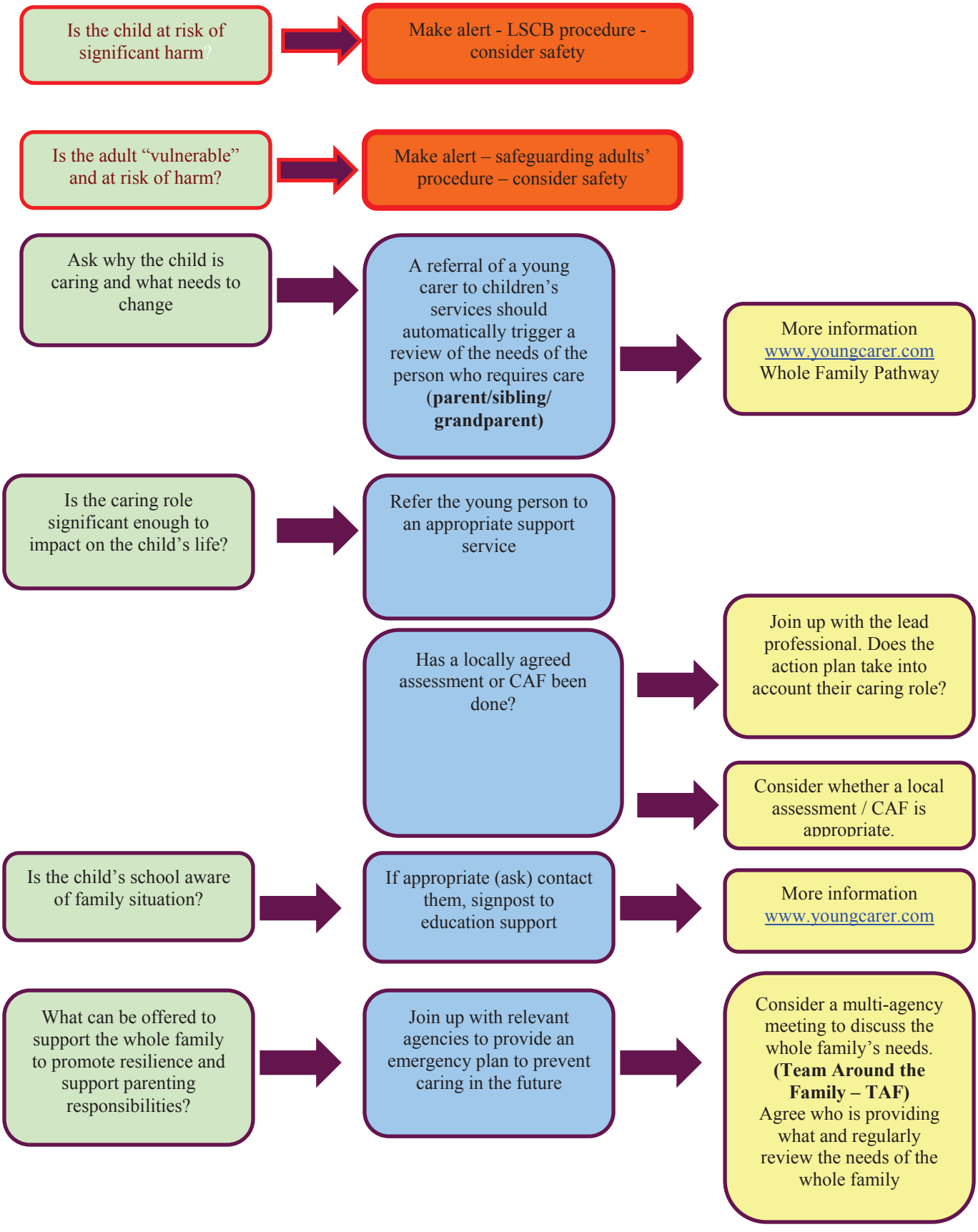
Flowchart for Adult Social Services

When a referral is made for an adult with a disability or illness, consider:



Flowchart for Children's Services

When a referral is made for a child who is a young carer consider:



APPENDIX C

SOURCES & REFERENCES

[1] **HM Government**, *Recognised, Valued and Supported: next steps for the Carers Strategy*, Department of Health, 25 November 2010. Gateway ref:15179

[2] **Association of Directors of Adult Social Services & Association of Directors of Children's Services** , *Working together to support young carers: A model memorandum of understanding between statutory directors for children's services and adult social services,* ADASS/ADCS, December 2009

[3] **The Children's Society, Include Project.** Prevention Through Partnership Programme - *Improving Outcomes for Children, Young People and Families with Multiple Problems funded by the Department for Education***,** http://www.youngcarer.com/resources/ptp

[4] **Association of Directors of Adult Social Services & Association of Directors of Children's Services**, *SIGNPOSTS, See me, hear me, talk to me – talk to my family as well, Working together to improve outcomes for young carers in families affected by enduring parental mental illness or substance misuse, ADASS October 2011.*

[5] **Association of Directors of Adult Social Services & Association of Directors of Children's Services,** *Young Carers: personalisation and whole family approaches,* ADASS October 2011.

[6] The Children's Society **Include Project**, *Whole Family Pathway*[updated for 2012] *http://www.youngcarer.com/resources/whole-family-pathway*

[7] *Think Local Act Personal, A sector wide commitment to moving forward with personalisation and community based support*, January 2011 http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/THINK_LOCAL_ACT_PERSONAL_5_4_11.pdf

[8] **Think Local, Act Personal Partnership***, Making it Real, Marking progress towards personalised community based support.,* 2011, http://www.thinklocalactpersonal.org.uk/Browse/joinMIR/About/?parent=9147&child=9091

[9] HM Government, *Positive for Youth A new approach to cross-government policy for young people aged 13 to 19, Department for Education, 2012. http://media.education.gov.uk/assets/files/positive%20for%20youth.pdf*

[10] **Frank, Jenny & Mclarnon Julie,** *Young carers, parent and their families: key principles of practice- supportive guidance for those who work directly with, or commission services for, young carers and their families,* The Children's Society, 2008.

[11] **Include Project**, *Working with the Whole Family: Developing the vision for young carers Include Partnership Conference Report,* The Children's Society, September 2011. [Summary Report]

[12] **Houmoller Katharin, Bernhas Sarah and Rhodes, Tim**, *Juggling Harms – Coping with parental substance misuse,* London School of Hygiene & Tropical Medicine, 2011.

[13] **Department for Education**, Common Assessment Framework, expected to be updated in 2012 with an emphasis on locally agreed assessment arrangements See: http://www.workingtogetheronline.co.uk/consultation/managing_ind_2012.html http://education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf

[14] **Department of Health,** *Getting it right for children, young people and families -Maximising the contribution of the school nursing team: Vision and Call to Action,* Gateway Ref:17158, DH, March 2012. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133352.pdf

[15] **Royal College of General Practitioners***, Supporting Carers in General Practice E-learning Programme*, [developed in partnership with the Princess Royal Trust for Carers and The Children's Society, 2011. http://www.e-fh.org.uk/projects/supportingcarersingeneralpractice/

[16], NHS Confederation, [Endorsed ADCS] *Operating principles for health and wellbeing boards - Laying the foundations for healthier places, NHS Confederation, 2011.*
http://www.nhsconfed.org/Publications/reports/Pages/Operating-principles.aspx

[17] **York Consulting**, *Turning around the lives of families with multiple problems - an evaluation of the Family and Young Carer Pathfinders Programme* DFE RB154, 2011. September 2011.

[18] Becker F and Becker S, Young Adult Carers in the UK, Experiences, Needs and Services for Carers aged 16-24, Princess Royal Trust for Carers, 2008.

[19] **Association of Directors of Adult Social Services & Association of Directors of Children's Services,** *Young Carers: personalisation and whole family approaches,* ADASS October 2011.

[20] Department of Health, ***Carers and Disabled Children Act, 2000 and Carers [Equal Opportunities] Act 2004, Combined Policy Guidance***, Department of Health and Department for Education and Skills, August 2005. See also: Social Care Institute for Excellence, Adult services [SCIE]: ***Practice Guide 5: Implementing the Carers [Equal Opportunities] Act, 2004***, SCIE, 2005, updated 2007.

[21] **Wardale, Louise**, ***Barnardo's Keeping the family in mind*** [resource pack]
web address: http://www.barnardos.org.uk/resources/research_and_publications/keeping-the-family-in-mind-resource-pack-2nd-edition/publication-view.jsp?pid=PUB-1600

[22] **Social Care Institute for Excellence** [SCIE] *At a glance 09*, July 2009 . See Also: **Social Care Institute for Excellence** [SCIE], *Think Child, think Parent, think family: At a glance 32* SCIE, November 2010.

See also: **Association of Directors of Adult Social Services & Association of Directors of Children's Services**, *SIGNPOSTS, See me, hear me, talk to me – talk to my family as well, Working together to improve outcomes for young carers in families affected by enduring parental mental illness or substance misuse, ADASS October 2011.[Appendix E]*

[23] **HM Government**, *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children*. March 2010.
See also: CWDC, Safeguarding and Integrated Working, 2009.

[24] **Department of Health**, *A Vision for Adult Social Care: Capable Communities and Active Citizens* DH Nov 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121971.pdf

[25] **Department of Health**, *Statement of Government Policy on Adult Safeguarding*, 16 May 2011, Gateway Reference 16072
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126748

[26] **HM Government**, *Carers at the heart of 21st century families and communities, "A caring your side. A life of your own."* HM Government June 2008.

Your Notes:

August 2012

Committee: Health & Wellbeing Board

Date: 13.06.2014

Wards:

Subject: Merton CCG Call to Action Report

Lead officer: **Eleanor Brown, Chief Officer**

Contact officer: **Lynn Street, Director of Quality**

Recommendations:

A. The Health and Wellbeing Board is asked to note the Merton Clinical Commissioning Group (CCG) Call to Action Report.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of Call to Action is to simulate debate in local communities, amongst patients, health care professionals and commissioners, about how best to deliver healthcare services in the face of the future challenges of a funding deficit and growing demand for services. It is predicted that there will be a shortfall of approximately £38 billion in the NHS in terms of service provision over the next ten years.

The NHS belongs to the population of England – A Call to Action discusses the key problems and opportunities that the future NHS must address. It provides a framework for this discussion, outlining the key issues facing the NHS and the case for future change.

The Call to Action aimed to:

- Build a common understanding about the need to renew our vision of the health and social care services, particularly to meet the challenges of the future
- Give NHS stakeholders (patients, clinicians, commissioners, etc.) an opportunity to tell us how to maintain current NHS values in the face of future pressures
- Gather ideas and solutions to develop both the CCG's two year operating plan and five year strategic commissioning plan.

In Merton CCG Engagement activities for Call to Action complemented our existing engagement and strategic planning. The feedback we received is being fed into our two-year operating plan and five-year strategic commissioning plan in particular transferring primary care and integration of services. Call to Action feedback will also shape the national vision, identifying what NHS England should do to drive service change.

2 DETAILS

We promoted Call to Action and our online survey through existing communications and engagement channels, such are the CCG website, twitter, engagement activities; and via partner channels including Merton Healthwatch, Merton Council and patient and community group events, GP practices, e-newsletters and contact distribution lists. Hard copies of the online survey were available from GP Practices, libraries, at engagement activities and by post on request.

The main tool to collect views and ideas was an online survey that was available for eight weeks on Merton CCG's website and is included in the report as Appendix 3.

Approximately 425 people have been reached by Merton's Call to Action, 369 through 15 engagement events, 58 surveys completed, 45 of which were completed online. For a full breakdown on demographic data, please see Appendix 1.

Key themes to emerge included; access to appointments and in particular general practice; increased integration of services and keeping well and healthy.

3 ALTERNATIVE OPTIONS

4 CONSULTATION UNDERTAKEN OR PROPOSED

Summary of channels used:

- GP members; promotion to CCG members, Patient Participation Groups, hard copy surveys sent to practices to place in practice waiting areas for patients
- Face to face meetings; linking into existing engagement activities, events and regular meetings (see appendix 2 for engagement grid)
- Website; created an online survey (see survey questions in appendix 3)
- Social media; promotion of online survey via Merton CCG's twitter account
- Media; press releases to promote online survey sent to Wimbledon Guardian to gain media coverage to reach the wider population
- Partner channels; Merton Council, Libraries, NHS partners including all acute trusts and community services provider, Health Watch and Merton Voluntary Services Council.

5 TIMETABLE

N/A

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

As part of the South West London's strategic planning group, Merton CCG, along with the other 5 CCGs, face a shortfall of £210m over the next 5 years.

7 LEGAL AND STATUTORY IMPLICATIONS

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION 8.1IMPLICATIONS

A demographic breakdown of respondents is attached to the report as Appendix 1.

9 CRIME AND DISORDER IMPLICATIONS

None for the purposes of this report.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None for the purposes of this report.

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

The Merton CCG Call to Action Report, Appendix 1, 2 & 3.

12 BACKGROUND PAPERS

None for the purposes of this report.

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NHS
Merton
Clinical Commissioning Group

Merton's Call to Action feedback report

23 May 2014

right care
right place
right time
right outcome

1. Call to Action

The purpose of Call to Action is to simulate debate in local communities, amongst patients, health care professionals and commissioners, about how best to deliver healthcare services in the face of the future challenges of a funding deficit and growing demand for services. It is predicted that there will be a shortfall of approximately £38 billion in the NHS in terms of service provision over the next ten years.

The NHS belongs to the people – A Call to Action, discusses the key problems and opportunities that the future NHS must address. It provides a framework for this discussion, outlining the key issues facing the NHS and the case for future change.

The Call to Action aimed to:

- Build a common understanding about the need to renew our vision of the health and social care services, particularly to meet the challenges of the future
- Give NHS stakeholders (patients, clinicians, commissioners, etc.) an opportunity to tell us how to maintain current NHS values in the face of future pressures
- Gather ideas and solutions to develop both the CCG's two year operating plan and five year strategic commissioning plan.

In Merton CCG Engagement activities for Call to Action complemented our existing engagement and strategic planning. The feedback we received is being fed into our two-year operating plan and five-year strategic commissioning plan in particular transferring primary care and integration of services. Call to Action feedback will also shape the national vision, identifying what NHS England should do to drive service change.

2. Merton Challenge

- **Merton's population is getting bigger**. We have a growing and high birth rate and at the same time an ageing population. Young and old make more demand on services.

- Merton's population is generally healthy compared to England average but this masks **significant variation** in life expectancy and mortality rates within the borough.

- Society has developed cures for many of the killer diseases we suffered when the NHS was created 65 years ago, but as **we live longer, patients have more long term, complex conditions**. Our lifestyle choices - like drinking, smoking, diet and lack of exercise - are now the main factors

causing poor health.

- **Patient's expectations of services have changed**. Patients want more information, convenience, more personal control of their own conditions and the best quality. We expect services to be joined up and to fit around our lives. We expect the NHS to offer care and information using technologies we use in our everyday lives. We expect more choice, the best and newest medicines or therapies and to have more control and say over how we are treated.

- Simply making gradual improvements to current services will not be enough to keep up with the pace of change and growing demands. Unless we **transform services**, patients will experience longer waiting times, poor quality and outdated care.

- **A disproportionate amount of Merton's healthcare budget is spent on hospital services**. The borough of Merton does not have an acute hospital, yet spends 64% of its total health budget on acute services. In comparison 12% is spent on primary care services and only 8% spent on community services.

Right care at the right time in the right place with the right outcome. The national direction is for more integrated care that is closer to home. In Merton the movement to more locally based services in the community has been happening since 2000, but the Better Care Fund seeks to accelerate this with the Better Health Care Closer to Home programme.

- Following the global economic downturn, NHS England is assuming that the national **NHS budget** will remain at its current levels - or **flat growth** in real terms. But as demand rises and other costs rise, like medicines, energy, pension costs, etc. the NHS will rapidly become unsustainable and generate huge cost pressures. It is estimated that without radical changes to the way services are organised and run, the NHS in London will have an affordability gap of £4bn by 2020.

3. Approach

We promoted Call to Action and our online survey through existing communications and engagement channels, such are the CCG website, twitter, engagement activities; and via partner channels including Merton Healthwatch, Merton Council and patient and community group events, GP practices, e-newsletters and contact distribution lists. Hard copies of the online survey were available from GP Practices, libraries, at engagement activities and by post on request.

The main tool to collect views and ideas was an online survey that was available for eight weeks on Merton CCG's website.

Summary of channels used:

- GP members; promotion to CCG members, Patient Participation Groups, hard copy surveys sent to practices to place in practice waiting areas for patients
- Face to face meetings; linking into existing engagement activities, events and regular meetings (see appendix 2 for engagement grid)
- Website; created an online survey (see survey questions in appendix 3)
- Social media; promotion of online survey via Merton CCG's twitter account
- Media; press releases to promote online survey sent to Wimbledon Guardian to gain media coverage to reach the wider population
- Partner channels; Merton Council, Libraries, NHS partners including all acute trusts and community services provider, Health Watch and Merton Voluntary Services Council.

4. Feedback results

Approximately 425 people have been reached by Merton's Call to Action, 369 through 15 engagement events, 58 surveys completed, 45 of which were completed online. For a full breakdown on demographic data, please see appendix 1.

Feedback from meetings and events include a desire to see:

- Exercise classes and groups to be available on prescription to help those who need it, but cannot afford it, to improve health and well-being
- Improvement of patient information and advice on local services, to enable people to make informed decision about where to go for treatment and when, e.g. alternatives to A&E
- Increased integration and collaboration between health and social care, and hospital and community services to improve outcomes and experience for patients
- Greater focus on prevention, awareness raising, health campaigns, training and education on specific conditions
- Investment in the workforce to prepare for the changes within the NHS

Survey results

Answers to questions as follows:

Health and social care services can support people to be more in control of their own care and to take more responsibility for their own health by;

- Greater access to GP and hospital appointments, and choice of healthcare provider
- Improving general patient and condition specific information and advice on local services and treatment options available
- Guidance from health professionals and advocates to identify local groups, tools and training from within the community that can offer extended support such as self management programmes
- Providing easy access to affordable exercise and other preventative activities, and encouraging participation through community engagement

The NHS (including primary, hospital, community care and mental health) and social care services could better use technology by;

- Using Skype and Facetime for patients who are house bound or have mobility issues – GP and Nurse appointments, assessments and hospital consultations
- NHS or health app to monitor weight reduction, healthy eating, exercise, order repeat prescriptions and reminders to take medication
- Greater use of text messages, emails and automated phone calls for appointment reminders and inform patients of routine test results
- Online access to information about specific conditions, how to use medication, new and existing treatments

The advantages and disadvantages to providing the same quality of care at the weekend, overnight and in the week would be;

- Outcomes for patients would improve if healthcare provision were consistent throughout the week
- Resourcing the appropriate staff required to provide the additional services would be problematic, night shifts/weekend especially
- Waiting times and list would be improved, and it would relieve pressure on daytime services and A&E
- Funding the cost of extended services on the existing budget would not be possible

The NHS could make resources go further to meet more people's needs by;

- Providing better care within the community, community nurses, drop in advice sessions, the Expert Patients Programme to reduced need for hospital services
- Make better use of technology, online consultations, email and text messages appointment reminders, repeat prescriptions, appointments made on-line
- Raise awareness of the costs of treatment, services and the impact of wasted appointments 'did not attend'

If you could change anything about the NHS what would it be?

- Improve GP and hospital appointment systems, easier access to appointments and faster referrals to hospital and other support services
- Place NHS services in the community to support people with long term conditions and their carers to reduce the need for hospital services

What could be done to reduce the demand on hospital services and make sure people are supported in the community?

- Redirect individuals who inappropriately use A&E to more suitable services such as walk in centres, GPs and pharmacists
- Raise the awareness of other community and voluntary groups who can provided advice, support and services to patients and carers
- Extend out of hour services, walk in centres open longer, GPs extend hours, i.e. longer days and available at the weekends
- Mobile surgeries reaching out to communities most with high health care needs, promote prevention and general health and well-being

What can NHS Merton CCG and other partners do over the next five years to deliver more health and social care services in the community?

- Work in partnership with voluntary, community and public sector to improve and integrate services, join budgets to improve services and access to services
- Involve patients, public and carers in the planning, development and reviewing of services through engagement activities and patient groups

What things would make the biggest difference in improving patient experience?

- Improve communication between patient, carer, healthcare professional and healthcare provider organisations and sign posting to other community advice, support and education organisations
- Increased access to GP, hospital and specialist appointments, and faster referral and treatment times

5. Conclusion

The report captures the themes and concerns raised by participants during the Call to Action discussions held between October 2013 and April 2014, and reflects national findings reported in NHS England's http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2014/04/final-engagement-report.pdf

Merton CCG will continue to engage with patients and the public on the themes raised and look to find possible solutions. The Call to Action engagement findings will inform our operating plan and commissioning intentions.

As part of our ongoing patient and public involvement we will ask the Merton CCG patient reference group to help identify changes we have made as a result of the feedback which we will then publish on our website.

Appendix 1: Demographic Breakdown

Total number of surveys completed	58
Online surveys 45	45
Paper surveys	13

How old are you?

Under 25		25-34	6
35-44	9	45-54	10
55-64	15	65 and over	15
Prefer not to say	3		

Do you work for the NHS?

Yes	8
No	44
Prefer not to say	6

Do you consider yourself to have a disability?

Yes	4
No	51
Prefer not to say	3

Please tell us your postcode?

Post code	CR4	SW1	SW16	SW19	SW20	SM1	SM4	SM5	SM6	SE15	KT3	Not Given
No	9	1	1	15	10	3	8	2	2	1	1	5

Please tell us your role and, or organisation you represent?

Role or organisation	**Numbers**
Skipped	6
Jigsaw 4U	2
Merton Council	1
Merton CCG	1
Nurse / Consultant	1
Technician	1
Age UK	3
Community Learning	1
Merton Seniors Forum	1
Mental Health Support	1
Carer	1
Psychotherapist - Private	1
Patient Participation Group	1
Not given	37

Which NHS services have you, or the person you care for, used in the last year?

Services	You	Cared
I haven't used an NHS service in the last year	4	3
GP or Practice Nurse	45	16
Out-of-hours/111	5	6
Walk-in centre	8	7
Urgent care centre	3	4
A&E	17	8
Hospital (pre-booked appointment)	26	5
Community health services	9	0
Pharmacist	19	4
Optician	9	2
Other services: Physiotherapist 2, Community Mental Health 2, and Counselling services 1.		

Please tell us your ethnic background?

White	British	26	Irish		Other White background	15		
Mixed	White and Black Caribbean		White and Black African		White and Asian	5	Other Mixed background	2
Asian or Asian British	Indian	3	Pakistani		Bangladeshi		Other Asian background	
Black or Black British	Caribbean	4	African		Other Black background			
Other Ethnic Groups	Chinese		Other ethnic group		**Not answered**	3		

Appendix 2: Engagement grid

	Stakeholder group	Channels	Meetings (where possible)	Dates	Lead / Presenter	Actions / Progress
1	**25 Member Practices** (Clinical)	• Launch email promoting Call to Action and online survey • CCG intranet • Presentation at an existing event • Promotion via GP leads		30 Jan 2014	Nan-see McInnes	Completed
		• Presentation	Members event	9 Oct 2014	CCG Chair	80+ in attendance
		• CCG newsletter		Feb 2014	Nan-see McInnes	MCCG February newsletter focus on C2A
2	**Localities**	• Launch email promoting Call to Action and online survey • Presentation and discussion • Request written feedback / online survey		3 March 2014	Nan-see McInnes	Go live on Monday - out to all PM and Locality Leads
		• Presentation	PM Forum	27 Feb 2014	Eleanor Brown / Jenny Kay	14 in attendance
		• Presentation	Practice Leads Forum	30 Jan 2014		17 in attendance

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right time
right outcome

	Stakeholder group	Channels	Meetings (where possible)	Dates	Lead / Presenter	Actions / Progress
3	**Merton CCG – All Staff**	• Launch email promoting Call to Action and online survey • CCG intranet • Email online survey • Newsletter		Feb 2014	Nan-see McInnes	Newsletter, upload presentation and survey to intranet and website - Completed
		• Presentation and discussion	Staff Briefing	9 Jan 2014		20 in attendance
4	**Merton CCG – Leadership**	• Launch email promoting Call to Action and online survey • CCG intranet		Feb 2014	Nan-see McInnes	Newsletter, upload presentation and survey to intranet and website - Completed
		• Presentation and discussion • Feedback Report	Governing Body Board seminar Governing Body Board seminar	19 Dec 2014 29 May 2014	Eleanor Brown	20 in attendance
	Practice population including Patient Participation Groups	• Email promoting Call to Action and online survey • Poster • Hard copies of survey	Attend if requested - PPG meetings	4 Mar 2014	Nan-see McInnes and Clare Lowrie-Kanaka	
		• Presentation and discussion Presentation and discussion	Lampton Road Patient Reference Group	26 March 2014 25 Mar 2014	Clare Gummett Jenny Kay	12 in attendance Sent to PRG members on 4 March 2014 18 in attendance

6	**Voluntary sector groups, lay user groups, faith groups, community groups, etc.**	• Materials to be sent to Hub organisations for wider distribution i.e. MVSC, Healthwatch, Ethnic Minority Centre, Age UK, Carers Support Merton and others • Launch email to be distributed to their contact lists • Send printed surveys and posters • Presentation and discussion at existing meetings, where possible		3 Mar 2014	Nan-see McInnes and Clare Lowrie-Kanaka	
		• Presentation and discussion Other networks/contacts: • Imagine • Alzheimer's Society • Age UK Merton • LGBT forum • Merton Young Carers • Ethnic Minority Centre (EMC) • Merton Centre for Independent Living • Merton Voluntary Sector Council	• Diabetes UK Wimbledon • Inter Faith Forum • Joint Consultative Committee (JCC) with Ethnic Minorities • Carers Support Merton Carers Cafe	17 March 2014 26 Feb 2014 6.30pm 19 March 7.15pm 18 Mar 2014 7pm	Clare Gummett Jenny Kay Andrew Murray and Cynthia Cardozo Eleanor Brown	20 in attendance 6 in attendance 20 in attendance: 15 Community Reps 5 Councillors 15 in attendance

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right place
right time
right outcome

7	**Health and Wellbeing Board and Overview and Scrutiny Committee**	• Presentation and discussion	Merton Health and Wellbeing Board and Overview and Scrutiny Committee	3 Dec 2013 Ongoing dialogue to June 2014: - 28th Jan 14 - 25th Mar 14 - 24th Jun 14		
8	**HealthWatch**	• Presentation and discussion	Healthwatch meetings	31 Jan 2014 5th Feb 2014	Dr Karen Worthington and Cynthia Cardozo Dr Sion Gibby and Jenny Kay	These meeting were cancelled due to lack of numbers. Waiting for an update from Healthwatch on possible new dates
		• Launch email promoting Call to Action and online survey		4 Mar 2014	Clare Lowrie-Kanaka	
9	**General public**	• CCG, Healthwatch and MVSC websites • Online survey • Social media to promote online survey • Press release to promote response from public	Via community meetings, patient group meetings and HealthWatch, see above	4 Mar 2014	Nan-see McInnes and Clare Lowrie-Kanaka	
		• Presentation, table discussions	Engage Merton	16 October 2013	All	57 in attendance
		• Online questionnaires and paper questionnaires in GP practices, Civic Offices, Libraries and other central points	Questionnaires	January – March 2014		58 completed questionnaires (45 online, 13 paper copies)

10	**Community Pharmacists**	• Launch email promoting Call to Action and online survey • Presentation and discussion	LPC meeting	29 January 2014: Sedina Agama and Jenny Kay	Sedina Agama and Jenny Kay	70 in attendance
11	**Providers:** Acute Mental health SMCS Third sector	• Launch email promoting Call to Action and online survey	Via provider staff briefings through the communications route	Ongoing through Jan – Mar 2014	Nan-see McInnes and Clare Lowrie-Kanaka	

Appendix 3: Survey questions

1. How can the health and social care services support people to be more in control of their own care?

2. How can the health and social care services support people to take more responsibility for their own health?

3. Mobile, smartphone and computer technology are now a part of life. Please give us your views on how the NHS (including primary, acute hospital, community care and mental health) and social care services could better use this type of technology. For example, what would you use it for (emails/texts/app, etc.) and in which setting?

4. What do you see as the advantages and disadvantages of providing the same quality of care at the weekend and overnight as well as during the week?

5. Thinking about health and social care services, what three things would make the biggest difference in improving patient experience?

6. Please tell us your ideas as to how the NHS can make resources go further to meet more people's needs? If possible please be specific about the setting, i.e. primary care, hospital, community care and mental health.

7. If you could change anything about the NHS what would it be? Feel free to give anonymised examples of your experiences.

8. What could we do to reduce the demand on hospital services and make sure people are supported in the community? Feel free to give anonymised examples of your experiences.

9. What can NHS Merton CCG and Merton Council do over the next five years to deliver more health and social care services in the community?

Committee: Health and Wellbeing Board

Date: 24 June 2014

Agenda item:

Wards: All

Subject: Better Care Fund and Integrated Services

Lead officer: Simon Williams, Director of Community and Housing

Lead member: Councillor Caroline Cooper-Marbiah

Forward Plan reference number:

Contact officer: Simon Williams, Director of Community and Housing

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Recommendations:

A. That progress with the Better Care Fund plan, as described in this report, is noted.

B. That consideration is given to the proposals to apply for NHS England Tech Fund financing for the data sharing component of the project, as set out in paragraphs 3.5 to 3.11 below.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of the report is to present progress with implementing the Better Care Fund through the project governance structure that was set up as part of the original submission.

2 APPROVAL OF THE PLAN

2.1. The Plan was submitted on 4 April 2014 and final, formal approval is still awaited. NHS England has advised that a final realignment of BCF outcomes with CCGs' two-year Operating Plans will be required to be resubmitted by 27 June 2014 but this will not affect the continuing delivery of the outputs set out in the original submission, which are already under way.

3 GOVERNANCE

3.1. Delivery of the Plan is being managed by the Merton Integration Board, a stakeholder group of all Merton commissioners and service providers and, on a week-by-week basis by a project team at service manager and operational level, chaired by the project manager. Six workstreams deliver the scheduled outputs and these are managed, in turn, by a designated lead from the project team.

3.2. **Workstream 1: Finance and Performance**. The purpose of this work stream is to manage the financial and funding aspects alongside creating a sustainable performance management framework to demonstrate that the plan is delivering the expected performance changes within the overall health and social care environment. To this end, progress so far has focused on the need to develop a robust performance management framework and a draft model has been completed, which is currently being refined. The model will be considered by the Integration Board at this end of

this month and has been populated with the first month's data from 2014/15 to refine the recording mechanisms.

3.3. **Workstream 2: The Merton Model**. This is by far the largest and most complex of the workstreams, as it deals with the operational restructuring of pathways and teams to deliver Merton integrated services across three localities. LBM has already restructured into three localities to reflect primary care divisions and Sutton & Merton Community Services, the community healthcare provider, is scheduled to have completed this division by 1 July. Considerable work has taken place to define processes and pathways as they currently operate (in order to ensure that there is clarity about what needs to be changed) and to engage all those involved in service delivery in developing a model for the new ways of working.

3.4. To date, a service design workshop has been held on 23 April to examine how the hospital discharge processes could operate in future and a second workshop is scheduled for 17 July to examine how the prevention of admission processes can be redesigned to fit the new ways of working.

3.5. A separate group reporting to the project team has been established to progress development with the Merton Model and meets fortnightly.

3.6. **Workstream 3: Data and IT**. Consideration of the implications of joining up data has been summarised in a draft report prepared for Merton, Sutton and Croydon CCGs and LB Croydon by the South London CSU. The proposals centre around a proposal based on expanding the use of a product already procured by Kingston CCG called 'Graphnet CareCentric'. The system allows logged-in users of one 'member system' (e.g. EMIS) to see approved records from another 'member system' (e.g. CareFirst or PACS). There is no 'write to' functionality; only 'view' functionality, so it's not creating a virtual single system but it means that limited, agreed records can be easy and securely shared between disciplines.

3.7. This has benefits over other options that have been identified, including a rapid deployment, as the existing licence could be extended without re-procurement. This would reduce time to going live by 6-12 months as well as reducing procurement costs. Experience of deploying this system also exists within the CSU.

3.8. There is urgency to this decision, in that we can access funding from the NHS England Tech fund but applications have to be in 14 July and funds are being allocated as bids are received. The fund will look favourably on collaborative projects.

3.9. LB Sutton has agreed to front a bid (it must come from a local authority or health provider) and we need to decide whether we want to be party to a joint bid with Sutton and any other boroughs wishing to be a part of the network.

3.10. While Merton and Sutton (and any other partners) would be looking to access funding quickly, there would have to be a lot of work taking place in the sphere of supporting clinicians (notably GPs) to use this and it is important that other systems are adequate to manage any data integration. It is also important that the views of patients, service users and the public

were considered at all stages to address concerns about the nature of data sharing.

3.11. If an application is made for the funding, it will not be necessary to proceed immediately with the extended procurement of the Kingston product and that time should naturally be used to undertake practitioner and public engagement.

3.12. In addition to the above, work is taking place to examine how the current Mascot Telecare service can be expanded to provide telehealth support to patients. Evidence is being sought on the types of condition that can be supported by an extended telehealth service.

3.13. **Workstream 4: Workforce Development.** A draft workforce strategy is being prepared to support the development of the Merton Model work stream and a first draft is scheduled to be reviewed by the project team by the end of June.

3.14. **Workstream 5: Engagement**. The chief executive of the MVCS is a member of the Integration Board and the manager of Healthwatch Merton is an active member of the project team, supporting the project to develop a meaningful and robust engagement strategy and plan throughout all the development work. The first engagement work will take place in July, as an initial review of pathways in localities is progressed with further activities taking place as more outputs emerge from the project.

3.15. **Workstream 6: Quality integrated commissioning**. Progress has been made in reviewing the implementation of an overarching Quality Assurance Framework with the support of the CCG's new Director of Quality, Lynn Street.

3.16. A review of the effectiveness of MDT meetings is also being scoped and this will be led by Dr Carrie Chill, the CCG's Clinical Director for Integration. This work will focus on ensuring that MDTs operate efficiently and consistently across Merton and deliver the best outcomes for all involved.

4 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

4.1. None specific for this report

5 LEGAL AND STATUTORY IMPLICATIONS

5.1. The pooled fund is under S75 of the NHS Act 2006.

6 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

6.1. None specific for this report

7 CRIME AND DISORDER IMPLICATIONS

7.1. None specific for this report

8 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

8.1. None specific for this report

9 APPENDICES

9.1. None specific for this report

10 BACKGROUND PAPERS

10.1. Merton Better Care Fund Submission: April 2014.

10.2. Better Care Fund Guidance issued by DCLG and DH December 2013, including main Annexe, Technical Guidance, and planning template.

Committee: Health and Wellbeing Board

Date: 24 June 2014

Wards: All

Subject: East Merton Model of Care - Update Report

Lead officer: Adam Doyle – Director of Commissioning and Planning Merton Clinical Commissioning Group

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Recommendations:

A. To note the update

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to provide an update to the Health and Wellbeing Board on the development of the East Merton Model of Care and Mitcham Local Care Centre.

2 BACKGROUND

2.1. The Merton Better Healthcare Closer to Home programme has six key delivery objectives, to:

- Improve outcomes for patients;
- Provide more care locally;
- Tackle health inequalities;
- Meet changing demographics and healthcare needs;
- Modernise the estate; and
- Use resources more efficiently.

2.2. The programme aims to meet these objectives through the development of new care pathways that better meet the patients' needs by keeping them at the centre of all service redesign. In designing the new pathways the intention is that the patient will be able to access these services closer to where they live.

2.3. The development of a new facility, a local care centre (LCC), in Mitcham has been identified as a key component of the Merton Better Healthcare Closer to Home programme. The delivery of this new facility is in response to the poor condition of the current estate and the opportunity to consolidate services into one modern, purpose built facility.

2.4. Whilst the renewal of the community estate is a key priority, this development needs to be designed in response to the overall model of care to be implemented in East Merton. The new facility must act as a hub for primary care services with the clinical services designed to meet the needs of the local population served.

3 DETAILS

3.1. The project is in its early stages of initiation and comprises of two main workstreams; the development of a new model of care within the East Merton locality and the development of a new healthcare facility within Mitcham. The first meeting of the Project Board for the development of the Mitcham LCC will take place on 20th June.

3.2. The East Merton GP Locality Group, chaired by Dr Karen Worthington as the locality lead, is developing a new model of care to address the health needs of their local population.

3.3. A Health Needs Assessment (HNA) has been undertaken, led by the Director of Public Health, which has highlighted some key areas of concern with regard to the health of the population of East Merton.

3.4. East Merton has the areas within the Borough with shorter life expectancy. Most of the excess deaths are attributable to cardiovascular disease and cancer. However, admission rates do not reflect the differences in mortality from these conditions. Diabetes is more prevalent in East Merton than the west of the borough, respiratory disease is common and the positivity rate for chlamydia is higher than both London and England.

3.5. The child health element of the HNA found that childhood immunisation coverage is lower than the World Health Organisation target, emergency attendance for children under 4 is higher than England levels, there has been an increase in childhood obesity, hospital admissions for alcohol specific conditions in children and young people are among the highest in London and children's dental health is declining.

3.6. Specifically the new model of care will improve access to health and social care services that support patient with long term conditions. There will also be an emphasis on the prevention of ill health and specifically focusing on working with children and young people to promote lifestyle changes in the early years.

3.7. A critical success factor will be enhancing and improving access to primary care and public health services within the locality.

4 ALTERNATIVE OPTIONS

4.1. Not applicable

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. There is a programme of Patient and Public engagement currently under development. The first stage of this process is to seek the involvement of members of the public through the Health Hub at the Mitcham Carnival on June 14th 2014.

5.2. A further event will be held to explain the process, programme and the options for involvement in this important piece of work. From this event we will establish the key areas of public interest and agree the most appropriate methods of engagement.

5.3. The overall aim is to involve members of the public at all stages of the project, from the establishment of the model of care and the design of the Mitcham LCC facility to how the facility will operate when it opens its doors.

6 TIMETABLE

6.1. The high level milestones and timetable for the development of the Mitcham LCC is set out in the following table.

High Level Milestones/Tasks	Target Date
Prepare Economic Case	31/07/2014
Obtain sign off of Economic Case	31/07/2014
Obtain instruction to proceed from NHS England	15/08/2014
Submit Stage 1 Business Case	15/01/2015
Planning approval for preferred option	15/01/2015
Obtain sign off of Stage 1 Business Case	31/01/2015
Obtain approval of Stage 1 Business Case from NHS England	31/03/2015
Submit Stage 2 Business Case	15/06/2015
Obtain sign off of Stage 2 Business Case	30/06/2015
Obtain approval of Stage 2 Business Case from NHS England	15/07/2015
Financial Close	22/07/2015
Start on site	01/08/2015

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. There are currently four sites under consideration, two in the ownership of NHS Property Services and two owned by the London Borough of Merton.

7.2. Work is currently underway to develop sufficient detail to enable a full economic appraisal to be undertaken to establish the preferred option.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. Section 242 (1B) of the NHS Act 2006, as amended by the Local Government and Public Involvement in Health Act 2007, provides that: Each relevant English Body must make arrangements as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information or in other ways) in:

- The planning of the provision of those services;
- The development and consideration of proposals for changes in the way those services are provided;
- Decisions to be made by that body affecting the operation of those services.

8.2. The NHS Act 2012 chap. 7 PART1 s26 makes similar provision for CCGs.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. An Equality Impact Assessment is in the process of being completed.

10 CRIME AND DISORDER IMPLICATIONS

10.1. Not applicable

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. Risk Management workshop to be scheduled as part of project set-up

12 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- Mitcham LCC Highlight Report (from September)

13 BACKGROUND PAPERS

13.1. Project Initiation Document

MERTON COUNCIL

NHS Merton Clinical Commissioning Group

Mitcham Local Care Centre Project Initiation Document

Sue Howson and Keith Foster

23 May 2014

Version 0.2

right care
right place
right time
right outcome

Document Control

Version Control

Version	Date	Issued to:	Author(s)
0.1	14/05/14	Adam Doyle, MBHCH Programme SRO, MBHCH Programme Board	Sue Howson Keith Foster
0.2	23/05/14	Adam Doyle, MBHCH Programme SRO	Sue Howson Keith Foster

Change Control

Version	Changes:	Author(s)

Contents

Appendices

1 Introduction and Background

1.1 Introduction

1.1.1 This Project Initiation Document (PID) sets out the details of the next stage of the Mitcham Local Care Centre (LCC) development project, to develop the required business cases and to reach award of the development contract. The form of this contract will be decided at the early stages of the project through the development of a robust Economic Case.

1.1.2 The PID should be read in conjunction with the Mitcham LCC Strategic Outline Case (SOC) which was approved in May 2014 by the NHS Merton Clinical Commissioning Group (MCCG) Governing Body. This development is sponsored by MCCG and South West London St Georges Mental Health NHS Trust.

1.1.3 The document provides details on the scope and objectives of the project, the approach to be followed, governance arrangements and project control processes to be employed to ensure that the project is delivered within allocated resources and timeframe.

1.2 Background

1.2.1 The shape of health services is changing. Primary care and community services are at the very heart of the modern NHS. Many activities that traditionally have happened in an acute hospital can now be undertaken more effectively and more conveniently in community settings, community hospitals, GP surgeries or in patients' own homes. "Our health, our care, our say" (Department of Health, 2006) laid out a vision that confirms a radical shift from acute hospital based services to a more local model, providing innovative, flexible and accessible primary and community care. This has since been followed up by various policy documents from the Department of Health that further support this strategy, including NHS 2010-2015: From Good to Great. Preventative, People-Centred, Productive (2009), Equality and Excellence: Liberating the NHS (2010), The NHS belongs to the people - A Call To Action (2013) and Everyone Counts – Planning for Patients 2014/15 to 2018/19 (2013).

1.3 Better Healthcare Closer to Home

1.3.1 These drivers for change, underpinned by the need to use resources more effectively and efficiently, resulted in the health and social care organisations in the Sutton and Merton health economy working together to produce a master plan for the future service configuration across the two boroughs. A programme to coordinate inputs, manage the process of development and to deliver the change was constituted and named the Better Healthcare Closer to Home (BHCH) programme.

1.3.2 BHCH was a transformational programme that aimed to reshape and modernise health services in Sutton and Merton. The proposed new service models and service configurations aimed to provide 21st century healthcare, designed around the needs of local people.

1.3.3 MCCG has adopted the underpinning principles of this strategy and has established a Merton Better Healthcare Closer to Home (MBHCH) Programme Board to drive through the required changes to services and the investments required in the healthcare estate.

1.3.4 The programme had six key delivery objectives, which remain valid and are at the core of the MBHCH programme. All proposed changes are aimed at:

- Improving outcomes for patients;
- Providing more care locally;
- Tackling health inequalities;
- Meeting changing demographics and healthcare needs;
- Modernising estates; and
- Using resources more efficiently.

1.3.5 The BHCH programme identified a need to invest in the healthcare estate in order that the transformational changes in service delivery could be realised. This focused on providing purpose designed healthcare buildings to replace facilities, valued by the community, but unsuitable for the delivery of modern healthcare and that are rapidly deteriorating due to lack of investment. These new healthcare buildings will, through location and design, facilitate the delivery of integrated health services allowing people to be treated, wherever possible, close to where they live.

1.3.6 MBHCH aims to meet these programme objectives through the development of new care pathways that better meet the patients' needs by keeping them at the centre of all service redesign. In designing the new pathways the intention is that the patient will be able to access these services closer to where they live.

1.3.7 The BHCH programme envisaged a network of LCCs, an important component in the range of primary care facilities that form the estate infrastructure required to meet the service and clinical objectives of the BHCH programme.

1.3.8 The MBHCH programme is currently developing the Nelson LCC, which is due to be completed in January 2015 with a planned opening date in Spring 2015, and has examined the feasibility of an LCC in Mitcham in the SOC.

1.3.9 The LCCs will act as a hub for primary care services. The clinical services within each LCC will be designed to meet the needs of the local population served; however, certain core services are planned to be provided in all LCCs. These include enhanced primary, community and mental health services and integrated health care support for patients with Long Term Conditions (LTCs). Community teams delivering care directly into people's own homes will support these services.

1.3.10 Investment in the improvement of the St Helier acute hospital estate was also planned as part of the BHCH programme. The first stage has been completed in a planned four phase programme developing and enhancing Urgent Care Centre provision on the St Helier hospital site. The remainder of the programme is in abeyance pending a further strategic review.

1.4 The Mitcham LCC, The Case for Change

1.4.1 A Health Needs Assessment (HNA) was commissioned by the Merton Director of Public Health in January 2014. This indicates that, in comparison to the western half of the borough, East Merton has:

- A younger, more ethnically diverse population;
- In general, the most deprived areas in Merton; and
- The areas with shorter life expectancy. Most of the excess deaths are attributable to cardiovascular disease and cancer. However, admission rates do not reflect the differences in mortality from these conditions. Diabetes is also more prevalent in East Merton and respiratory disease is also common.

1.4.2 The child health element of the HNA found that childhood immunisation coverage is lower than the World Health Organisation target, emergency attendance for children under 4 is higher than England levels, there has been an increase in childhood obesity, hospital admissions for alcohol specific conditions in children and young people are among the highest in London and children's dental health is declining. There are also four times as many children living in poverty in the east of the borough in comparison to the western half.

1.4.3 Current services in East Merton are provided from 13 GP practices and three other sites from which community, mental health and a limited number of community-based outpatients services are delivered. Almost all diagnostics services are still provided on the main acute sites.

1.4.4 The current NHS estate within East Merton comprises two sites, neither of which has been extensively maintained in the recent past due to uncertainty surrounding their future.

1.4.5 The case for change for the investment in the Mitcham LCC is multifaceted. The high level objectives specific to this investment decision are to:

- Improve the range, integration and quality of healthcare services accessible locally and by doing so improve outcomes for patients;
- Modernise the facilities in the Mitcham locality thus avoiding safety and financial risks due to the deteriorating condition of the existing buildings;
- Develop modern, fit for purpose facilities that will facilitate the shift of more activity into a primary care setting and promote integration with secondary care services; and
- Provide an opportunity to rationalise the community estate and dispose of properties surplus to requirements.

1.4.6 The service strategy to be supported by the Mitcham LCC will continue to develop as local commissioning, community needs and partnerships evolve. However, the priorities are clear:

- Develop an integrated model of care that is patient centred and led by primary care;
- Maximise multi-disciplinary team working with secondary care;
- Create a vibrant environment for multi-agency work and partnerships;
- Meet the needs of the diverse communities in East Merton including services for children, maternity care, elderly care and services to support minority ethnic groups;
- Increase access; and
- Provide culturally sensitive approaches in the most frequently spoken languages.

1.4.7 There is a wide range of services that the Mitcham LCC Clinical Strategy identified as suitable for delivery from the LCC. Some are currently offered, or planned to be offered, by some practices; the LCC will not detract from these practice-based offerings or seek to duplicate them. However, it will be used to fill gaps in provision. The Clinical Strategy identified the most useful and important services to offer as Cardiology, Dermatology, Ear, Nose and Throat services, Gynaecology, Ophthalmology, Respiratory Medicine, Musculo-skeletal and Trauma and Orthopaedics services.

1.4.8 In addition, the Mental Health services currently provided at Birches Close and the Wilson Hospital will also need to be accommodated within the new building.

1.5 Project Objectives

1.5.1 The clinical strategy for the Mitcham LCC was developed in 2012. The purpose of the LCC was defined in this document as being to help people access a range of specialist and advanced services in a primary care context, without having to attend hospital. The expected outcomes were defined as:

- Help to ***reduce health inequalities*** by ensuring access to health services for diverse local communities;

- Improved ***access*** to specialist services for local people;
- Improved ***quality*** and scope of care available locally;
- Reduced unnecessary use of hospital services, and thus ***value for money***; and
- Improved ***partnerships*** between primary and secondary healthcare, health and social services and the voluntary sector.

1.5.2 Detailed objectives for the project reflect these expected outcomes and are divided into six categories: health promotion, clinical, design, sustainability, community and workforce.

Prevention objectives

- Build a model of care around keeping people healthy and early detection of disease when it can be cured or managed in the community; and
- Enable frontline staff to take advantage of every contact with patients to maximise prevention messages and referral to appropriate services, as agreed with the patient.

Clinical objectives

- By careful consideration of current and required service provision and facility, design and facilitate the development of integrated services and care pathways that put patients' needs foremost;
- Provide a comprehensive range of clinically appropriate services that can be safely and economically delivered in a primary/community setting;
- Introduce innovative service provision that embraces technology and new ways of working that facilitate the delivery of high quality, accessible services;
- Provide an efficient and effective working environment for all staff that acts as an enabler for multidisciplinary working practices and service integration; and
- Ensure that the configuration of services has a strategic and clinical fit within the wider network of health and social care in East Merton.

Design objectives

- Provide a purpose built modern healthcare facility that is fit for purpose and provides flexibility to meet the changing healthcare needs of the local population in the short, medium and long-term;
- Through design facilitate the introduction of innovative service provision that embraces technology and supports new ways of working;
- Reflect best practice in design of healthcare buildings embracing principles set down by the Commission for Architecture and the Built Environment (CABE), design guidance published by the Department of Health and NICE guidance for buildings;

- Reflect the clinical vision of modern health services and also provide a positive and sensitive response to the local environment;
- Embrace the principles of Access for All; and
- Actively facilitate the development of the surplus NHS owned land to improve overall viability and affordability of the scheme.

Sustainability objectives

- Embrace and promote sustainability during construction and operation by providing an environmentally responsible and responsive design solution;
- Design the building so that it can harness the natural environment to reduce energy consumption wherever possible; and
- Promote the use of sustainable means of transport.

Community objectives

- Provide a resource to the community that delivers an holistic service embracing both the prevention and treatment of ill health and promotes social well being by offering advice and support in partnership with statutory and voluntary organisations;
- Provide a centre which is integral to the local community by encouraging residents and service users to contribute to development and evolution of the site and on-going use, for example, by improving employment opportunities and work experience, supporting community interests e.g. local community group meetings, exhibiting local works of art etc.; and
- Be a 'good neighbour' to the surrounding properties and wider community.

Workforce objectives

- Improve the ability to attract and retain good quality staff;
- Enable 'cross fertilisation' of ideas and practice;
- Improve integration between professions and providers leading to more flexible use of staff; and
- Provide opportunities for broadening the range of skills, expertise and knowledge of staff.

2 Project Definition and Scope

2.1 Introduction

2.1.1 The overall aim of the project is to develop an LCC in Mitcham.

2.1.2 This section of the document sets out the scope of the project and the outputs to be delivered that will ensure successful delivery of this stage of the project, the business case and progress to Financial Close.

2.1.3 The following sections of the document refer to the governance arrangements and controls that will need to be in place to monitor progress and to manage any risks that impact on successful delivery. Whilst this sets out the scope and deliverables of the MCCG team it must be remembered that the success of the project is reliant upon the partnership working between MCCG and London Borough of Merton, as well as with other stakeholders.

2.2 Project Scope

2.2.1 It is important at the outset of the project that the scope is defined and, of equal importance, that it is agreed what is out of scope. This does not mean that the scope cannot change during the project but this will need to be agreed by the Project Board and any resource implications of this change in scope acknowledged. For example, a change in scope may result in a requirement for additional funding, project team resource or an extension to the project timeline.

In Scope

2.2.2 The current scope for the delivery of the project involves:

- Development of the economic case for the investment in a Mitcham LCC;
- Agreement of the procurement approach to be adopted;
- Development of either LIFT Stage 1 and Stage 2 business cases or an Outline Business Case (OBC) and a Full Business Case (FBC), depending on the agreed procurement route;
- Development of the detailed building design;
- Successful completion of the planning process for the new building;
- Achieving Financial Close for the scheme.

Out of Scope

2.2.3 The development of the clinical services model and the design, specification and procurement of clinical services is outside the scope of the project. However, it will be essential for there to be a close alignment between these processes to ensure that both are developed with common objectives and will reach operational readiness in a timely manner. The coordination of the two processes will be managed through the MBHCH programme management structure.

2.3 Project Objectives and Expected Benefits

2.3.1 The project objectives are set out in Section 1.5 in the Introduction to this PID.

2.3.2 The benefits anticipated from the successful development of an LCC in Mitcham are:

- Reduced health inequalities by enabling greater access to health services for the entire population of East Merton;
- Improved access to specialist services for the population of East Merton;
- Improved health of the population of East Merton;
- Improved quality and scope of care available locally in East Merton;
- Greater value for money from the delivery of health services;
- Improved partnership between all healthcare providers and agencies in East Merton;
- Greater integration of healthcare services and care pathways that put patients' needs first;
- A modern healthcare estate which is most cost effective to operate;
- The release of funds as a result of the disposal of surplus NHS-owned land.

2.4 Deliverables

2.4.1 The key deliverables from the project will be:

- The economic case for the investment in a Mitcham LCC;
- The preferred procurement route for the new development;
- Selection of the most appropriate site on which to develop the Mitcham LCC;
- The appropriate business cases for the investment in a Mitcham LCC;
- The detailed design of the new building;

- Planning approval for the development of the new building;
- A project structure and plan for the construction and occupation of the new building;
- A plan for the disposal of surplus NHS-owned land, including the decant of existing services from these properties.

2.5 Constraints

2.5.1 The two key constraints to the project are the availability of skilled personnel and project funding.

2.5.2 The successful delivery of the project is dependent on the availability of skilled, experienced personnel to manage and deliver the required outputs that constitute successful project delivery. Such personnel are not available within MCCG at the current time and so the deficit is being managed through the appointment of an external project management team.

2.5.3 It is likely that the funding of the project will need to draw on the funds generated by the disposal of surplus NHS-owned land in Mitcham. Since the CCG does not own these assets the mechanism by which these funds can be released to fund the new development needs to be understood and then executed. This will require close working with NHS Property Services (NHSPS).

2.6 Dependencies

2.6.1 The dependencies can be divided into two groups, those that are internal to the project, for example one work-stream's progress is influenced by that of another, and those that are external but that could influence the project scope, timeline or cost.

Internal

2.6.2 There is a requirement for the East Merton Locality to complete, or at least progress, its work on the clinical services strategy so that the services to be located in the Mitcham LCC are agreed. Without a view on the services to be delivered from the Mitcham LCC, it will not be possible to produce an outline design for the building and therefore the options for the development cannot be assessed and the cost of development cannot be calculated.

External

2.6.3 There is a dependency on gaining agreement from SW London St George's Mental Health Trust over the relocation of services from the existing sites in Mitcham in order to vacate these buildings within a timetable that will enable their timely disposal which will allow funds to be released for the new development.

2.6.4 There is a dependency on both SW London St George's Mental Health Trust and Sutton and Merton Community Services developing office accommodation strategies so that the existing sites in Mitcham can be vacated within a timetable that will enable their timely disposal.

2.6.5 There is a dependency on NHSPS developing the business case for the disposal of the surplus sites in Mitcham and then completing the disposals so that the funds can be made available for the scheme.

2.6.6 There is a dependency between the Mitcham LCC and the Nelson LCC to ensure that the combined service configuration provides adequate access across the whole borough.

3 Governance Arrangements

3.1 Introduction

3.1.1 This chapter outlines a proposed programme and project management structure and the processes that need to be in place to ensure that the project delivers the required facilities and service benefits the Mitcham LCC investment is designed to achieve. It sets out the necessary arrangements for managing risk and identifies those parts of the structure that are already in place.

3.1.2 The ultimate decision making forum for decisions within the remit of the CCG will be the MCCG Governing Body.

3.2 Roles and Responsibilities

MBHCH Senior Responsible Owner

3.2.1 The MCCG Director of Commissioning and Planning is the Senior Responsible Officer (SRO) for the MBHCH programme and accountable for delivery of the constituent projects within the agreed parameters. The SRO is supported by an experienced team of project managers who oversee the inputs required to deliver the projects to the agreed timescales, budgets and quality standards.

3.2.2 The SRO is responsible for ensuring that the project meets its objectives and delivers the projected benefits. The SRO is owner of the overall MBHCH business change and risk management process. The SRO is responsible for ensuring that the programme and the individual projects within it are managed effectively in the context of a clear business focus in terms of meeting the CCG's aims and objectives within the agreed resource and financial parameters.

MBHCH Programme Director

3.2.3 The MBHCH Programme Director has the responsibility for managing the input to both the Mitcham and Nelson LCC schemes. They will ensure that there is coordination between the two schemes and that avoidable duplication is managed out of the process to get the Mitcham scheme to Financial Close. They will report directly to the SRO.

3.2.4 The high level responsibilities of the MBHCH Programme Director with respect to the Mitcham LCC scheme are as follows:

- Planning and designing the project and proactively managing its overall progress;
- Defining the project specific governance arrangements;
- Managing the project's budget on behalf of the SRO;

- Facilitating the appointment of individuals to the project delivery team;

- Ensuring that the production of deliverables from the project is to the appropriate levels of quality, on time and within budget, in accordance with the project plan, project governance arrangements and the overall programme;
- Ensuring that there is efficient allocation of resources and skills;
- Managing third party contributions to the project;
- Managing project specific communications with stakeholders;
- Managing risks to the project's successful outcome;
- Initiating additional activities and other management interventions wherever gaps in the project are identified or issues arise;
- Reporting progress of the project at regular intervals to both the SRO and the Project Board.

Mitcham Project Manager

3.2.5 A Project Manager will be appointed to work with the MBHCH Programme Director and be responsible for the day to day delivery of the project.

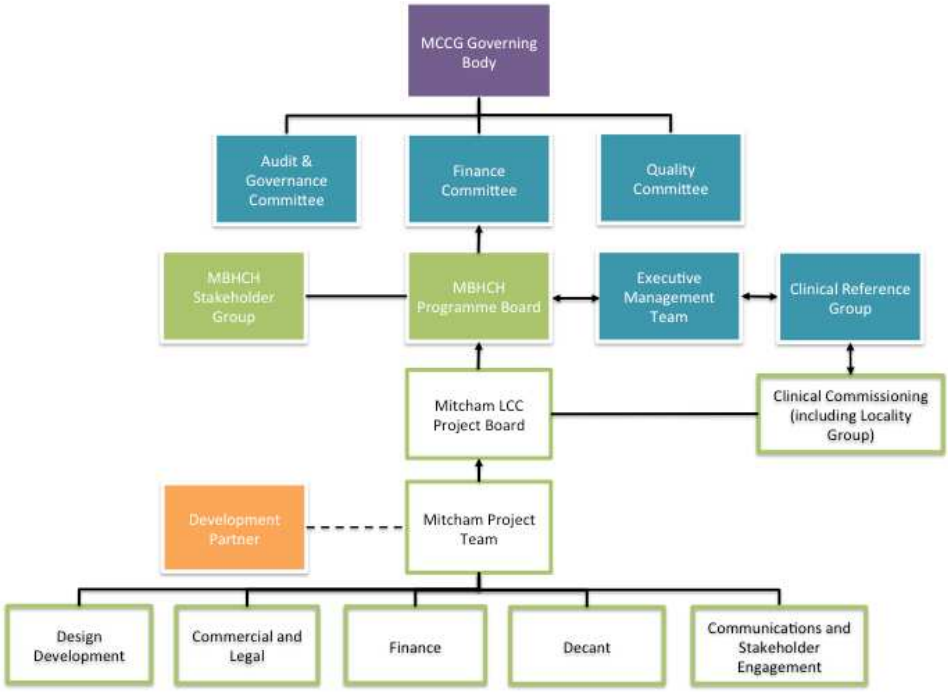
3.2.6 The high level responsibilities of the Project Manager are:

- Planning and designing the project and proactively monitoring its overall progress;
- Managing the project's budget on behalf of the MBHCH Programme Director;
- Ensuring that the production of deliverables from the project is to the appropriate levels of quality, on time and within budget, in accordance with the project plan;
- Ensuring that there is efficient allocation of resources and skills;
- Managing third party contributions to the project;
- Supporting project specific communications with stakeholders;
- Managing risks to the project's successful outcome;
- Initiating extra activities and other management interventions wherever gaps in the project are identified or issues arise;

Reporting progress of the project at regular intervals to the MBHCH Programme Director.

3.3 Project Management Structure

3.3.1 The project management structure is consistent with the principles in the Office of Government Commerce "Managing Successful Programmes and Projects". A structure is in place to manage the development of the Nelson LCC and this will be replicated for the Mitcham LCC once the project gets to Financial Close. Up to that point, a simplified structure is appropriate.



MBHCH Programme Board

3.3.2 The MBHCH Programme Board is already in place to oversee the overall MBHCH programme of which the Mitcham LCC is a part. As with other parts of the programme, the ultimate decision making forum will be the MCCG Governing Body and MCCG are the sponsoring organisation.

Mitcham Project Board

3.3.3 A Mitcham Project Board will be established to take responsibility for overseeing the delivery of the Mitcham LCC Project. It will report to the MBHCH Programme Board. At the final meeting of the Mitcham LCC Task and Finish Group it was agreed that the Group would be reconstituted as the Mitcham LCC Project Board to take the project through to Financial Close; additional members will be added to the Group, as follows:

- The Chief Financial Officer from MCCG;
- A communications and stakeholder management lead from S London Commissioning Support Unit (CSU);
- A representative from Community Health Partnerships (CHP);
- A representative from SW London St George's Mental Health Trust.

3.3.4 The Mitcham Project Board will have delegated authority from the MBHCH Programme Board to oversee and ensure delivery of the Mitcham scheme in line with the agreed specification and timescales. Its role is to ensure that resources are made available to deliver the project and that the project management arrangements are robust. It will form the main decision

making forum and provide direction and advice to the MBHCH Programme Director on issues outside their level of authority.

3.3.5 The Project Board will monitor progress against time, budget and quality and authorise actions to address any deviation from the agreed plan. The Project Board will be reconstituted again following Financial Close to reflect the construction phase of the project.

3.3.6 The Project Board will meet on a monthly basis. Terms of Reference for the Project Board are attached at **Appendix A**.

Mitcham Project Team

3.3.7 The MBHCH Programme Director will chair the Mitcham Project Team; the role of the team is to provide direction to the project work-streams and to monitor their progress against the project plan and allocated budgets. The work-stream leads will provide regular updates to the Project Team in the form of checkpoint reports.

3.3.8 The Project Team will provide the forum for initial discussions on project risks and identify possible solutions and mitigations. Risks/issues that cannot be managed by the Project Team will be escalated to the Project Board.

3.3.9 The Mitcham Project Manager will provide an aggregated progress report to the Project Board on a monthly basis (Highlight report)

Project Team membership:

- MBHCH Programme Director (Chair);
- Mitcham Project Manager;
- Work-stream leads:
  - Design Development;
  - Finance;
  - Legal and Commercial;
  - Decant;
  - Communications and stakeholder engagement.

3.3.10 Other attendance at the Project Team will be dependent upon the chosen procurement route but could include:

- Appointed clinical provider representatives;
- South London Commissioning Support Unit (CSU), various functions as required;
- NHS Property Services;
- South London Health Partnerships ;
- Community Health Partnerships;

- Appointed construction contractor.

Work-streams

3.3.11 Responsibility for some key deliverables will be delegated to work-streams by the Mitcham Project Team. Membership of these work-streams will be chosen specifically to ensure that the requisite expertise is present to deliver the required quality of output.

3.3.12 The project work-streams will be responsible for delivering key outputs as defined by the Project Team and will report progress on an agreed basis depending upon the status of the work-stream in the project timeline. They will be constituted where necessary to deal with specific deliverables, risks or issues as they become apparent throughout the course of project delivery and discontinued once the allocated work is complete.

3.3.13 The following work-streams will be established during the course of the project:

- Design Development. This work-stream will be responsible for the development of the design of the new building and have as its main deliverables the schedule of accommodation and the full set of 1:50 design drawings. This work-stream will also take the lead on the planning application for the new building and be also be responsible for the development of the equipment schedule, including ICT equipment, identifying equipment for transfer to the Mitcham LCC, if any, and a definitive list of equipment to be procured and an associated schedule of suppliers;
- Commercial and Legal. This work-stream will be responsible for putting together the commercial and legal framework within which the new building will be developed, including briefing and working with the external legal advisors to be appointed to support the scheme;
- Finance. This work-stream will be responsible for ensuring that the financial aspects of the business cases are completed and are consistent with the CCG's financial strategy and plans;
- Decant. This work-stream will be responsible for developing the plans for the moving of existing staff and services out of their existing accommodation into either the new building or alternative accommodation, as appropriate;
- Communications and Stakeholder Engagement. This work-stream will be responsible for all communications and engagement with stakeholders. Its key deliverable will be the development and execution of a communications strategy and plan that will provide guidance to the Mitcham project as a whole. The work-stream will work through the BHCH Stakeholder Group which will ensure that the content of communications are appropriate, timely and that the

most appropriate medium is used. The Group will provide editorial input to all written communications prior to Project Board sign off.

Clinical Commissioning Group

3.3.14 The East Merton Locality is already established and working on the development of the clinical services strategy. The Clinical Commissioning Group will work with the Locality and the Commissioning team within MCCG to design models of care and clinical pathways required to support the preparation of the clinical services specification in order that a procurement exercise can be undertaken or variations instructed to existing providers.

3.4 Project Resources

3.4.1 This section provides an outline of the resource that will be required to lead the Mitcham project to a successful conclusion. Most of the roles require expertise and experience in construction related projects and, as such, will require external resource to be procured. However, whilst these advisors will provide leadership in their area of expertise there will still be a requirement for MCCG to make available internal resource to provide input into the relevant work-streams.

3.4.2 Each work-stream will require a lead to take responsibility for the delivery of the required outputs from the group. The work-stream lead will be an expert in the area for which they hold responsibility and will have a proven track record of delivery. These work-stream leads will generally be experienced external consultants; they will be responsible for agreeing the final membership of the work-stream group to ensure successful delivery and will report on such to the Mitcham Project Manager. The work-stream group members will be made up from MCCG, the CSU, CHP, GP and provider resources. In order to deliver the project on time they will have to be released to undertake their role on the work-stream group.

3.4.3 In addition to the work-streams, the Clinical Commissioning and Communications Groups will require leaders and resource drawn from MCCG, the CSU and GP resources and the work-streams.

4 Project Controls

4.1 Controls

4.1.1 Project controls will be established primarily around a comprehensive, regular and effective reporting system consistent with those applied throughout the MBHCH programme. The following table outlines the key areas of project control.

Control	Responsibility	Frequency
Maintaining the risks and issues log	Project Manager, with assistance from Work-stream Leads	On-going – monthly reporting to Project Board
Tracking expenditure against budget	BHCH Programme Director with assistance from Project Manager	On-going – monthly reporting to Project Board
Tracking progress against project plan	Project Manager, with assistance from Work-stream Leads	On-going – monthly reporting to Project Board
Authority to approve change	Project Board	On-going – to be reported to SRO and BHCH Programme Board
Maintaining on-line filing system for key project documentation	Project Manager and Work-stream Leads	On-going
Signing off deliverables	SRO and Project Board	When deliverable is ready
Signing off project completion	Project Board, BHCH Programme Board, MCCG Governing Body	End of project

4.2 Risk Management

4.2.1 Risk management is an integral part of MBHCH programme management and is guided by the MBHCH Risk Management Policy, a copy of which is attached at **Appendix B**. The Mitcham project will hold its own risk workshop to inform the development of a project specific risk and issues register.

4.2.2 Reporting of significant risks will be managed through the project reporting mechanisms and will be a standing item on all programme and project agendas. If the risk cannot be dealt with by the Project Board, they will ensure that it is escalated to the BHCH Programme Board to manage the risk and provide instruction to the Project Board.

4.2.3 All new risks and issues will be identified by the work-stream groups or the project team and registered on the risks and issues log and discussed at the next available Project Board meeting. Validation and acceptance onto the Risks and Issues log will be the responsibility of the Project Team and will be ratified at the next project Board meeting.

4.2.4 All risks and issues will have a management plan developed, agreed and a named person identified and held accountable for managing the risk/issue. This person will be considered best able to manage the risk due to their requisite skill set and competencies.

4.2.5 The Risks and Issues log will be updated on an on-going basis and formally validated monthly by the Project Board.

4.3 Reporting

4.3.1 The outline responsibilities for timescales for project reporting are summarised in the following table.

Report	Prepared By	Purpose	Timescale for Completion
Project Highlight Report	Project Manager	To update the Project Board on the progress of the project and the overall progress against the project plan. To highlight any significant risks and issues that will impact on successful delivery	A week in advance of the Project Board meeting
Work-stream progress report	Work-stream Leads	Provides commentary on activities and milestones completed in the previous month and planned for the following month. Provides commentary on key risks and issues and how these are being managed. The content of these reports will inform the Project Highlight Report	Three days in advance of the Project Highlight Report

4.3.2 The templates for the Project Highlight report and the Work-stream Progress Report are presented in **Appendix C**.

4.4 Benefits Realisation

4.4.1 The CCG recognises the importance of the benefits to be realised through the development of the Mitcham LCC scheme but are also cognisant of realising the benefits of delivering an affordable and sustainable service model for the whole health economy.

4.4.2 A draft benefits realisation management plan will be produced as part of the project.

4.5 Timetable

4.5.1 The table below presents an outline programme for the development of the scheme to Financial Close.

Task	Timeline
Prepare PID for NHS England	May 2014
Present draft PID to MCCG Governing Body	May 2014
Obtain Governing Body sign off	May 2014
Submit PID to NHS England	June 2014
Obtain permission to proceed to OBC	June 2014
Prepare Economic Case • Confirm service strategy • Confirm demand and capacity calculations • Confirm functional requirements • Prepare block schematics of building • Site analysis and test fit • Obtain DV valuations of NHS PS sites • Obtain costs for LBM sites • Prepare Public Sector Comparator • Complete Generic Economic Models • Confirm qualitative assessment • Complete option appraisal • Complete Value for Money Analysis • Identify preferred option	May – July 2014
Present Economic Case to Project Board	July 2014
Obtain Economic Case sign off from BHCH Programme Board	July 2014
Obtain Governing Body sign off of Economic Case	July 2014
Present Economic Case to NHSE	July 2014
Obtain instruction to develop LIFT Stage 1 business case from NHSE	July 2014
Prepare Stage 1 business case	August 2014 – January 2015

Gain planning approval	December 2014

Task	Timeline
Present Stage 1 business case to Project Board	January 2015
Obtain Stage 1 business case sign off from BHCH Programme Board	January 2015
Obtain Governing Body sign off of Stage 1 business case	January 2015
Obtain CHP Board sign off of Stage 1 business case	January 2015
Submit Stage 1 business case to NHSE	January 2015
Obtain approval of Stage 1 business case from NHSE	March 2015
Prepare Stage 2 Business Case	April to May 2015
Present Stage 2 business case to Project Board	June 2015
Obtain Stage 2 business case sign off from BHCH Programme Board	June 2015
Obtain Governing Body sign off of Stage 2 business case	June 2015
Obtain CHP Board sign off of Stage 2 business case	June 2015
Submit Stage 2 business case to NHSE	June 2015
Obtain NHS England approval of Stage 2 business case	July 2015
Financial Close	July 2015
Start on site	July 2015

Appendix A Mitcham LCC Project Board Terms of Reference

A.1 Roles and Responsibilities

The role of the Project Board is to take responsibility for the strategic direction of the project and overseeing the management of all aspects of the project from commencement of construction through to operation.

The Project Board is to be responsible for:

- Approving the project budget;
- Ensuring that there is a system of cost control in place and to receive regular reports on existing and planned expenditure. Agree and ensure compliance within limits of delegation;
- Reviewing any requests for change and making the decision whether to instruct or reject;
- Signing off the project programme and monitoring progress against plan;
- Ensuring that effective project management arrangements are in place and providing leadership and direction to the Project Team;
- Ensuring that a robust risk management process is in place and to receive regular reports, escalating to the Better Healthcare Closer to Home (BHCH) Programme Board as appropriate;
- Arbitrating on any conflicts within the project;
- Addressing any issues that have major implications for successful project delivery;
- Keeping the project scope under control as emergent issues force changes to be considered;
- Ensuring that there is a Communication Strategy and Plan in place to ensure robust stakeholder engagement and management;
- Ensuring that clinical commissioning is appropriate for the service strategy;
- Sign off the completion of each project stage and key deliverables.

A.2 Reporting and Accountability

The Project Board reports to the Merton CCG (MCCG) BHCH Programme Board.

Membership

The membership of the Project Board should be as follows:

- MCCG Director of Commissioning and Planning (SRO and Chair);
- LB Merton Director of Public Health (Deputy Chair);
- MCCG East Merton Locality Lead;
- MCCG East Merton Locality member;
- MCCG Chief Financial Officer;
- LB Merton Director of Adult Care;
- LB Merton Head of Sustainable Communities;
- MBHCH Programme Director;
- CHP representative;
- SW London St George's Mental Health Trust representative.

The meeting will be quorate when four of the members are present, including either the Chair or Deputy Chair, the LB Merton Director of Adult Care, or appointed deputy, and a member of the MCCG East Merton Locality.

The Mitcham Project Manager will report to the Project Board and the following will be in attendance or co-opted as and when required:

- MCCG Chair of Health & Wellbeing Board;
- Work stream leads;
- Communication and Stakeholder Management Lead.

The Project Board should meet monthly.

Method of Working

The methods of working should include:

- All agenda items must be forwarded to the Project Director seven working days prior to the meeting;
- Agendas and papers will be circulated to all members at least five working days in advance of the meetings;
- It is assumed that members will have read the papers in advance of the meeting, to allow direct discussion at the meetings;
- It is expected that members will attend personally. Deputies may attend by advance agreement only;
- Members will be required to declare any potential conflicts of interest in the procurement aspects of the project. Members will also be responsible for ensuring the strict confidentiality of all commercially sensitive information about the project;
- Minutes and action logs will be circulated within five working days of the meeting.

Review

The membership of the Project Board will be reviewed and amended on completion and approval of the preferred procurement route.

Appendix B MBHCH Risk Management Policy

MBHCH Risk Management Policy v

Appendix C Reporting Templates

Highlight Report template

Workstream Highlight Report template

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Committee: Health and Wellbeing Board

Date: 24 June 2014

Agenda item:

Wards: All

Subject: Health and Wellbeing Board Development

Lead officer: Dr Kay Eilbert, Director of Public Health

Lead member: Councillor Caroline Cooper-Marbiah, Cabinet Member for Adult Social Care and Health

Contact officer: Clarissa Larsen Health and Wellbeing Board Partnership Manager

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Recommendations:

That the Health and Wellbeing Board:

A. Note the planned development of Merton Health and Wellbeing Board in its second year, the support secured from the London HWB Improvement Programme and agree to the proposed work programme.

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1. Purpose of report and executive summary

1.1 This report presents an update on the planned development of Merton Health and Wellbeing Board in its second statutory year. It sets out, following on from Merton's Health and Wellbeing Peer Challenge, the recent visit to Merton by the National Audit Office to inform reports to parliament on Health and Wellbeing Boards and the Better Care Fund. .

1.2 This report also outlines the funding secured to help develop the Health and Wellbeing Board and the focus on integration and prevention that will feed through to the review and refresh of the Merton Health and Wellbeing Strategy in 2015.

2. DETAILS

2.1 Background

2.1.1 Merton Health and Wellbeing Board (HWB) completed its first year as a statutory committee of the Council in April 2014.Iin its first year Merton HWB has delivered its statutory duties of producing a Joint Strategic Needs Assessment (JSNA), developing a Health and Wellbeing Strategy and promoting integration The Health and Wellbeing Board was also included in the remit of the Health and Wellbeing Peer Challenge in the autumn of 2013. Though only a few months into its statutory status the HWB received positive feedback and constructive comments on opportunities for future development.

2.1.2 These opportunities were built on at the Merton Partnership Conference on Health Inequalities and initiatives that emerged at the event are being developed. Case studies identified by the Peer Challenge team, including most recently Merton HealthWatch, have also been published as notable practice by the Local Government Association.

2.2 Merton Health and Wellbeing Strategy and JSNA

2.2.1 Merton's first Health and Wellbeing Strategy and delivery plan has now been in place for a year. Progress on all the four key priorities has been reported to the HWB and demonstrates strong links and joint working across the Council and with partners in the CCG, the voluntary sector and more widely.

2.2.2 It is proposed to review and refresh the Merton Health and Wellbeing Strategy in 2015. This will be in line with the latest JSNA and wider data available. It will also take account of legislative and national policy developments and will review the successes and any shortcomings in the delivery of the strategy to date.

2.2.3 The review and refresh of the HWB Strategy will be collaborative through a partnership task and finish group. Consideration will be given to refining the current priorities responding to the HWB Peer Challenge recommendation for the Board to 'ruthlessly prioritise' moving forward.

2.3 National Audit Office Study of Health and Wellbeing Boards and Better Care Fund

2.3.1 Following on from participating as a pilot authority in the Health and Wellbeing Peer Challenge, Merton was selected to participate in a National Audit Office (NAO) Study of HWBs and the Better Care Fund (BCF)

2.3.2 The NAO visited a small number of Health and Wellbeing Boards and were keen to include Merton because of the area alignment of the CCG and the Council; the levels of funding received, Merton's relatively low rate of avoidable emergency admissions and Merton's participation in Peer Challenge.

2.3.3 Representatives of the NAO visited Merton and met with a number of partners to consider the Health and Wellbeing Board plan for the Better Care Fund and more widely to promote local integration of health and social care. The interviews specifically focused on:

- how effectively central government is supporting Health and Wellbeing Boards to deliver the Better Care Fund's objectives
- the progress Health and Wellbeing Boards are making in planning for the Better Care Fund, and to
- identify local good practice.

2.3.4 The NAO are due to present their findings in a full report to Parliament which has been slightly delayed and is currently due for publication in July.

2.4 Health and Wellbeing Board Local Facilitation Fund

2.4.1 As part of the on-going London Health and Wellbeing Board Improvement Programme, which includes Peer Challenge, a Local Facilitation Fund was launched earlier this year to support HWB development. It was a requirement that the work should deliver clear outcomes and demonstrate value for money and that HWBs that are awarded funds give feedback that can be shared by others.

2.4.2 Merton was successful with its application and the has been awarded up to £6k to appoint a professional facilitator to conduct a development session with the Board to evaluate progress to date, establish strengths and identify any areas requiring support. This will be fully documented in a report which would be brought to the Health and Wellbeing Board.

In the light of findings the facilitator would help identify development needs for the HWB and set out proposals for future training or development for the HWB and its members. The facilitator has also been requested to conduct appropriate follow up work on the recommendations of the first report 6 months after the initial session to monitor progress.

2.4.3 Specifically the work will use the LGA Health and Wellbeing System Improvement Programme Development Tool to challenge and assess the development of Merton HWB to date, to establish where it does and can add value and identify future development

2.4.4 The work is also intended to support Merton HWB to link with other local authorities that are developing their own approaches to HWB development to identify synergies and any areas for sharing learning and possible future joint work.

2.5 Focus on Prevention

2.5.1 It is a statutory duty of HWBs to promote integration and the work taking place in Merton is reported separately to the Board. There is an increasing recognition, at national policy as well as local level, that prevention is also key to sustainability and that prevention will need to be a core focus of HWBs moving forward.

2.5.2 Following the move of Public Health to the Council there has been greater emphasis on prevention at the Health and Wellbeing Board and the Director of Environment and Regeneration has joined as an observer. The Public Health team has also now appointed a Consultant in Public Health specialising in prevention who will support the Director of Public Health to work across the Council and with partners to address the wider determinants of health and the levers that control these.

2.5.3 Plans are in place to establish a Harm Prevention Forum jointly with the Director of Environment and Regeneration which will report to the Health and Wellbeing Board. Work is also currently underway to establish the evidence base for targeted place based approaches to tackling health inequalities, as part of a proposed pilot project in East Merton, which was first initiated at the Merton Partnership Health Inequalities Conference.

2.6 Health and Wellbeing Board Forward Plan

The latest HWB Forward Plan 2014 is attached to this report in Appendix 1. The Forward Plan is an iterative document setting out planned reports but also responding to developments and any comments or additions are welcome.

3. Next Steps

With a new Chair, the Health and Wellbeing Board will continue to develop and learn from the London HWB Improvement Programme and the funded facilitation planned for the autumn. The focus on integration and prevention, in addition to tackling health inequalities, will continue and will be reflected in the forthcoming review and refresh of the Health and Wellbeing Strategy.

3. ALTERNATIVE OPTIONS

None for the purpose of this report.

4. CONSULTATION UNDERTAKEN OR PROPOSED

None for the purpose of this report.

5. TIMETABLE

It is proposed to hold the facilitated development session in autumn 204.

6. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Financial implications will be covered by the LGA funds that have been awarded.

7. LEGAL AND STATUTORY IMPLICATIONS

It is a statutory duty for each local authority to have a Health and Wellbeing Board as a committee of the Council.

8. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

It is a core aim of the Health and Wellbeing Board to address health inequalities.

9. CRIME AND DISORDER IMPLICATIONS

None for the purpose of this report.

10. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None for the purpose of this report.

11. APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1 - Health and Wellbeing Board Forward Plan

12. BACKGROUND PAPERS

None for the purpose of this report.

DRAFT Health and Wellbeing Board Forward Plan 2014 (at June 2014)

	Activity	Purpose/ Role of HWB	Timeline	Lead Officer	HWB Date
	Standing Items				
	Call to Action	Involved in and informed of developments.	Ongoing	EB	Standing Item
	HealthWatch Merton	Overview of work programme and progress of Merton HealthWatch	First year of operation 2013./14	BP	Standing Item
	Merton Integration Project	Engage the HWB as partners in the work programme.	Ongoing programme	SW/EB	Standing Item
	Health and Wellbeing Strategy Delivery Plan	Monitor and continually evaluate.	HWB Strategy agreed March 2013 ongoing to review 2014/15	KE	Standing Item
	East Merton Model of Care	Discuss and track progress of proposals for East Merton	Work currently being developed	KE/AD	Standing item
	Additional Items **HWB 30 September 2014**				
	Children				
1..	School Nursing Review	For information and discussion findings and recommendations of review.	Follow on from March HWB report	YS	30 September 2014

	Other Children's items TBC				
	Adults				
2.	Social Care Redesign Programme	Outline of proposed service redesign	TBC	SW	TBC
3.	Target Operating Model – Community and Housing, Early Years Education, EIP, CSC, Transforming Families, C&YP with Disabilities.	For information / alignment with Health and Wellbeing Strategy	Autumn 2014	TBC	TBC
4.	Learning Disability Annual Assessment	For information LD Annual Assessment	Awaiting NHS agreement	SW	30 September 2014
	Strategy				
5.	Harm Prevention Forum	Agree ToR and work programme of Harm Prevention Forum	TBC	KE	TBC
6.	Mental Health Strategy	Agree draft Mental Health Strategy		KE/AG	30 September 2014
7.	Place Based Engagement Model	Agree place based approach to local engagement	TBC	KE	30 September 2014
8.	Research Proposal for Embedding Prevention	Note and consider research proposal.	Autumn 2014	KE	TBC
	Additional Items for 25 November				
1.	Wider Council strategic service plans and other partner strategies. commissioning plans for information/discussion – alignment	For information / alignment with Health and Wellbeing Strategy	Autumn 2014 and on-going	TBC	TBC

	with HWB Strategy				
2.	Pharmaceutical Needs Assessment	Agree draft to comply with statutory role in relation to Pharmaceutical Needs Assessment from April 2013	Duty for PNA from April 2013 statutory April 2015	KE	25 November 2014
3.	Joint Strategic Needs Assessment (JSNA)	Agree programme of work to update JSNA for 2015		KE	25 November 2014
4	East Merton Community Health and Wellbeing Fund Update	Oversight of on progress to Round 2 of grant fund to address health inequalities.	Year 2 of two year programme	IB	25 November 2014
	HWB Date TBC				
	Build on protocol to clarify roles of HWB, Health Scrutiny and HealthWatch	Communicate clarity of roles and responsibilities.	Protocol agreed October 2013	KE	TBC
	Better Services Better Value	Discuss any future proposals.	Consultation not proceeding at present.	EB	TBC
	NICE (National Institute for Health and Care Excellence)	Information and guidance and evidence for HWBs and partners strategic links	Materials developed for HWBs	KE	TBC
	HIV Services	Update on provision and performance of HIV Services in Merton	Report for July to One Merton Group	KE	TBC
	Public and Patient Engagement in Health and Wellbeing	Oversight of HWB engagement across the JSNA, Strategy review, social care, CCG (PPGs and engagement strategy), HealthWatch and other partners	JSNA review autumn 2013 to feed into HWB Strategy refresh.	KE/ SW/ EB	Ongoing
	Procurement of substance misuse	Maintain strategic oversight of commissioning		TBC	TBC
	Ending Gangs and Youth Violence				
	Improve Transitions re CQC				
	Proposal for a joint Merton Adult Health and	Discussion of proposals		JK	TBC

	Social Care Quality Board				
	Autism Strategy	Agree approach and development of Autism Strategy	TBC	SW	TBC
	FGM (Female Genital Mutilation)	TBC	TBC	TBC	TBC
	Domestic Violence	TBC	TBC	TBC	TBC
	Transition of Health Visitors	Consider plans for transfer	TBC	KE/YS	TBC

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Committee: Merton Health and Wellbeing Board

Date: 24 June 2014

Agenda item:

Wards: All

Subject: Healthwatch Merton Update

Lead officer: Dave Curtis – Healthwatch Merton Manager

Lead member: Barbara Price – Healthwatch lead Trustee for MVSC

Contact officer: Dave Curtis, Healthwatch Merton Manager

Recommendations:

A That the Board note the progress made by Healthwatch Merton.

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of the report is to update the Board on the progress to date and the on-going developments within the Healthwatch service for Merton.

2. DETAILS

2.1 The Health and Social Care Act 2012 included a requirement on local authorities to establish a local Healthwatch in their area. This duty replaced the duty to establish a Local Involvement Network (LINk) from 1 April 2013.

2.2 As previously reported to the Board on 23 April 2013, Merton Voluntary Service Council (MVSC) was awarded the contract to deliver Healthwatch Merton in March 2013. A two-year contract was agreed with an option to extend.

2.3 Appendix 1 sets out activity undertaken since March 2014 and Appendix 2 shows the work streams established for 2014/15.

2.4 Key achievements over the last quarter include delivering a series of listening events, identifying the key issues for future work streams, leading on the engagement work strand of the Better Care Fund project and attending a range of local community events.

2.5 The main tasks for the next quarter will include commencing the work strands on hospital and GP services, developing a programme for delivering enter and view and launching our first annual report.

3. ALTERNATIVE OPTIONS

3.1 No alternative options are suggested.

4. CONSULTATION UNDERTAKEN OR PROPOSED

4.1 Extensive consultation took place in the autumn and winter. A series of Have your say events were supplemented by an online survey and attending a range of local groups. This information was used to help set the work strands for 2014/15.

5. TIMETABLE

5.1 The timetable for the key milestones is set out in Appendix 1.

6. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1 The contract for Healthwatch Merton will be £125,085 in 2014/15. Financial monitoring against this will be provided to the Council.

7. LEGAL AND STATUTORY IMPLICATIONS

7.1 Provision of an effective Healthwatch Merton is a statutory requirement under the Health and Social Care Act 2012.

8. HUMAN RIGHTS, EQUALITIES AND COMMUNIITY COHESION IMPLICATIONS

8.1 Healthwatch Merton is subject to MVSC's Equalities Policy. The contract requires Healthwatch Merton to monitor use of the service and report quarterly to the Council.

9. CRIME AND DISORDER IMPLICATIONS

9.1 None

10. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1 Healthwatch Merton is subject to MVSC's Health and Safety Policies.

11. APPENDICES - THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- Appendix 1 –Healthwatch Merton Work Report

12 BACKGROUND PAPERS

- Health and Social Care Act 2012.

WORK REPORT

Name: David Curtis

Position: Healthwatch Manager

Period Covered: 15th March 2014 – 10th June 2014

Work during period:

Monitoring and Reporting:

- Report as required to the Health and Wellbeing Board.
- Report as required to Board of Trustees
- Draft end of year report to Merton Council lead commissioner completed
- Workstreams programme report produced
- HWM annual report in progress to be completed by month end and already includes outreach and information report plus feedback and workstreams explanation.

Publicity:

Website: Began developing young person's section

Ongoing – Volunteer opportunities posted - Local signposting - News stories - Events updated – website and social media kept relevant and up to date - regular tweets

Newsletters: Two electronic newsletters produced and disseminated

Developed and designed new HWM folder for use with any promotional materials

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Events, Meetings and Public Engagement opportunities attended and present at:

Quality Care Commission Healthwatch Advisory conference; Facilitated at Merton CCG Equality Delivery System event; St Marks Family centre's parents with mental health issues group (held a discussion workshop on the attendees experiences of health and social care)

Have attended these events / forums / Meetings:
Kingston Hospital Healthwatch network; SWLSTG Foundation Trust Steering Committee Meeting; Wimbledon Community Forum; St Georges Stakeholder Steering Group; South west London Patient and Public Engagement Steering Group; Merton CCG Equality Delivery System event; Epsom / St Helier: Your hospitals, your services, your say; Patient Reference Group; Club Wimbledon Open Day (55+); Merton Integration - Service Development workshop.

Partnership work:

- GP partnership tool review, 23rd April, Vestry Hall with Sylvia Wachuku-King of Wellbeing You
- Integration project team – health and social care

Work Stream setting 2014/2015

Organised and ran these events

- Final listening event completed, 17th march, Wimbledon friend's house
- Feedback and the future, 31st March, Acacia centre

Workstream programme report complete and shared at feedback and the future event.

Planned and promoted our GP service s and Hospital inpatient/ outpatient listening events

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Children and Young people:
Developed next phase of work with Young Advisors in line with workstream programme looking at the development of Healthwatch participation and engagement strategy.

Enter and View:
External trainer delivered days training 20th May and the training was attended by 15 people. We will know shortly how many of those would like to become authorised representatives for the Enter & View programme.

Volunteers:
Recruiting volunteers for: Engagement and Outreach; Enter and View

Main tasks in next quarter:

*Establish additional work for HWM from Integration project and East Merton medical centre project
*Communication: ongoing update info and signposting section of website / produce young people's section on website / create printed newsletter.
* Complete annual report, print and share.
* finalise 3 month, 6 month and year long work and outreach plan based on workstreams.
* Continue partnership work and support of relevant events
* Volunteers: Enter & view and outreach opportunities.
*Develop Enter & View programme with LBM

HWM – Summary of what we have been doing and how we have been influencing since August 2013

Overview of how we have influenced and continue to influence changes in local services. Healthwatch Merton has a seat on the Health and Wellbeing Board. This provides us with a clear route to champion the views of patients and public and influence future decision making across Health and Social Care within Merton.

This is also the case with the Integration Project of Health and Social Care Services within Merton whereby Healthwatch Merton is the named engagement Lead to monitor this strand and puts Healthwatch Merton at the centre of being able to ensure the public feed directly into shaping these services.

Healthwatch Merton meet regularly with a wide range of senior health and social care staff including CEOs and Executive Directors of provider organisations, the Chair and Engagement lead of the Merton Clinical Commissioning Group, senior Directors of the NHS England local area team, and senior Directors in Merton Council. We meet in a range of ways, including specific one to one meetings at our request, meetings with other local Healthwatch's, formal, scheduled meetings.

Healthwatch Merton work with NHS England Area Team and regularly take part in the South London Quality Surveillance Group meetings.

Healthwatch Merton has built a relationship with the Merton Clinical Commissioning Group (CCG) and influence via attendance/contribution to the following groups:

*Patient Reference Group (supporting the further development of Patient Participation

groups at GP surgeries and strengthen this network of participation.)

*Better Healthcare Closer to Home Programme Board (Includes Nelson Project, Development of Healthcare services in East Mitcham)

*Merton Clinical Quality Committee

*Currently developing a CAMHS engagement project to inform how Mental Health services can work more effectively with children and young people.

Working protocols are established between Healthwatch Merton with the Health and Wellbeing board and Health scrutiny to ensure that intelligence gathered plays a key role in influencing the provision and effectiveness of services.

Healthwatch Merton have held a number of public meetings focused on aspects of proposed change in health and social care in Merton and use our engagement activities as a way of engaging with the public in a wide range of ways across the borough. **(See attachment – HWM newsletter)**

*JSNA Event (Joint Strategic Needs Assessment) – Healthwatch Merton jointly hosted this event with Public Health and this was the first time in Merton that Public Health engaged directly face to face on this with local people to directly influence the JSNA findings. The latest JSNA was not currently published at this stage)

*Engage Merton (jointly hosted with MCCG) the event findings directly influenced Merton CCG commissioning intentions for 2014/16 and their five year strategy.
- In addition it also feed into the MCCG Patient Participation and Involvement Strategy.

Healthwatch Merton held several listening events and all the feedback gathered informed our workstreams programme for 2014/2015 and the process can be read in more detail when our annual report 2013/14 is published in July. The GP services report to be produced from our workstreams programme will be passed to the MCCG to directly influence a key business plan element of theirs to Improve GP services across Merton. **(See attachment – HWM workstreams)**

Healthwatch Merton provided in advance raw data to the CQC from feedback gathered from September 2013 – March 2014 to inform real time inspections of GP services in Merton.

Total people directly reached and voices heard on various topics = 691
Excluding the 50 people that attended the launch we have had 238 people attend our registered events, this includes about 125 individual people.

49 of which attended our three dedicated listening events, the rest attended the partnership events.

We have attended at least 25 public events/community groups/forums to present and discuss Healthwatch and at each there was a (conservative) average of 15 people, equalling 375 contacted through this general outreach.

We received a total of 71 priority cards.

691 (238 + 375 + 71)

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Healthwatch Merton Workstreams Programme Report 2014/15

Workstream	Evidence	What We Do	How We Will Do It	Who Will be Involved	Next Step
Locally Directed					
GP Services	From our Workstream survey and listening events **MCCG business plan this is as an area of improvement*	Research and mapping to identify improvement patients want to see across the borough	Piece of research and report	HWM team MVSC associate Patients Voluntary and community organisations	Workshops May – July 14 Report Published September 2014
Hospital: Inpatient/ Outpatient	From our Workstream survey and listening events	Engagement work to identify areas within this we should focus on • 3 focused workshops • Develop work plan • Start Delivery of work plan	Engagement and work plan development	HWM team Patients Voluntary and community organisations Public	Workshops May – July 14 Develop work plan September 2014 Start work October 2014 – March 2015
Operational					
Children and Young People	HWM work has been on adult Health and Social Care	Develop our Children and Young Participation and engagement plan	Work with Children and Young people Groups/ forums to develop and review our plan	HWM Manager Youth Partnership VCM young people Youth Parliament Young Advisors	April – July 2014. Then implement plan once agreed

Top Down					
Integration	Largest reform of health and social care in years Integration Plan and BCF Plan	Watching brief on integration and BCF Lead on patient public engagement	Integration Reference group meeting 4 times a year and comprising of 8-10 people 4 events to engage patients and public between April and September 2014 On-going information and communication using HWM channels and bulletins	HWM team 8-10 volunteers Integration Project Manager HWM team Integration Project Manager Voluntary and community organisations Patients Service users Public Carers	April 2014 – March 2016 April 2014 – September 2014
Existing					
Mental Health	Link Mental Health Report Mental Health Review Report	Feed into commissioning and review implementation	1 event	HWM team Mental Health Users Volunteers	September 2014