Merton Council
Health and Wellbeing Board

Date: **19 April 2016**

Time: **1.00 pm**

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

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

1	Apologies for absence	
2	Declarations of pecuniary interest	
3	Minutes of the previous meeting	1 - 6
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9	Adult Safeguarding Board Annual Report 2014/15 Business Item for HWBB to note	69 - 90
10	Feedback on Westminster Briefing-The Future of Health and Wellbeing Boards Verbal Report to be given at the Meeting	

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
- Judy Saunders

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
- 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

HEALTH AND WELLBEING BOARD
24 NOVEMBER 2015

PRESENT: Councillors Caroline Cooper-Marbiah (in the Chair), Maxi Martin and Gilli Lewis-Lavender
Dr Andrew Murray (Vice Chair), Adam Doyle, David Freeman, Dr Karen Worthington, Simon Williams, Dr Kay Eilbert, Yvette Stanley, Dave Curtis and Marriette Akers

ALSO PRESENT: Clarissa Larson and Lisa Jewell

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies were received from:

Chris Lee – Director of Environment and Regeneration
Khadiru Mahdi – Chief Executive Merton Voluntary Services Group
Melanie Monaghan – Community Enterprise Network

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

No declarations of Pecuniary Interest were made

3 MINUTES OF THE MEETING HELD ON 29 SEPTEMBER 2015 (Agenda Item 3)

The Minutes of the Meeting on 29 September 2015 were approved as a correct record

4 ANNUAL REPORT OF MERTON SAFEGUARDING CHILDREN BOARD (Agenda Item 4)

The Director of Children, Schools and Families presented the annual report of the Merton Safeguarding Children Board. This annual report is a statutory requirement which provides a rigorous and transparent assessment of the performance and effectiveness of child safeguarding and promotion of welfare of children in the borough. Based on the evidence set out in this report, the MSCB judge the current safeguarding arrangements to be effective.

Board Members commented that they were happy with report and the work of the MSCB and asked about future priorities. The Director of CSF replied that the priorities would be those set out in the report and would include; a strategic multi agency response to the issue of neglect, supporting children and young people with special needs, ensuring children are safeguarded from radicalisation and violent extremism, implementing the review of the MSCB Governance, Structure and Board Business Processes, and to maintain strategic oversight of Child Sexual Exploitation.

RESOLVED

The Health and Wellbeing Board considered and commented on the MSCBs annual Report.

5 ADULT SOCIAL CARE - LOCAL ACCOUNT 2013-15 (Agenda Item 5)

The Director of Community and Housing presented his report on the Adult Social Care Local Account 2013-15, which in future would be published every year. Mariette Akkermans, Healthwatch, asked a question regarding the National Benchmarking Data contained in the report noting that some of the targets were low. The Director of Community and Housing explained that there were no set targets and that Merton achieved better than average and were improving. This data was given to aid transparency by comparing to other authorities.

The Chair of the CCG asked about the role of the HWBB in relation to social care. The Director of Community and Housing acknowledged a role for the HWBB in looking at the impact of savings in social care and the potential for collective action. He predicted a different social care offer in future and the contribution of the voluntary sector in this was discussed.

RESOLVED

The Health and Wellbeing Committee noted the report on the Adult Social Care Local Account 2013-15.

6 MERTON CLINICAL COMMISSIONING GROUP (MCCG) COMMISSIONING INTENTIONS 2016-17 (Agenda Item 6)

The Director of Commissioning and Planning, Merton CCG, presented the report that outlined the CCGs plans and priorities for 2016/17. The report was informed by the Health and Wellbeing Strategy, best practice and by the South West London commissioning intentions, and been discussed with the public, patients and other stakeholders.

The Board noted section in the report regarding the East Merton Model of Care and Mitcham Development, and asked about the completion date of the new medical centre. Adam Doyle confirmed that the target completion date had always been and still was, Summer 2019.

Mariette Akkermans of Healthwatch asked the CCG if they were aware of the Healthwatch report on GP services in Merton. Dr Andrew Murray replied that he was very aware of this quality report and that the CCG were looking to improve primary care in Merton.

Councillor Lewis-Lavender asked about future services being drop-in and ‘1stop shop’. Dr Andrew Murray agreed that the CCG wanted to make the patient journey as smooth and easy as possible for the patient.

RESOLVED

The Committee noted the information in the report.

7 COMMUNITY SERVICES PROCUREMENT (Agenda Item 7)

The Director of Commissioning and Planning, CCG Merton, advised the Board that the contracts for community health had been awarded in September 2015, with the contract for Lot 1 being awarded to the Central London Community Health NHS Trust and Lot 2 to Connect Physical Health Limited. The process is now at the mobilisation stage and contracts will be signed in December 2015.

The Director of CSF thanked all her colleagues in Adult Social care, Public Health, the CCG and her own department for this comprehensive process, and said the new specification is of a higher calibre and will deliver more.

RESOLVED

The HWBB noted the progress made regarding the procurement of Community Health and plan

8 TRANSFORMING CARE (Agenda Item 8)

The Director of Commissioning and Planning, Merton CCG, presented the report that met the recent requirements of NHS England for progress on Transforming Care to be reported to the HWBB. The report provided a brief background and summary of the current position. The Board were told that a more detailed report, considering the wider requirements of the programme and what plans the local authority and CCG need to put in place to meet these, would be brought to a future HWBB meeting

RESOLVED

The HWBB noted the report.

9 JOINT STRATEGIC NEEDS ASSESSMENT SUMMARY 2015 (Agenda Item 9)

Amy Potter, Consultant in Public Health, presented the Joint Strategic Needs Assessment (JSNA) Summary for 2015, which set out key health headlines, changes and trends under each of the life course themes, key recommendations and signposts to future work.

The Board noted that a lot of work had been done by the Public Health team to put up to date JSNA information on-line. Amy presented a set of slides, showing a summary of JSNA 2015 information, these slides are attached to this minute.

Councillor Maxi Martin asked about how the JSNA addressed the needs of seldom heard groups and in particular the higher risk of diabetes in the east Asian community. Amy Potter replied that the JSNA presents a health needs assessment that tries to understand what the need is and how different it looks in different communities. Trained Health Champions work to help address the needs of different community groups.

Councillor Maxi Martin also asked about the number of children and young people admitted to hospital with injuries and noted that the JSNA will highlight changes to these numbers.

Councillor Maxi Martin then asked about the increase in STDIs shown in the JSNA information. The Director of Public Health explained that they will work with the new providers of community health services on sexual health and chlamydia screening.

The Chair of Merton CCG said that he was very pleased with this work. He commented that there are now 24 rather than 25 GP practices in Merton and this will be corrected. He suggested that future Health Impact Assessments come to the HWBB.

The Chief Officer of Merton CCG noted that HWB strategy was built on the JSNA, and that the JSNA informs commissioning intentions and these links could be made more transparent

The Director of CSF talked about non-accidental injuries and suggested that some issues do need to be explored. Although the number was small there could be underreporting. Neglect is a key issue and accidental/non-accidental injuries are part of neglectful households, and an area where partners can work together.

Councillor Lewis-Lavender suggested that all Councillors should be a Health Champion and the Director of Public Health said that she would train Councillor volunteers who came forward to be Health Champions.

RESOLVED

The Health and Wellbeing Board agreed the annual Merton Joint Strategic Needs Assessment (JSNA) Summary document 2015

10 ANNUAL PUBLIC HEALTH REPORT (Agenda Item 10)

The Director of Public Health presented her report - ‘The Time for Prevention is Now – Merton Annual Public Health Report 2015’ – which makes the case for prevention and celebrates the work of Public Health and its partners since 2013 to address health inequalities and embed prevention. She then presented the information attached to her report to illustrate the importance of prevention and the work done by Public Health and its partners to embed prevention and reduce inequalities.

The Chair of the CCG commended the report and said that it was a wonderful legacy for the Director of Public Health on her retirement. He added that the approach of the report would inform the CCG vision and strategy.

The Director of Community and Housing reinforced the importance of embedding prevention in everything we do and that Public Health is an issue for the whole Council. He commented on the excellent ward profiles.

The Board discussed provision of ESOL classes for residents and heard that this is being taken forward in the commissioning of adult learning. Councillor Maxi Martin asked how the Council would reach all residents who needed these classes. The Director of Community and Housing said that there were a lot of ways this could be achieved and that contact and statistical knowledge could be used.

The Healthwatch representative asked the Board to note that the voluntary sector was a partner in prevention but that their work was threatened by cuts in funding.

RESOLVED

The HWBB noted Merton's Annual Public Health Report – The Time for prevention is Now.

11 CROSSRAIL 2 (Agenda Item 11)

Dr Andrew Murray explained the CCG views on Crossrail 2; that they were in favour of Crossrail 2 but were disappointed that the original proposed stop at Tooting had been replaced by a proposed stop at Balham. The Tooting stop would have been very convenient for both Staff and patients at St George's Hospital, and the CCG intended to make their support for a stop in Tooting known in their response to the Crossrail 2 consultation. The HWBB supported this view, and the Director of Public Health agreed to feed this back to the Future Merton team who were compiling the consultation response on behalf of Merton Council.

12 DATES OF FUTURE MEETINGS (Agenda Item 12)

The Board were asked to note the following Future Dates of HWBB meetings:

Confirmed dates:
26 January 2016 3pm-5pm
19 April 2016 1pm – 3pm

Provisional dates (all 3pm – 5pm) subject to Council Approval:
28 June 2016
4 October 2016
29 November 2016
24 January 2017
28 March 2017

Dates up to and including 28 June 2016 had already been agreed with CCG members. All dates after this were to be sent to the CCG for their approval.

The Chair then thanked Dr Kay Eilbert for all the enthusiasm and energy she had brought to her role as Director of Public Health at Merton Council. The Chair and the HWBB wished her all the best for her future and her retirement.

Committee: Health and Wellbeing Board

Date: 19th April 2016

Wards: All

Subject: East Merton Model of Health and Wellbeing

Lead officer: Adam Doyle, Chief Officer, MCCG / Dr Dagmar Zeuner, Director of Public Health, LBM

Lead member: Councillor Caroline Cooper Marbiah

Contact officer: Amy Potter, Consultant in Public Health, LBM / Cynthia Cardozo, Director of Transformation MCCG

Recommendations:

A To agree that the HWBB take accountability for the East Merton Model of Health and Wellbeing (EMMoHWB).

B To commit to a preliminary delivery timeline for the health facility and the EMMoHWB.

C To agree the programme structure for the delivery of the EMMoHWB.

D To agree the EMMoHWB delivery priorities for action for 2016/17 as childhood obesity and social prescribing.

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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to set out the Health and Wellbeing Board's (HWBB) agreed mission for the East Merton Model of Health and Wellbeing (EMMoHWB), set out and agree a timeline for the delivery of the health facility at the heart of the model, and to agree priorities for 2016/17 of childhood obesity and social prescribing.

The EMMoHWB is a partnership effort to build a local sustainable model of health and social care that is asset based, focusing on the whole person, community and wider health and care system, which has a preventative and proactive approach at its heart and fully embraces health and social care integration as well as the important links into the social determinants of health.

The EMMoHWB will form a blueprint for the whole Merton vision for Health and Wellbeing transformation, taking a whole systems approach to design and implement a model of health and wellbeing that meets the health and social needs of the population, stemming the increase in the significant inequalities in health outcomes between the east and west of Merton, and providing more equal opportunities for all residents of Merton to be healthy.

2. DETAILS

2.1 Context

At the last meeting of the HWBB it was agreed, following a facilitated discussion, that our focus and core priority as a Board will be to develop and deliver the East Merton Model of Health and Wellbeing. The EMMoHWB will deliver the Health and Wellbeing Strategy at a local level, cutting across all the themes, to both address health inequalities and promote prevention.

The HWBB commitment followed an earlier HWBB session in November 2014 and the commissioning of Consilium Partners Ltd jointly by London Borough of Merton (LBM) and Merton Clinical Commissioning Group (MCCG) to initially take forward the work to develop the EMMoHWB. Two Design Workshops have now taken place with a range of stakeholders and a visit to the Bromley by Bow Centre by the Design Group and HWBB members and partners has helped both inform and enthuse plans for East Merton.

This has been further supported by a successful bid under the Local Vision programme which has awarded the HWBB 30 funded days of one or two enablers/facilitators to work on the EMMoHWB. The two facilitators proposed bring particular local knowledge and special expertise to help us to develop the new model of health and wellbeing: Mari Davis has already worked with the HWBB over the last year, and the proposal is to continue our work with Mari whilst also bringing in Allison Trimble who was a founding member and CEO of the Bromley by Bow Centre to work collaboratively with Mari and the HWBB.

Our approach is not just about the new building of a healthcare centre in East Merton but about developing a new, innovative model of health and wellbeing in partnership with the local community– starting by building real insight through engagement and a Community Power Mapping Exercise. There is an opportunity for all partners including GPs and Councillors who have such close links with local communities to work effectively together. The aim is to build a movement of behaviour change around the new building. This will in turn support the delivery and success of the East Merton Model of Health and Wellbeing, as a blueprint for the whole Merton vision for Health and Wellbeing transformation.

2.2 Timelines

The key draft milestones for Merton CCG to deliver the health facility are as follows:

Task	**Timeline**
Develop Options Paper for balance of services (health, social care, voluntary sector) to go onto the Wilson site	June 2016
Community engagement around the developed options	Autumn 2016
Final decision on what services to go in the building	December 2016
Work up of building plans and financial case (12 months)	December 2017
Financial close (sign off on plans) and start on site	March 2018
Building work finished	December 2019
Building operational (doors open to public)	June 2020

Therefore, the proposed timeframe and actions for the development of the EMMoHWB are as follows:

Task	Timeline
Consilium final report produced	End April 2016
Programme structure set up	End April 2016
Community engagement and power mapping	May 2016
Mapping of estates and assets	May 2016
Review of evidence around points of intervention across the life course	May 2016
Develop approach to childhood obesity through the EMMoHWB	May 2016
Review of evidence and best practice on social prescribing and develop local pilot	May 2016
Contribute to Options Paper for balance of services to go into the Wilson	May 2016
Present update to the HWBB on progress to date	June 2016
Community engagement around the developed options	Autumn 2016
Development of final model of EMMoHWB	December 2016

A more detailed action plan and timelines will be set once the programme structure is in place, and an update will be brought to the HWBB in June 2016.

2.3 Process and structure

In order to effectively deliver the EMMoHWB, it is proposed to set up a clear programme structure. The establishment of a new Merton Model of HWB Steering Group is proposed by MCCG, to be convened by Cynthia Cardozo, Director of Transformation for MCCG, that will report to the HWBB.

It is important for the HWBB to think through the co-Chairing/co-Sponsor arrangements with LBM and the voluntary sector to ensure that a partnership approach is hard wired into the programme structure (not just the Steering Group, but also any sub-groups). One example is the proposal that the Steering Group will be co-Chaired by the Director of Public Health to ensure joint ownership and vision, and strong links into LBM.

The remit and structures are in preliminary development but sub-Steering Group workstreams could include:

- **Estates/facilities workstream**, for discussion and decisions about estate availability in the Mitcham area, the design and layout of the healthcare facility on the Wilson site, and what wider services could be re-located there from elsewhere in the borough, for example advocacy and advice services.
- **Funding model workstream**, to develop clarity around the options for sustainable funding sources for the core delivery model of the healthcare facility and the broader EMMoHWB, as well as exploring from the start future funding models that could support the EMMoHWB to grow and be entrepreneurial.
- **Community engagement workstream**, led by the voluntary sector, to plan and oversee engagement infrastructure and low cost models for on going dialogue with the community, for example through Citizen's Cafés.

- **Community delivery model workstream**, to develop the model for health care and social care integration in the facility and within the wider model; this should also consider workforce issues underpinning the delivery of the model.
- **IT workstream**, to consider how IT can best be used as an enabler underpinning health and social care integration and the wider model of health and wellbeing.

2.4 Delivery Priorities 2016/17

At the HWBB development session in January 2016 it was agreed that clear stepping stones should be set annually for the EMMoHWB. Potential delivery priorities for 2016/17 that were discussed were childhood obesity and social prescribing. Both these priorities have good strategic fit with the borough's Health and Wellbeing Strategy, with LBM's wider priorities including expansion of self care and social capital, as well as with Merton CCG strategy and the broader South West London Sustainability and Transformation Plan (STP) which brings local health and care leaders, organisations and communities together to develop local blueprints for improved health, care and finances over the next five years, delivering the NHS Five Year Forward View, including the ambition for a radical upgrade in prevention.

Outlined below is a suggestion for what taking forward these priorities might look like in practice for the HWBB.

Throughout both these suggested priority areas, there is opportunity to 1) ensure an asset based approach, identifying and building on individual, family, community and other assets, 2) consider key life course points where interventions are more likely to lead to behaviour change and build on national social marketing and programmes, and 3) make the links across families rather than individuals through a 'Think Family' approach to ensure best use of resources and 'Make Every Contact Count'.

2.4.1 Childhood Obesity

Childhood obesity is a national priority (with the government obesity strategy due out in autumn 2016), as well as a London priority – all London boroughs have recently been part of a whole system Childhood Obesity Thematic Review (Sector Led Improvement), sharing learning and best practice. Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood, including increased risk of diabetes, a priority for both Merton CCG and in the South West London STP, along with reducing childhood obesity itself.

We now plan to work across HWBB partners and with residents to design and implement a whole system approach to reverse the trend in childhood obesity and give Merton children the best start in life, from strengthening commissioned services and pathways for pregnant women, children and families, through to action on the wider environmental determinants of obesity, working through settings such as schools, public sector spaces and workplaces.

A Merton 3 year action outline plan for Prevention of Childhood Obesity is being prepared - to be considered by the HWWB on 28 June. This action plan is being

designed to reduce inequalities in the following 'headline' outcomes between east and west Merton:

- Reduced rates of children who are overweight or obese
- Increase rates participation of participation of physical activity
- Improved rates of breastfeeding
- Improved dental health among children

The plan will provide a framework for enabling different stakeholders across the council (including public health, children's services, education, environment, transport and planning) and NHS organisations to work with the community to tackle childhood obesity as part of the related and wider health and wellbeing improvements.

Key components will include:

Communications and engagement with families, children and young people to promote healthy eating and physical activity through Council activities (such as MyMerton, and Mitcham Festival), as well as participation in national and London-wide campaigns and initiatives such as the SugarSmart (tax) Debate to reduce consumption of sugary drinks.

Improving the local food environment and culture to increase availability of healthy food and drinks through:-

- Targeted work with local businesses and community venues by Environmental Health on the Healthy Catering Commitment, and Merton Food Charter
- Review of Council planning and regulations to restrict growth of fast-food outlets around schools and family settings

Maximising the role of Early Years and Schools as settings and services promoting healthy eating and weight through for example:-

- Strengthening the role of Health Visiting, Family Nurse Partnership and School Nursing in obesity prevention, close collaboration with wider children's services and as part of the implementation of the Community Services Contract (joint commission between LBM and CCG).
- Working with all early years providers (including nurseries, and children centres) to improve the diet of under 5s through working to achieve accreditation in programmes such as *Eat Better, Start Better.*
- Ensuring the delivery of the new Schools meals contract achieves required nutrition standards and healthy choices.

Promoting active travel (cycling and walking) and physical activity through strengthening partnership working on design, promoting and commissioning sport, recreational and physical activity opportunities that are community and family focused.

Build partnership working with local community and voluntary sector organisations and networks on the healthy food and active travel agendas and linked to wider sustainability issues (for example food growing, recycling and environmental quality)

2.4.2 Social Prescribing

Social prescribing (SP) is “a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being and can be done with or without the use of an intermediary such as a link worker or navigator. SP enables primary care services to refer to a variety of holistic, local, non-clinical services such as:

- Voluntary Work Agencies
- Further Education
- Social Or Lunch Clubs
- Self-Help Groups
- Befriending Organisations
- Leisure And Sports Clubs
- Cultural Groups Including Book Groups And Art Or
- Dance Classes
- Citizens Advice
- Employment support
- Housing support and advice

The evidence base for social prescribing is continually growing, is predominantly evaluated pilots that show that SP enables a more appropriate use of health care professionals’ time, and reduces unnecessary medical prescribing. Whilst medical interventions are inevitably necessary to treat specific health problems, the importance of strong social networks, access to friends, family and support, and an active social life cannot be underestimated. Social Prescribing is based on a wider recognition of the influence of social, economic and cultural factors on health outcomes, as well as the impact that positive social and learning opportunities have on health and wellbeing.

Developing a strong model for social prescribing is a great opportunity to engage with primary care in east Merton. Building on the evidence base and case studies of good practice from elsewhere, we will work in 2016/17 to develop and pilot a tiered model for primary care social prescribing based on need, from enabling better individual self care, through to connecting individuals and their families with existing services (information and signposting), to a more hands on ‘navigator’ approach to work with individuals to support them to access opportunities, and/or provide coaching. The model would include consideration of options for funding (both start up and on going delivery costs, including staff and any supporting costs such as a digital directory of services). Acknowledging the wider pressures on GPs, the pilot will also consider the most suitable and sustainable models for delivering social prescribing, including staffing and opportunities to engage the voluntary sector to deliver social prescribing in partnership with primary care.

A Department of Health vision document stated that care must again be about reinforcing personal and community resilience, reciprocity and responsibility, to prevent and postpone dependency and promote greater independence and choice[1] . Traditional approaches to improving wellbeing, reducing health inequalities and achieving other social goals have focused on the deficits and problems of individuals and communities. In contrast, using an approach such as social prescribing values assets identifies the skills, strengths, and capacity of communities and transcends barriers between different levels of care while facilitating a multi agency approach to meeting health needs. Expanding the boundaries of primary care is a recurring theme in a range of primary care guidelines, including stronger engagement with local authorities and closer links with, for example, Citizens Advice Bureaus, benefits and housing agency workers and all this strengthens community resilience.

It will be important to develop robust evaluation of the pilot, including the potential return on investment to the NHS and other parts of the system, to inform decisions around further investment.

3. NEXT STEPS

If the HWBB agrees the programme structure, timelines and delivery priorities these will be taken forward by partners. The next meeting of the HWBB in June 2016 is due to be a seminar and will focus on the East Merton Model of Health and Wellbeing reviewing progress to date and specifically developing the actions around the chosen priorities of childhood obesity and social prescribing.

4. ALTERNATIVE OPTIONS

None for the purpose of this report.

5. CONSULTATION UNDERTAKEN OR PROPOSED

Work on both the priorities for 2016/17, and on the wider EMMoHWB will involve consultation and community engagement.

6. TIMETABLE

Not for the purpose of this report.

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Not for the purpose of this report

8. LEGAL AND STATUTORY IMPLICATIONS

None for the purpose of this report

[1] Department of Health (2010) A Vision for Adult Social Care: Capable Communities and Active Citizens. Department of Health, London

9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

EMMoHWB is focused on addressing inequalities of health.

10. CRIME AND DISORDER IMPLICATIONS

Not for the purpose of this report.

11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

Not for the purpose of this report. .

12. APPENDICES – the following documents are to be published with this report and form part of the report

None

13. BACKGROUND PAPERS

None

STRATEGIC ITEM

Committee: Health and Wellbeing Board

Date: 19 April 2016

Wards: All

Subject: Merton Better Care Fund Plan

Lead officer: Adam Doyle Adam Doyle, Chief Officer, MCCG , Simon Williams Director of Community and Housing

Contact officer: Murrae Tolson, Assistant Director Integration MCCG

Recommendations:

A. That the Merton Better Care Fund plan and submission template, as attached to this report, is approved and submitted to NHS England.

PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to present the final draft of the Merton Better Care Fund Plan to the Health and Wellbeing Board for review and approval before submission to NHS England.

The deadline for submission of the final plan is 25th April.

The plan builds on approved plans for 2015-16 and reviews progress in the first year of the BCF as the basis for developing the 2016-17 Merton BCF plan.

1. BACKGROUND

1.1 The Better Care Fund is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups and local authorities in every single area to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation.

1.2 The local flexibility to pool more than the mandatory amount remains. From 2017-18, the government will make funding available to local authorities, worth £1.5 billion by 2019-20, to be included in the Better Care Fund. In 2016-17, it is important that Better Care Fund plans are aligned to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of 7-day services.

1.3 In place of the 2015/16 performance fund are two new national conditions, requiring local areas to fund NHS commissioned out-of-hospital services and to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The conditions are designed to tackle the high levels of DTOC across the health and care system, and to ensure continued investment in NHS commissioned out-of-hospital services, which may include a wide range of services including social care.

2. DETAILS

2.1 Merton 2015/16 BCF delivered the foundations for integration in Merton. Whilst the 2015/16 BCF plan aimed for a 0.4% reduction of non-elective admissions, for the period April – Dec, a 2.4% reduction was realised.

2.2 The 2016/17 BCF plan needs to deliver an enhanced local community response through a joint health and social care infrastructure delivered by community services, mental health services, primary care, social care and voluntary sector partners. This is a key enabler for the local Sustainability and Transformation plan.

2.3 In order to develop this response, Merton stakeholders have committed to integrate health and social care services by 2020 through a Multi-speciality Community Provider (MCP) as the vehicle for integration. Building on the 2015/16 BCF plan and budget of £12.2m, the 2016/17 BCF plan lays the foundations for further integration through a substantially greater pooled budget of £91.4m.

2.4 There is currently a signed section 75 in place between the CCG and local authority. This will be updated to reflect amendments to the 2016/17 pooled budget and include a ring-fenced risk pool with supporting risk and gain sharing arrangement.

2.5 The CCG and local authority will ringfence an amount of £1,015k from the BCF pool and retain this as part of the risk share agreement. These funds will be retained and remain uncommitted with the terms of managing the fund set out in the Section 75 between the CCG and the Local Authority. These funds will be released at the end of the year, should the CCG meet the NEL QIPP target and spent as agreed by the Health and Wellbeing board. However, if the CCG do not meet the NEL QIPP target, the fund will be used to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand.

2.6 Reporting and monitoring the 2016/17 BCF budget will reflect the current service line reporting for health and social care services and therefore individual scheme investments may be subject to cost improvement and QIPP plans. This enhanced transparency of reporting has been agreed in order to allow:

2.6.1. Greater understanding of commissioned services and expenditure across health and social care provision.

2.6.2. Greater freedom for resourcing interim and permanent health and social care reablement packages of care.

2.6.3. Joint understanding of current resources for potential inclusion in future population based capitated budgets.

2.7 The key priority for the 2016/17 BCF plan is to strengthen the relationships and collaboration between multiple providers in Merton through 3 interlinked projects and a DTOC action plan:

2.7.1. Integrated health and social care assessments

2.7.2. Seven day working

2.7.3. Improved communication enabled by information technology

2.7.4. Action plan to address DTOC.

2.8 Integrated health and social care assessments and seven day working will be an integral part of the East Merton Model of Care.

2.9 Whilst the BCF programme will focus on improved communication between health and social care providers enabled by information technology, this project will form part of the wider IT strategy as part of the CCG transformation plan.

2.10 The Merton Adults programme board has been established to act as the BCF Programme Board and will report to the CCG's Governing Body and the Council's Cabinet via the Merton Health and Wellbeing board

2.11 The Merton Operational Integration group is re-constituted from the previous Merton Model group. The group have responsibility for delivering the BCF projects and DTOC action plan.

2. ALTERNATIVE OPTIONS

A condition of the minimum NHS contribution to the Fund (£5,508k) being released into pooled budgets is contingent on local partners developing a joint spending plan that is approved by NHS England. The alternative to not submitting a plan is therefore that the CCG withholds the NHS minimum contribution to the fund.

3. CONSULTATION UNDERTAKEN OR PROPOSED

The 2016/17 BCF plan builds on stakeholder engagement conducted as part of the 2015/16 BCF engagement activities and user engagement conducted as part of the CCG community services procurement.

The Merton Adults programme board, Merton CCG Transformation committee and Merton CCG EMT have reviewed and agreed the 2016/17 BCF plan.

4. TIMETABLE

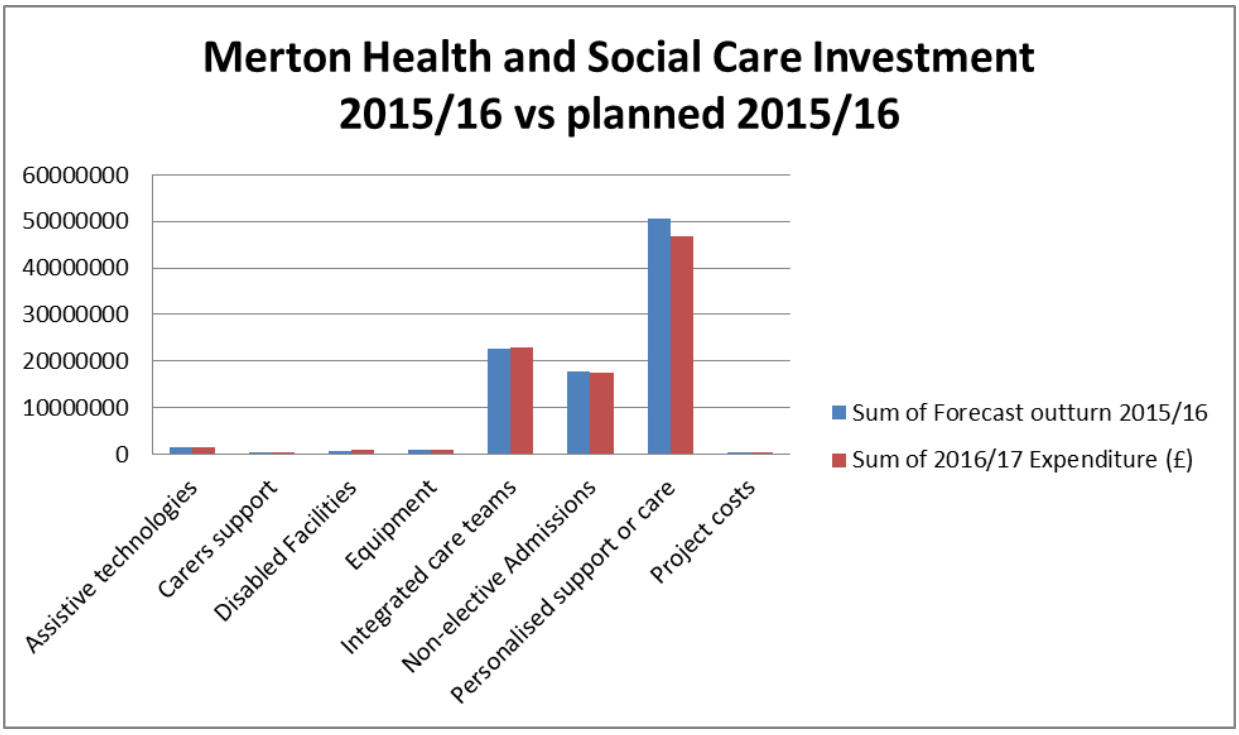
The deadline for submitting the BCF plan is the 25th of April 2016.

5. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

The commitment of the partner commissioning authorities in financial terms is set out the plan and can be summarised as follows:

Merton BCF HWBB Funding Sources	BCF budget (000)	Gross contribution (000)
Local Authority Contribution(s)		£ 36,581
Merton Local authority	£ 36,581	
CCG Minimum Contribution		£ 11,580
CCG transfer to local authority	£ 5,508	
CCG (min) Out of hospital	£ 6,072	
Additional CCG Contribution		£ 42,073
Merton CCG additional investment in Out of hospital	£ 24,659	
Merton CCG cost of NEL admissions	£ 17,414	
Capital Funding		£ 990
Disabled Facilities Grant	£ 990	

The combined budget will be spent on the following areas:



6. LEGAL AND STATUTORY IMPLICATIONS

No specific implications.

7. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Merton Better Care Fund plan inherently aims to address the needs and improve the outcomes for Merton residents included in two of the nine protected characteristics under the Equality Act 2010, namely age and disability. The Better care Fund does not appear to have any adverse effects on people who share Protected Characteristics. However a formal equality impact assessment will need to be undertaken early in the planning phase to assure that the proposed programmes do not inadvertently disadvantage any sub-groups with protected characteristics.

The 2016/17 BCF plan is not about introducing new services, but about simplifying the existing processes and pathways to achieve a more responsive, better quality response for people with support needs. The BCF plan is in alignment with the vision of Merton's Health and Wellbeing Board to improve health and social care outcomes for the population of Merton by:

- Ensuring commissioned services are tailored to the needs of individual patients;
- Addressing the diverse health needs of Merton's population; and
- Reducing geographical, age and deprivation-related variation.

The vision for services as set out in the 2015/16 BCF plan remains the key principle of service delivery for 2016/17 and encompasses a wide range of stakeholders and services including:

- Patients, services users and carers,
- GPs and Primary Care,
- Key workers in health and social care,
- Community Health,
- Reablement,
- Mental Health, incl. dementia and memory clinics,
- End of Life services,
- and Voluntary Sector Services (including Carers Support).

The key priority for the 2016/17 BCF plan is to strengthen the relationships and collaboration between multiple providers in Merton through 3 interlinked projects and a DTOC action plan:

a. Integrated health and social care assessments
b. Seven day working
c. Improved communication enabled by information technology
d. Action plan to address DTOC.

Within the scope of the BCF programmes, it is likelier than not that inequalities will be addressed and reduced, and a positive impact will be evidenced on both years spent in good health and reducing the gap in life expectancy, that parity of esteem will be ensured for both mental and physical health management including dementia, and that patient's right to choice and privacy will be respected. It is recognised that a significant amount of engagement is required to bring all partners on board and ascertain what support people need to prevent admission or long term care and empower front line staff to make these changes.

8. CRIME AND DISORDER IMPLICATIONS

None

9. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None specific to this report

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

Merton DRAFT BCF plan vo.3

Merton BCF template submission

11. BACKGROUND PAPERS

Better Care Fund 2016/17 Policy Framework:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf

Better Care Fund 2016/17 Planning Requirements:

https://www.england.nhs.uk/wp-content/uploads/2016/02/annex4-bcf-planning-requirements-1617.pdf

DRAFT 0.3

Merton Better Care Fund plan 2016/17

Consultation history

Version	Audience	Date	Outcome
DRAFT 0.1	Merton Adults Health and Care Board	15/3/16	Inclusion of NEL activity in BCF budget Amendment of Reablement target Creation of Risk pool
DRAFT 0.2	Adam Doyle and Simon Williams	18/3/16	Amendments to reablement target
DRAFT 0.2	NHSE	21/3/16	Submission
DRAFT 0.2	Merton CCG Clinical Transformation Committee	05/04/16	Comments via e-mail
DRAFT 0.3	Adults programme board, CCG EMT.	05/04/16	Inclusion of Risk sharing arrangements. Amendments following initial feedback from NHSE KLOE.
DRAFT 0.3	Merton Health and Wellbeing board	19/4/16	
Final 1.0	NHSE	24/4/16	

Table of Contents

Executive Summary

- Merton has a rich history of integrated working between health and social care.
- 2015/16 delivered the foundations for integration in Merton. Whilst the 2015/16 BCF plan aimed for a 0.4% reduction of non-elective admissions, for the period April – Dec, a 2.4% reduction was realised.
- The 2016/17 BCF plan needs to deliver an enhanced local community response through a joint health and social care infrastructure delivered by community services, mental health services, primary care, social care and voluntary sector partners.
- In order to develop this response, Merton stakeholders have committed to integrate health and social care services by 2020 through a Multi-speciality Community Provider (MCP) as the vehicle for integration. Building on the 2015/16 BCF plan and budget of £12.2m, the 2016/17 BCF plan lays the foundations for further integration through a substantially greater pooled budget of £91.4m.
- The CCG and local authority will ringfence an amount of £1,015k from the BCF pool and retain this as part of the risk share agreement. These funds will be retained and remain uncommitted with the terms of managing the fund set out in the Section 75 between the CCG and the Local Authority. These funds will be released at the end of the year, should the CCG meet the NEL QIPP target and spent as agreed by the Health and Wellbeing board. However, if the CCG do not meet the NEL QIPP target, the fund will be used to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand
- Reporting and monitoring the 2016/17 BCF budget will reflect the current service line reporting for health and social care services and therefore individual scheme investments may be subject to cost improvement and QIPP plans. This enhanced transparency of reporting has been agreed in order to allow:
    a. Greater understanding of commissioned services and expenditure across health and social care provision
    b. Greater freedom for resourcing interim and permanent health and social care reablement packages of care
    c. Joint understanding of current resources for potential inclusion in future population based capitated budgets.
- The key priority for the 2016/17 BCF plan is to strengthen the relationships and collaboration between multiple providers in Merton through 3 interlinked projects and a DTOC action plan:
    a. Integrated health and social care assessments
    b. Seven day working
    c. Improved communication enabled by information technology
    d. Action plan to address DTOC.
- The 2016/17 BCF plan is not about introducing new services, but about simplifying the existing processes and pathways to achieve a more responsive, better quality response for people with support needs. We therefore recognise that a significant amount of engagement is required to bring all partners on board with the vision, create an environment for change, truly listen to what support people need to prevent admission or long term care and empower front line staff to make these changes.
- The Merton Adults programme board has been established to act as the BCF Programme Board and will report to the CCG's Governing Body and the Council's Cabinet via the Merton Health and Wellbeing board.
- The Merton Operational Integration group is re-constituted from the previous Merton Model group. The group and have responsibility for delivering the BCF projects and DTOC action plan.

History and context

Merton has a rich history of integrated working between health and social care.

The 2015/16 BCF plan, submitted in September 2015 was approved following the Nationally Consistent Assurance Review (NCAR) process by NHS England and acknowledged to be clear and ambitious.

The vision of Merton's Health and Wellbeing Board is to improve health and social care outcomes for the population of Merton by:

- Ensuring commissioned services are tailored to the needs of individual patients;
- Addressing the diverse health needs of Merton's population; and
- Reducing geographical, age and deprivation-related variation.

This vision is built around and evidenced by the Merton Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS), as set out below.

Ultimately our vision should deliver:
the right care, at the right time, in the right place with the right outcomes.

Merton's Health and Wellbeing Board has agreed that the Better Care Fund Vision will be delivered through four principal objectives:

The table below sets out the vision for services as set out in the 2015/16 BCF plan and remains the key principle of service delivery for 2016/17.

Ref	Stakeholder/Service	What will success look like?
2.1	Patients, Service Users and Carers	More coordinated care through key workers. Smoother discharge through single access pathway. More opportunity to be treated in the community and at home.
2.2	GPs and Primary Care	Timely and responsive multi-disciplinary working.
2.3	Key worker	Key worker role and responsibilities established and localities working to this model through health liaison workers and/or other professionals.
2.4	Social Work	The 'Proactive' teams working in localities to a single pathway coordinated with healthcare teams. Single, agreed support planning process developed and operated across localities with teams working consistently to the agreed process and operating procedures. A single assessment process delivered at least through a 'trusted assessor' arrangement. Role of social care OTs and social care hospital discharge teams reviewed.
2.5	Community Health	Planned care functions delivered in localities working to a single pathway in coordination with social work teams. Single, agreed support planning process developed and

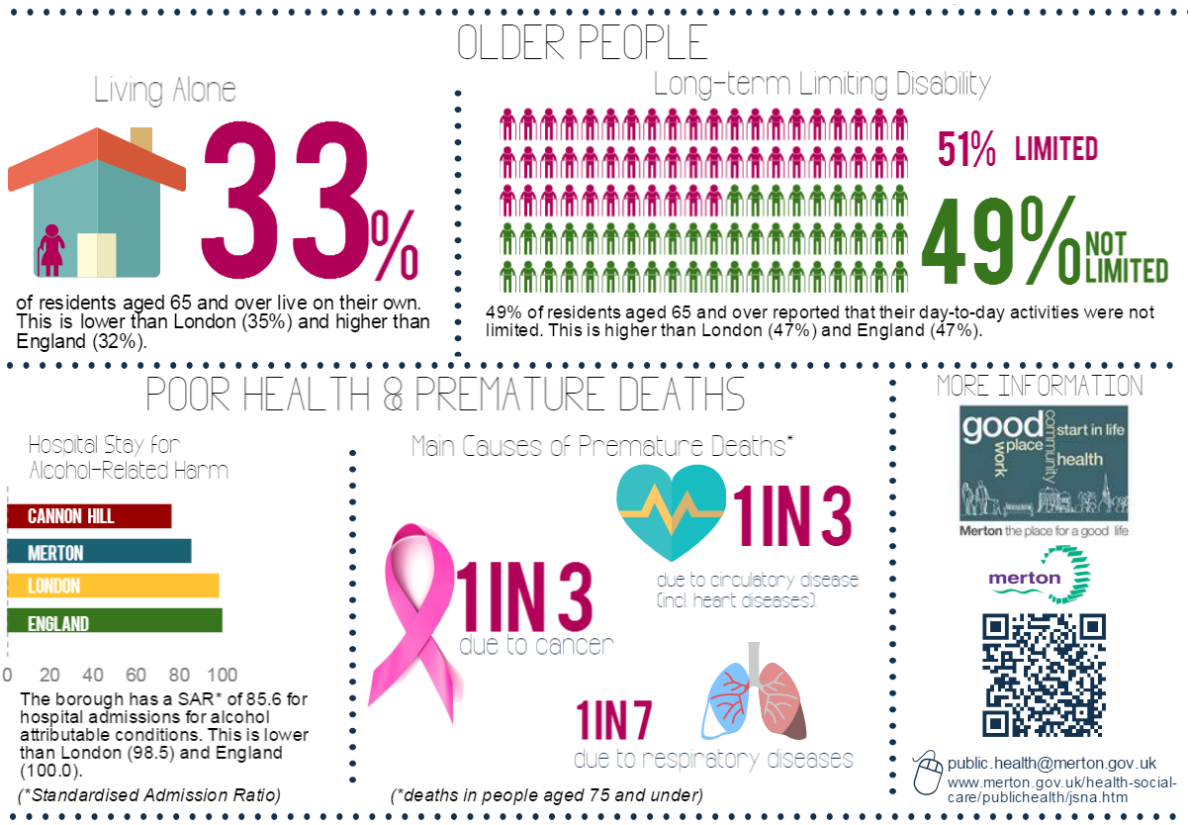
Ref	Stakeholder/Service	What will success look like?
		operated across localities with teams working consistently to the agreed process and operating procedures. A single assessment process delivered at least through a 'trusted assessor' arrangement.
2.6	MILES, reablement and step up beds	Processes for straightforward referral to reablement in place.
2.7	Mental Health, incl. dementia and memory clinics	Formal links to MH services in place with MH workers potentially based within localities. Integrated pathways to dementia hubs and memory clinics.
2.8	Location	Explore options for co-location in 2016/17.
2.9	End of Life	End of life services integrated into the locality pathways.
2.10	Process	Agreed, single access and assessment processes in operation. Key worker processes agreed and operational. Some degree of integration within processes to MH services. Trusted assessor agreements in place.
2.11	Acute Trusts	Fewer inappropriate admissions, as patients being managed by integrated teams in the community. Early involvement of community services following non-elective admission. Coordinated discharge function with single pathway of access to all locality services resulting in fewer Delayed Transfers of Care.
2.12	Voluntary Sector	Integrated into locality pathways and overall patient and service user processes.
2.13	Equipment	Local access to equipment, including swift prescribing and delivery to prevent unnecessary delays to discharges.
2.14	Management	Collectively managed resources identified.

Our population

JSNA

Merton's 2014 population projection is 203,200 people living in nearly 80,400 occupied households. Population density is higher in the east wards of the borough compared to the west wards. Based on GLA trend-based projections, Merton's population will increase by 13,245 people between 2014 and 2020 with the number of people aged over 65 forecast to increase by over 2,100 people (9.2%).
As a whole, Merton is less deprived than the average for both London and England. However, three wards are more deprived than the average for London: Cricket Green, Figge's Marsh and Pollards Hill.

Health outcomes are generally better than those in London and in line with or above the rest of England. However, there are inequalities between East and West, and within population groups.
Greater London Authority (GLA) population data (2014) shows Merton's current BAME population is 76,188. Black, Asian and Minority Ethnic (BAME) groups make up 35.1% of the population, lower than London (40.2%).



Risk stratification

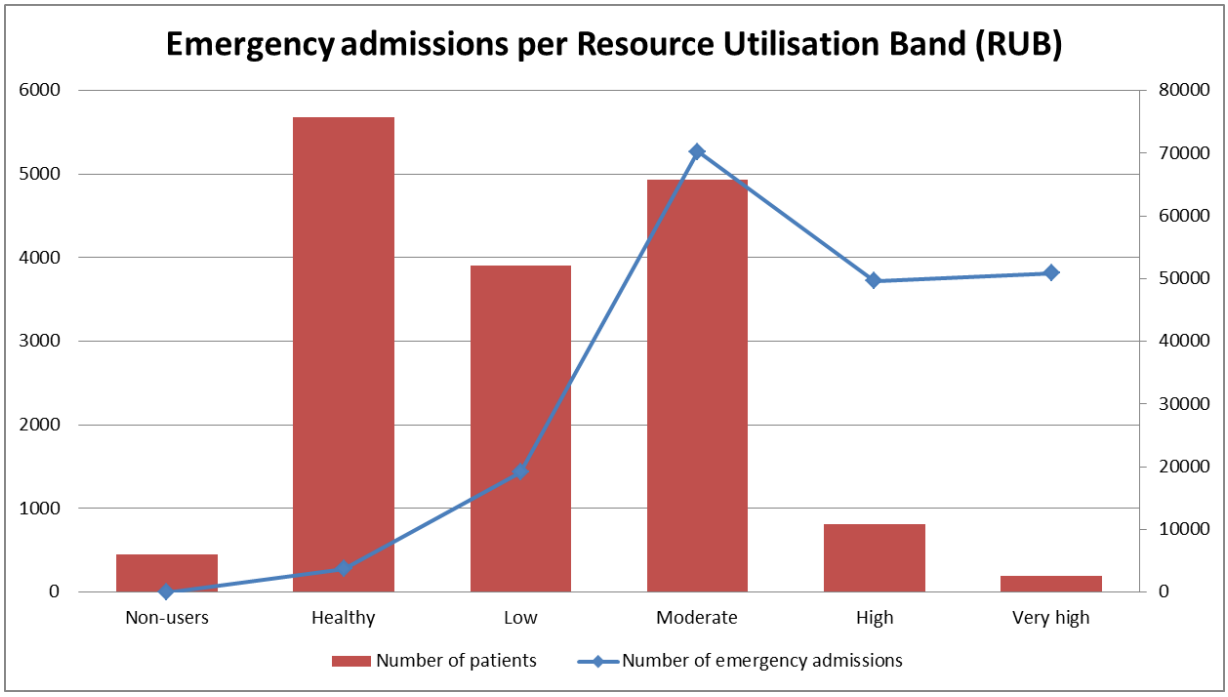
All twenty-five GP practices in Merton undertake risk-stratification profiling to identify patients at high or very high risk of:

(a) Deterioration and subsequent escalation in the community (potential Acute spend).

(b) Patients who are frequent attenders in Acute services (existing Acute spend).

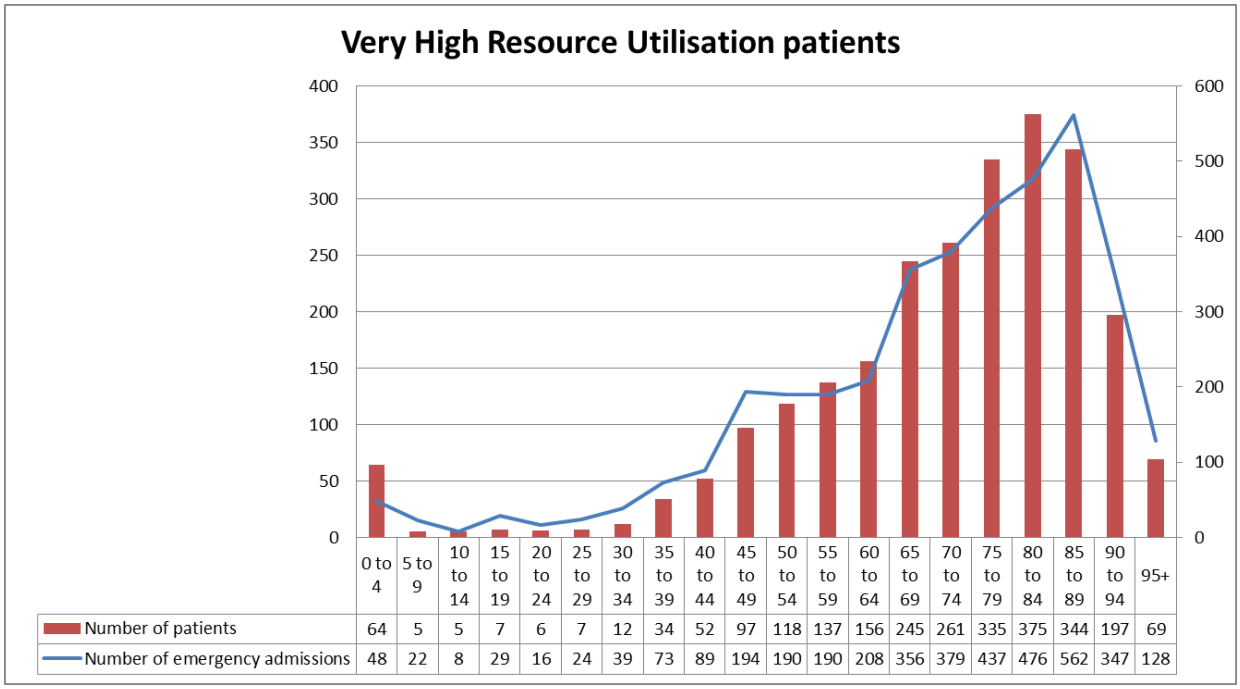
Merton uses the ACG SOLLIS system and practices have been trained in using this to identify the high risk cohort of the population. Figure 1 shows the number of patients and number of emergency admissions for each of the Resource Utilisation Bandings (RUB). This shows that there are a small number of patients in the Very High and High RUB categories who experience a high number of emergency admissions. For this reason, the 2016/17 plan is shaped based on the typical needs of those patients in these two RUB categories.

FIGURE 1 MERTON REGISTERED PATIENT PROFILE AS PER RISK STRATIFICATION



Over the past 12 months there were 2526 patients who were grouped in the "Very High Resource Utilisation Banding". These patients had 3815 emergency admissions in the past 12 months. Figure 2 shows that the very high risk patients who are 60 years old or above account for 76% if emergency admissions for this population group.

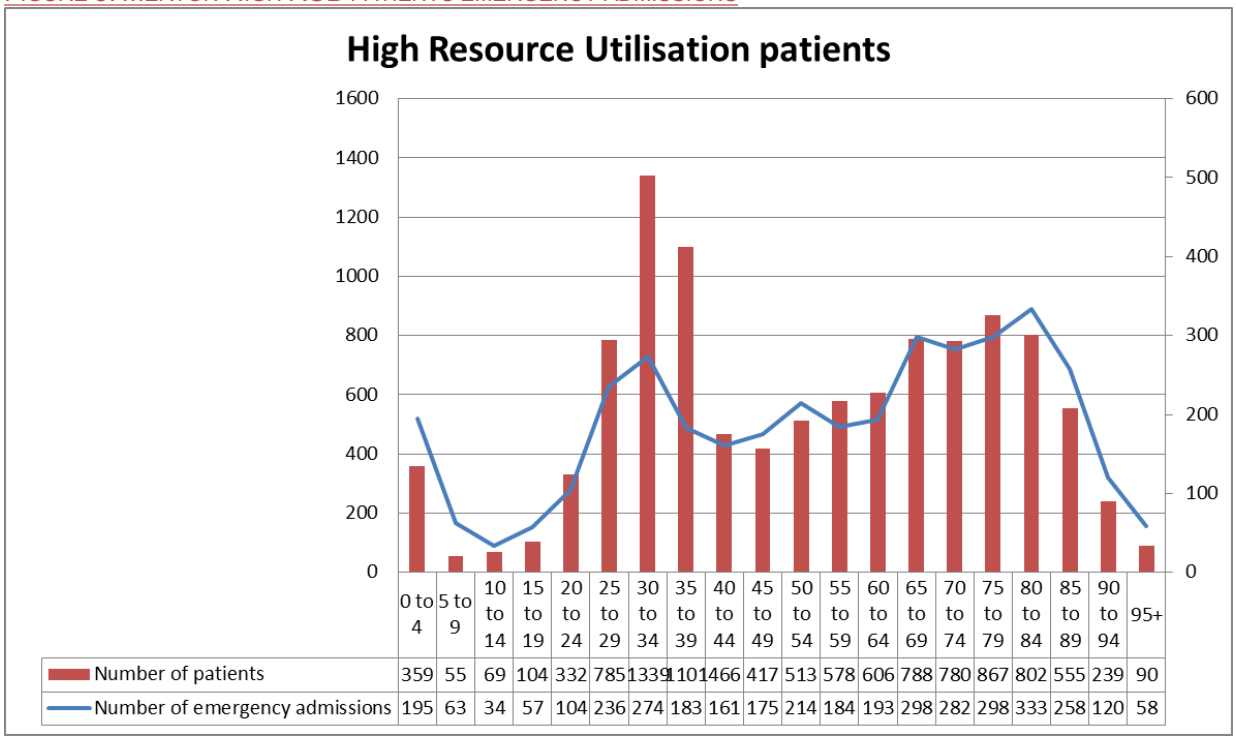
FIGURE 2: MERTON VERY HIGH RUB PATIENTS EMERGENCY ADMISSIONS



	0 to 4	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 to 94	95+
Number of patients	64	5	5	7	6	7	12	34	52	97	118	137	156	245	261	335	375	344	197	69
Number of emergency admissions	48	22	8	29	16	24	39	73	89	194	190	190	208	356	379	437	476	562	347	128

There were 10854 patients grouped in the High Resource Utilisation Band who had a 3720 emergency admissions in the past 12 months. Whilst this group had a lower rate of emergency admissions, there was a similar pattern of increased rate of admissions for those people who are 65 years or older.

FIGURE 3: MERTON HIGH RUB PATIENTS EMERGENCY ADMISSIONS



Integrated working

In the absence of an integrated health and social care data set, Merton CCG compared the number of patients identified as high risk of admission, those that were assessed for continuing care and those who accessed community health services to establish the level of integrated working between these parts of the health system as shown in figure 4.

Whilst it can be postulated that the people with the highest care and support needs should be supported through case management, community services and continuing care, the analysis revealed poor integrated support packages for these individuals with only 80 people in support of all 3 health service support services. These individuals accounted for 234 non-elective admissions.

FIGURE 4: OVERLAP OF HEALTH SERVICE RESPONSE FOR TOP 2% OF PATIENTS.

RUB/Risk Data	Number of Patients	Number of Emergency (NEL Admission) Events
No. within Top 2%	**4276**	**5980**
No. in Community Care	**11,987**	**8779**
No. in Continuing Care	**736**	**437**
No. within Top 2% AND on AUA	2082	2870
No. within Top 2% AND NOT on AUA	2194	3110
Pts in Top 2% AND Community Care	2122	5147
Pts in Top 2% AND Continuing Care	212	408
In Top 2% AND Community Care AND Continuing Care	130	355
In Top 2% AND Commnuity Care AND Continuing Care and AUA	80	234
In Community Care AND Continuing Care NOT Top 2%	201	25
In Community Care ONLY	9,663	3626
In Continuing Care ONLY	322	9

As part of the CCG QIPP planning, non-elective admissions for people older than 50 years were analysed. This analysis showed that there is a cohort of people who experience multiple admissions:

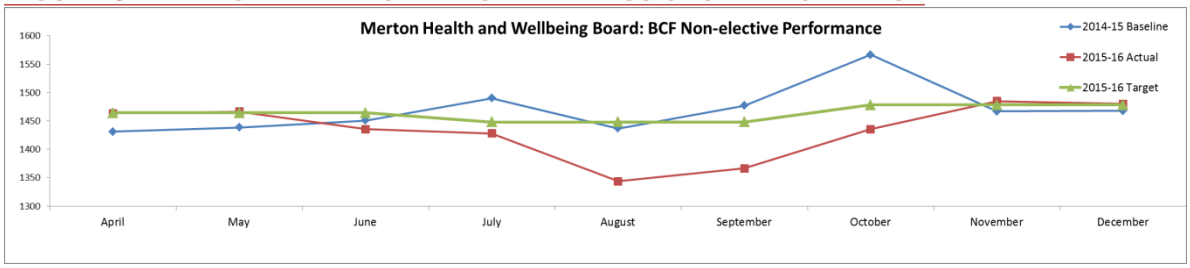
Number of admissions	Sum of Individual Patients	Sum of Total_Cost_Inc_MFF	Sum of Excess_Bed_Days_Cost	Average Spell Cost
16	2	£ 60,516	£ -	£ 1,891.13
15	2	£ 32,656	£ -	£ 1,088.53
11	1	£ 20,915	£ -	£ 1,901.36
10	3	£ 24,875	£ -	£ 829.17
9	5	£ 55,115	£ -	£ 1,224.78
8	9	£ 172,782	£ 10,493.91	£ 2,254.00
7	14	£ 133,841	£ 6,520.58	£ 1,299.19
6	26	£ 300,402	£ 10,563.90	£ 1,857.94
5	45	£ 466,890	£ 24,461.73	£ 1,966.35
4	92	£ 801,468	£ 35,207.31	£ 2,082.23
3	267	£ 1,863,396	£ 164,978.60	£ 2,120.37
2	746	£ 3,255,140	£ 247,418.07	£ 2,015.90
1	2839	£ 5,779,095	£ 539,191.84	£ 1,845.69

This data was reviewed and discussed by GPs as part of the CCG QIPP planning process. Based on the age distribution, HRG treatment category and number of admissions, it is anticipated that, based on the number of admissions people experience, a percentage of these NEL admissions could be reduced with an improved integrated health and social care response.
While every person who has experienced a non-elective admission will be considered for case management, the CCG estimate that approximately 1/5 of very high resource band patients (505) would benefit from case management, resulting in 525 prevented admissions.

2015/16 BCF Performance.

Whilst the 2015/16 BCF plan aimed for a 0.4% reduction of non-elective admissions, for the period April – Dec, a 2.4% reduction was realised.

FIGURE 5: MERTON HWB NON-ELECTIVE ADMISSIONS PERFORMANCE



Permanent admissions of older people to residential and nursing care homes are however above plan with a likely outturn of 105 new admissions for 2015/16. The Merton system has experienced significant challenges with Delayed Transfers of Care during 2015/16. We are aware that this is aggravated by silo processes between various health responses, silo processes between health and social care and lack of capacity in the residential- and care home market. The local metric for number of people accessing reablement is on track to exceed the target.

FIGURE 6: MERTON HWBB METRICS PERFORMANCE DASHBOARD

Health and Wellbeing board Metrics	2015.16 target	Target for Previous Year	YTD	RAG Status	Direction of Travel	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	<395.3	342.6	272.4	AMBER	↓	37.1	78.4	115.6	156.8	177.5	218.8	239.4	272.4	309.6
Number of new placements to Permanent Care Homes 65+ (C72) (monitoring of number of people)	< 100 new admissions	83.0	66.0	AMBER	↓	9	19	28	38	43	53	58	66	75
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (effectiveness of the service)	85.7%	81.2%	N/A	N/A										
Proportion of older people (65 and over) who were offered a Reablement or Intermediate Care Service during the period October to December	2.5%	NA	N/A	N/A										
Number of older people (65 and over) who were offered a Reablement or Intermediate care service - (clients Reablement services started per month)	91	9	372.0	GREEN		25	21	29	39	53	50	54	53	48
Delayed transfers of care from hospital per 100,000 population (Quarter)	239		696	RED		617			565			907		
Number of delayed transfers of care from hospital	393.0		380	RED	↓	404	294	311	289	280	356	529	453	502
Social care-related quality of life (User Survey) Enhancing quality of life for people with care and support needs sed.	18.8	18.8%	TBD	N/A										

Strengthening the vision

Merton's five-year planning process is created in partnership with the SW London Commissioning Collaborative with our Sustainability and Transformation plans currently in development. The strategy as a whole will require fundamental changes to how services are delivered across south west London. Over the next five years, there will be an increasing shift in services from the acute to community with the development of more proactive out-of hospital services. The Merton BCF plan sets out the planned health and social care response that will be available to support people out of hospital in Merton. This will inform the assumptions about the level of non-elective activity that can be shifted from acute to community settings. The STP will therefore be able to consider the workforce implications across South West London related to the shift in Merton activity

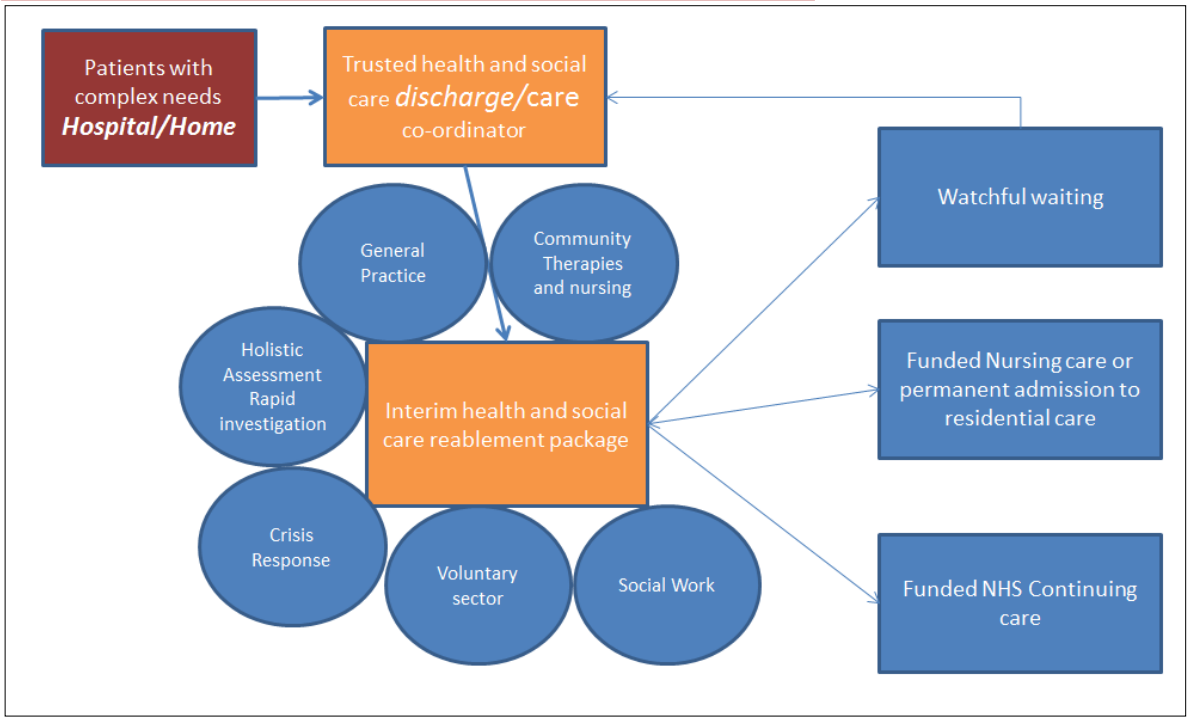
Whilst the BCF schemes and their impact in 2015/16 have been successful, we know that there are challenges with the current delivery model that needs to be addressed. Current challenges identified following review of 2015/16 BCF progress:

1. **Case finding**
   Whilst risk stratification is a helpful tool, it currently only captures health related factors impacting on people's wellbeing. As a historical reporting tool with a two month time lag, it also identifies people who have already experienced an increase in health resource utilisation. Although intangible, local knowledge of people's circumstances has proven to be more predictive to identify increased support needs, however local processes have not yet been embedded to respond to this local knowledge. There are therefore a number of instances when people who have not benefitted from a health and social care co-ordinated support response.
2. **Multi-disciplinary working**
   Whilst formal MDT meetings are in place across Merton's 25 GP practices, these are considered to be of varying degrees of effectiveness due to advance planning, attendance and nature of people's care and support needs. Whilst MDT meetings can be effective, local feedback has been that communication outside of formal meeting structures is a better mechanism to co-ordinate support for people.
3. **Silo processes with multiple points of access**
   For people with either pro-active and/or re-active support needs, there are multiple points of contact and access routes implying duplication, multiple handovers and depending on the point of access, predestined pathways.
4. **Push vs pull**
   There are limiting access criteria for a number of Merton services which means our services transact with people based on contracting arrangements and budgetary responsibility. This hampers working in partnership to customise support and create individualised support packages for those with the highest needs.

The 2016/17 BCF plan therefore needs to enhance our local community response through a joint health and social care infrastructure delivered by community services, mental health services, primary care, social care and voluntary sector partners.

The key focus of work for 2016/17 will therefore be to harmonise existing services and responses around individual's support needs. Figure 7 depicts the vision for an integrated health and social care response for Merton enabled by a greater pooled budget across health and social care. .

FIGURE 7: MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE RESPONSE



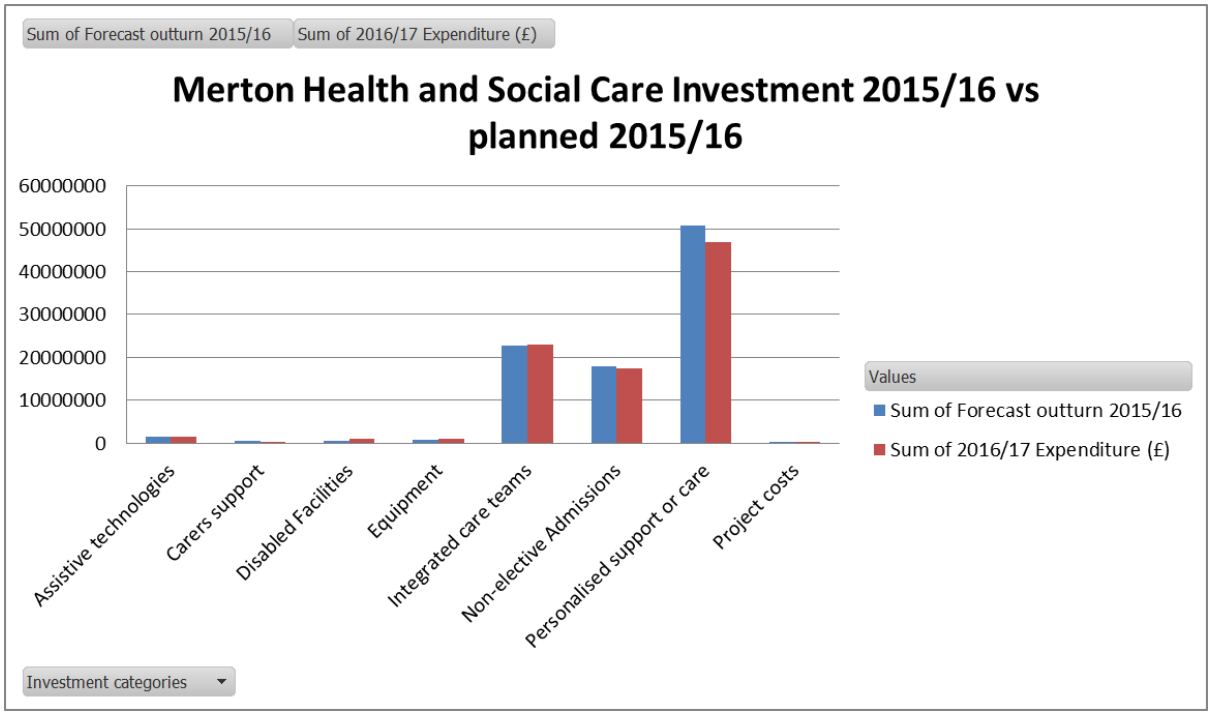
In order to develop this model, Merton stakeholders have committed to integrate health and social care services by 2020 through a Multi-speciality Community Provider (MCP) as the vehicle for integration. Building on the 2015/16 BCF plan and budget of £12.2m, the 2016/17 BCF plan lays the foundations for further integration through a substantially greater pooled budget of £91.4m.

2016/17 BCF Budget

The scheme level investment of the Merton 2016/17 BCF budget is set out in Appendix 1. Reporting and monitoring the 2016/17 BCF budget will reflect the current service line reporting for health and social care services and therefore individual scheme investments may be subject to cost improvement and QIPP plans. This enhanced transparency of reporting has been agreed in order to allow:

1. Greater understanding of commissioned services and expenditure across health and social care provision
2. Greater freedom for resourcing interim and permanent health and social care reablement packages of care
3. Joint understanding of current resources for potential inclusion in future population based capitated budgets.

FIGURE 8: TYPE OF INVESTMENT FOR MERTON 2016/17 BUDGET



2016/17 BCF plans

The key priority for the 2016/17 BCF plan is to strengthen the relationships and collaboration between multiple providers in Merton through 3 interlinked projects:

1. Integrated health and social care assessments
2. Seven day working
3. Improved communication enabled by information technology

The Draft programme plan is included in Appendix 3, with the high level project deliverables described below:

Project 1: Integrated health and social care assessments for people with support needs

The 2015/16 BCF plan implemented the foundations of integrated working. This included formation of locality MDT teams with access to dementia nurses and end of life services, community prevention of admission teams, in-reach nursing, intermediate care bed provision, Holistic Assessment and Rapid Investigation service (HARI) and restructuring reablement services. During 2015/16 the CCG achieved a 67% diagnosis rate for people with dementia, making it possible to better support people who have dementia and the carers who support them. The CCG also procured a new community service contract with the new provider delivering to an outcomes based service specification from the 1st of April 2016.

During 2016/17 we will build on these foundations by:

1. Aligning the access and operating criteria between the various health and social care services in order to reduce the number of handoffs during people's support journey.
2. Strengthening case management of people through improved case finding of people with support needs across health and social care.
3. Improve links between pro-active and reactive services so that people can benefit from step-up and step down of support.
4. Expand the intermediate care offer across health and social care so that people benefit from reablement before permanent packages of care are set up.

Whilst there are tangible deliverables for this project, much of the benefit relies on a change in culture to facilitate person centred support. This project will therefore follow a change management methodology with a number of the "Plan, Do, Study Act" cycles. Two of the likely outcomes will be greater co-location of health and social care staff and single point of contact for a joint health and social care response.

Through this vehicle Merton will maintain provision of social care services in 2016-17 as people with support needs will be met by a joint health and social care response. This is consistent with the 2015-16 BCF plans.

As a unitary authority, Merton benefits from close working between social care and housing with a direct referral route to the occupational therapy team for people who may require home improvements. The Disabled facilities Grant will therefore be used to facilitate improved access to capital costs for home improvements in order to support people in their own homes.

This project will also ensure that informal family carers continue to be supported by the by the local authority and the NHS. Currently Merton Social Care staff assess, develop support plans and arrange services for carers via commissioned agencies, a contract for carers support, small one off grants and Direct Payments. Funding is provided through and Ageing Well grant to Carers Support Merton to provide support such as information and advice, support groups and mentoring for carers.

We are now working with Carers Support Merton to develop a Carer's Hub. During 2016/17 this will become a wraparound, one stop shop for carers to offer advice and information, carer's assessments, support planning, reviews in addition to the bespoke services this type of voluntary organisation can offer to carers. One off grants and Direct Payments for Carers will also continue. This comprehensive service to carers will support carers to continue in their caring role and also promote early intervention when circumstances change and needs increase, thus preventing the need for hospital admissions due to carer breakdown. Interim care arrangements will be put in place if a carer needs hospital treatment with extra support should it be required at the time of hospital discharge to shorten length of stay and risk of readmission.

This project in the whole will ensure that the national condition of a joint approach to assessments and care planning is met with an embedded process for identifying an accountable professional where funding is used for integrated packages of care.

To enable this approach, the CCG has, as part of BCF, invested an increased amount into a new community service contract for increased provision of out-of-hospital services. This includes specific investment in community dementia nurses, as supporting people living with dementia is a high priority. The CCG has also invested additional funds into the Memory Assessment service so that it is better aligned with best practice guidance. Merton is in the process of developing a new dementia 5 year strategy in collaboration with all key stakeholders.

This project is the vehicle for delivering the CCG QIPP (Quality, Innovation, Productivity and Prevention) for non-elective admissions and aims to curtail growth and prevent 525 emergency admissions during 2016/17. The consequential impact of this project will be shared and agreed with our main acute providers, St. Georges NHS Foundation Trust, Epsom and St. Helier University Trust and Kingston Hospital Foundation Trust as part of the annual contract negotiation process.

The value of the QIPP will be retained as part of the local risk sharing agreement and is set out in section 10: Risk Pool

Project 2: Seven day working

The 2015/16 BCF plan delivered a 7 day working response for community prevention of admission and social work assessments in hospitals. We need to extend this offer so that all people with support needs get a similar response over weekends as they do during the week. This will improve flow across the system and assist with the action plan to reduce the number of Delayed Discharges of Care from hospitals.
To achieve improved flow requires us to understand where the bottle necks currently occur and what actions need to be taken to address these bottle necks.
During 2016/17 we will:

1. Identify what responses the system requires in order to meet people's support needs 7 days a week, 365 days per year.
2. Identify the current resources available to the system to meet these needs
3. Map current resources to current requirements in order to identify the gaps.
4. Redeploy resources in order to meet 7 day working system requirements.

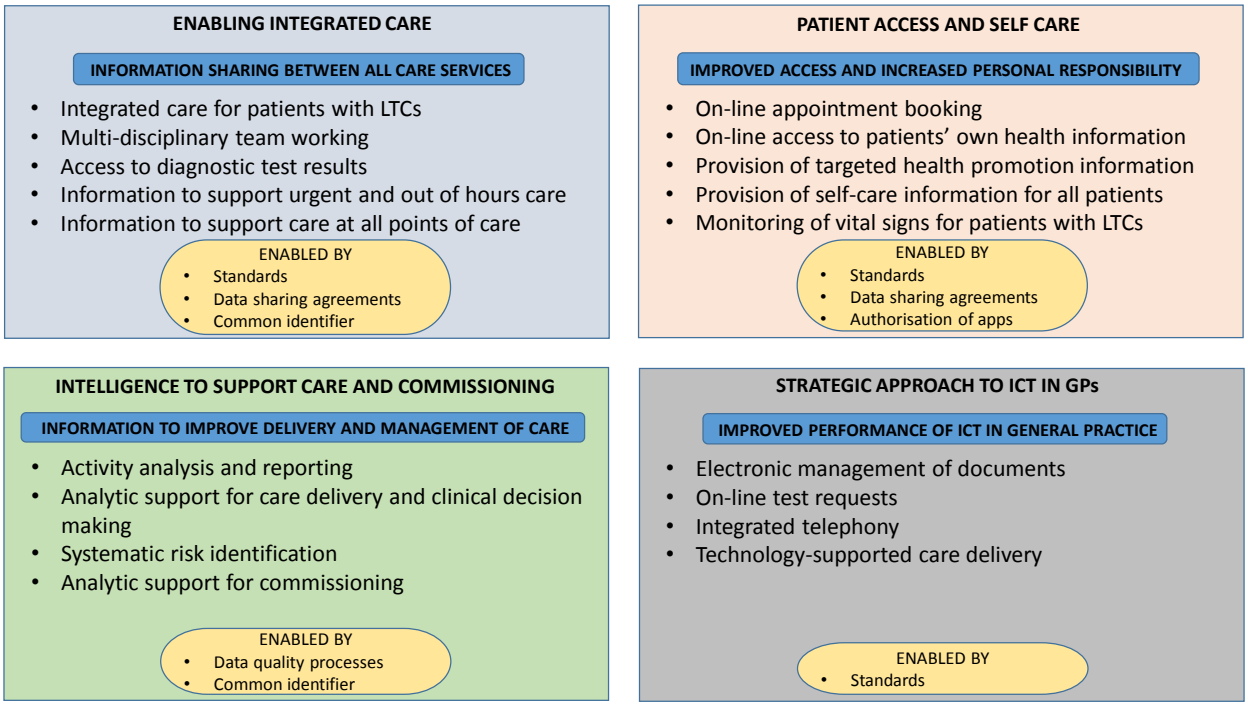
This project will ensure that Merton works towards national condition of meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;

Project 3: Improved communication enabled by information technology.

Our strategic ICT objective is "To have in place robust and fit-for-purpose ICT systems and services that support service transformation and enable integration across commissioners and care providers." We will work with our GPs, key providers and partners to ensure interoperability and the effective use of ICT across the local healthcare system.

The strategic components required to deliver our ICT strategic objective are grouped under four themes and supporting enablers; they have been aligned to the national and local objectives and commissioning and business plans and are summarised in figure 9.

FIGURE 9: MERTON ICT STRATEGIC OBJECTIVES



The focus for information technology project is to support the model for integrated care through information sharing between health and care providers within Merton.

All Merton NHS providers currently use the NHS number as unique patient identifier. 85% of Merton Adult Social Care clients have their NHS number recorded on their social care records. This places the system in a good position to share patient information to improve direct patient care across health and social care.

The key expected benefit from delivering the projects is that, where appropriate, clinicians and decision makers will have the most complete, accurate and up to date information concerning their patients; including consultation, diagnosis, referral, treatment and medical history; available at all points of care. Access to this information will allow clinicians to provide better care for patients. It will also allow the sharing of patients' records so that their flow through routine, urgent and emergency care services is improved and all patients are seen by the right clinician in the right place first time.

To achieve this, we will be working to implement an interoperability platform that links to our providers patient and client records. The project will involve:

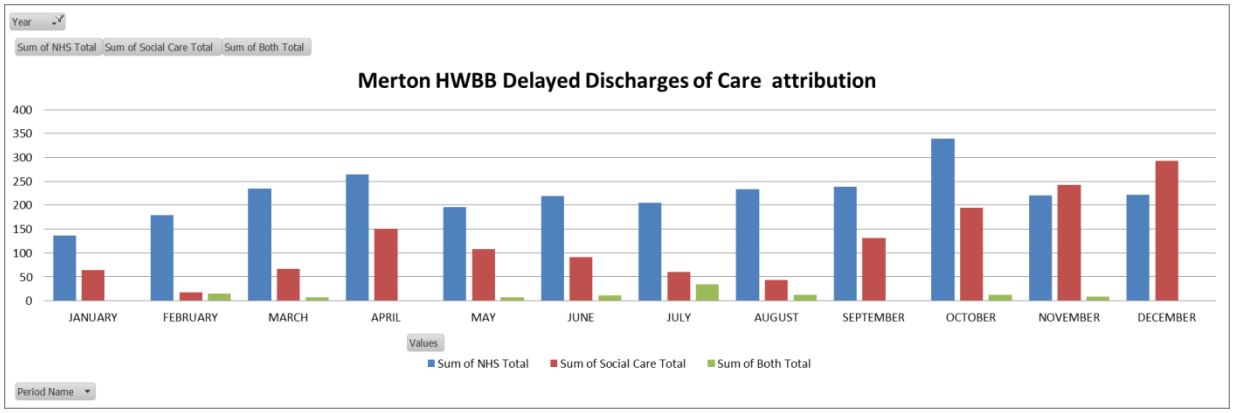
1. Identification of an Interoperability platform
2. Provider engagement to explore benefits of sharing patient information across organisational boundaries
3. Data sharing agreement between service providers
4. Patient and service user engagement about sharing and use of personal information
5. Implementation of interoperability platform

This project will deliver on the national condition Better data sharing between health and social care, based on the NHS number.

Action plan: Delayed Transfers of care (DTOC)

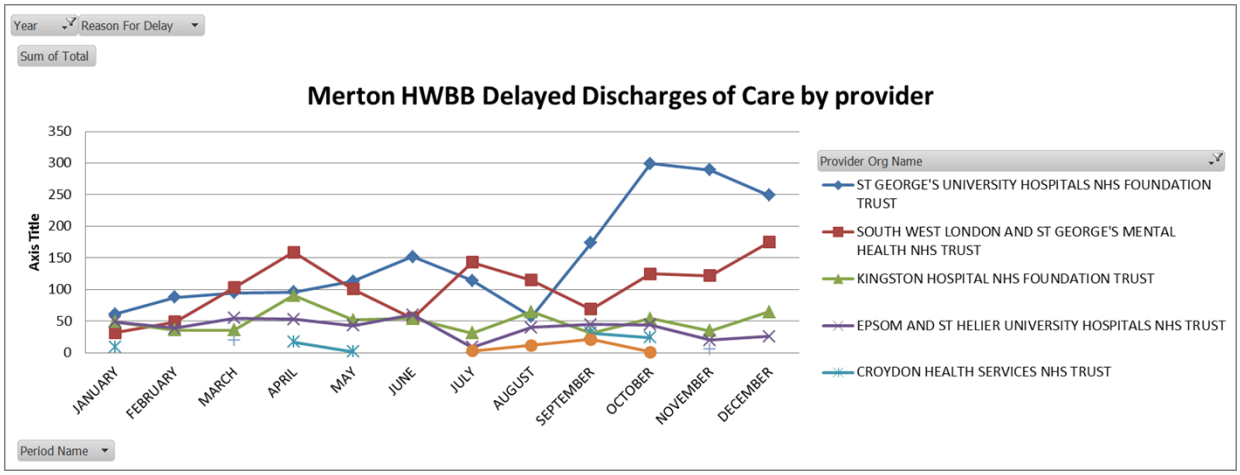
Historically, Merton has compared favourable to other HWB areas for the number of DTOC days. DTOC pressures have been managed through commissioning of health responses such as in-reach nursing, local authority provision of reablement and local escalation of complex cases. However, we have experienced an increased number of DTOC bed days for the period Oct – Dec 2015 due to increased pressures, particularly with social care supported discharges. This has been ascribed to lack of residential and domiciliary care provision in the local care market.

FIGURE 10 MERTON HWB DTOC ATTRIBUTION



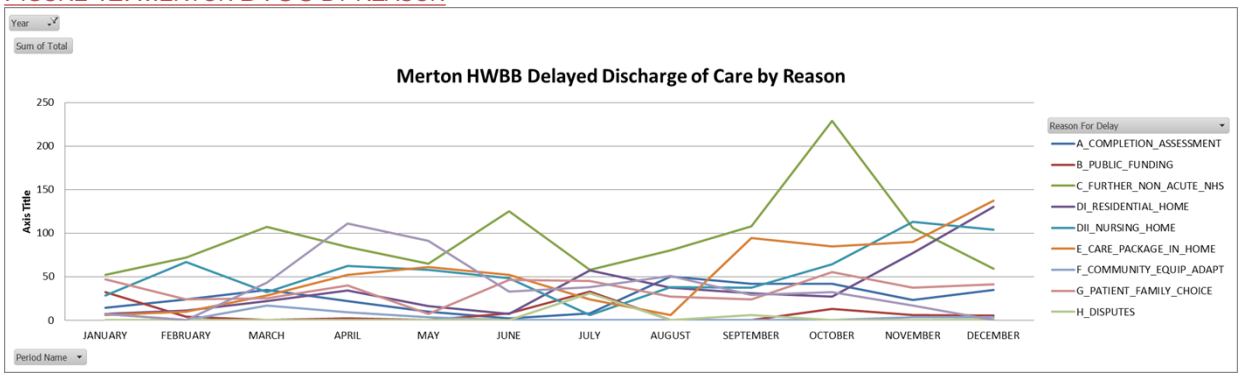
These increased pressures have been more evident at our main acute provider, St. Georges NHS Foundation Trust.

FIGURE 11: MERTON DTOC BY PROVIDER



Whilst Q2 saw an increase in DTOC due to awaiting care packages in people's homes, awaiting further NHS non-acute care has seen greater increases in overall number of delayed bed days despite provision of in-reach nursing by our community services provider.

FIGURE 12: MERTON DTOC BY REASON



Improving Delayed Discharges of care is a priority for the local health economy. The CCG and local authority have engaged with our main acute trusts to gain a better understanding of the issues contributing to DTOC. We participated in the Epsom and St. Helier winter pressures discharge event to facilitate discharges prior to the Christmas period and gained an understanding of the system pressures causing delayed transfers of care. Initiated following the St. Georges System Resilience group's "One version of the Truth" deep dive, we participated in the Multi-disciplinary Accelerated Discharge event (MADE) on 18th and 19th of January followed by a complex discharge workshop on the 24th of February. We join the bi-weekly Kingston hospital DTOC conference call and regularly attend the St. Georges weekly discharge meeting.

This engagement has informed a more strategic approach to managing DTOC. We have therefore development an action plan to ensure the key enablers for improved DTOC are implemented. The accountable officer overseeing delivery of this action plan is the Merton Director of communities and housing. The various actions will be delivered through the 3 BCF projects as listed in the DTOC action plan in Appendix 4. The main themes for the DTOC action plan are:

1. Improved care and support out-of-hospital for people delivered through Integrated Health and social care assessments. (Project 1)
2. Improved system flow to facilitate discharges 7 days per week. (Project 2)
3. Development of Discharge to Assess pathway. (Project 1)
4. Joint health and social care domiciliary and care homes market management approach

Merton do not consider it necessary to implement additional measures such as a risk sharing arrangement, as our levels of DTOC compare favourable to other HWBB. However, we will be working in partnership to stimulate and manage the local residential and domiciliary care market through a more collaborative brokerage function for continuing health care and social care.

Stakeholder engagement

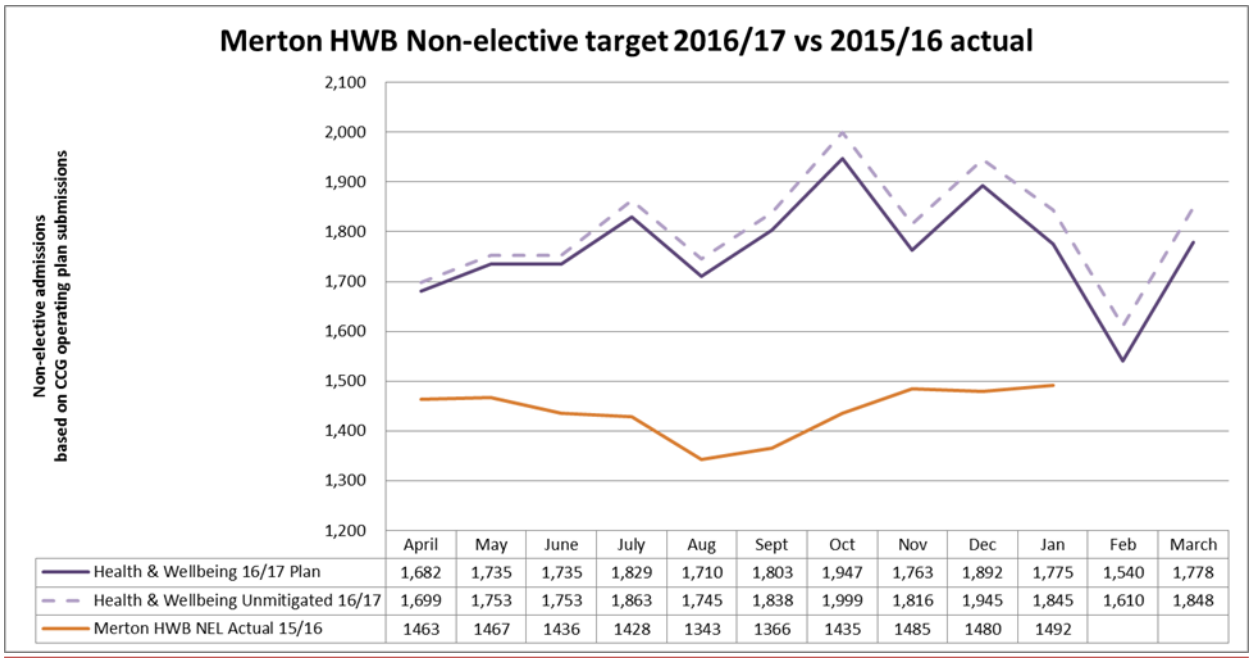
Merton intends to use the BCF plan as a vehicle for system transformation to enable integrated health and social care by 2020.
The 2016/17 plan is not about introducing new services, but about simplifying the existing processes and pathways to achieve a more responsive, better quality response for people with support needs. We therefore recognise that a significant amount of engagement is required to bring all partners on board with the vision, create an environment for change, truly listen to what support people need to prevent admission or long term care and empower front line staff to make these changes. Stakeholder engagement needs to be an integral part of how we do things and shapes the change journey.
At the time of writing, a number of events and forums were identified as opportunities to engage with various stakeholders. This included System Resilience Groups, Voluntary sector engagement events and public engagement events. The stakeholder engagement plan as shown in Appendix 5 will be further developed over the course of the year to ensure system wide engagement with the transformation plan.

Health and Wellbeing Board Metrics

1. Non-elective admissions

Figure 13 presents the forecast vs target position for Non-elective admissions for the CCG and Merton Health and Wellbeing board. This HWB unmitigated position reflects the forecast position without any QIPP reductions, whilst the target reflects the reduction with the CCG complex patients QIPP applied.

FIGURE 13: HWB AND CCG NON-ELECTIVE PERFORMANCE

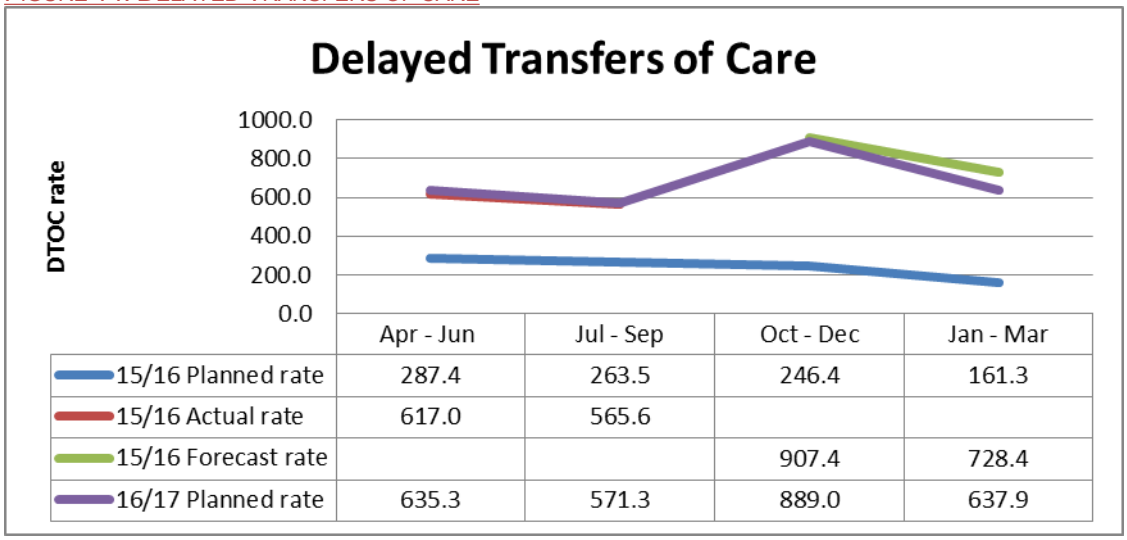


	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Health & Wellbeing 16/17 Plan	1,682	1,735	1,735	1,829	1,710	1,803	1,947	1,763	1,892	1,775	1,540	1,778
Health & Wellbeing Unmitigated 16/17	1,699	1,753	1,753	1,863	1,745	1,838	1,999	1,816	1,945	1,845	1,610	1,848
Merton HWB NEL Actual 15/16	1463	1467	1436	1428	1343	1366	1435	1485	1480	1492		

Figure 14 – 18 presents the forecast outturn for 15/16 Health and Wellbeing Board metrics and the targets for 2016/17.

2. Delayed Transfers of Care

FIGURE 14: DELAYED TRANSFERS OF CARE

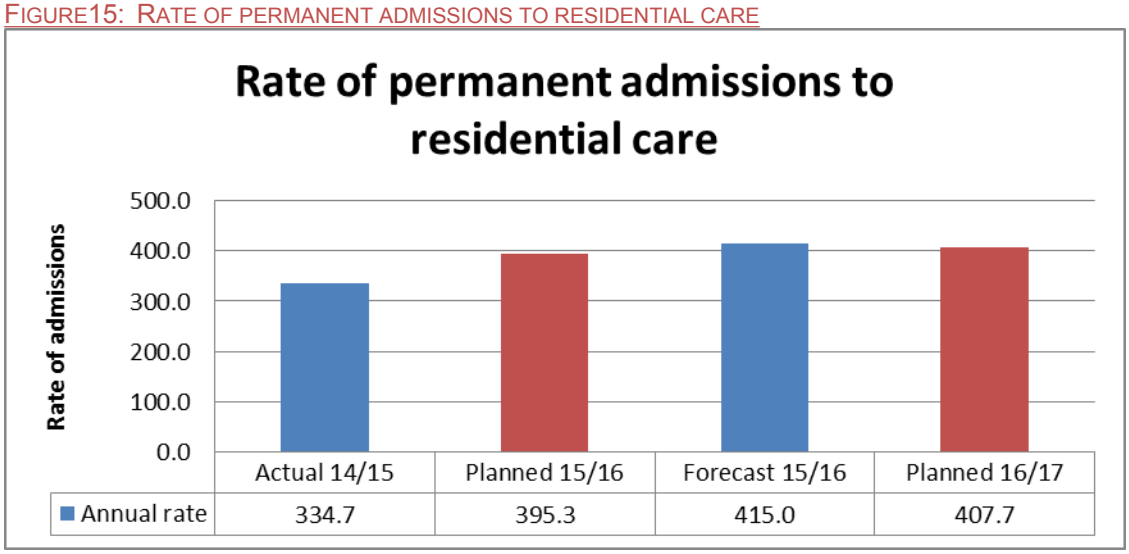


	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar
15/16 Planned rate	287.4	263.5	246.4	161.3
15/16 Actual rate	617.0	565.6		
15/16 Forecast rate			907.4	728.4
16/17 Planned rate	635.3	571.3	889.0	637.9

The system has experienced significant challenges with delayed discharges of care during 2015/16. We are aware that this is caused by silo processes between various health responses as well as between health and social care. An action plan to address this has been developed, however we anticipate that the effects of these actions will begin to take effect from Q3 and 4. Therefore, although we are planning for a reduced rate of DTOC in 2016/17, we expect to see a more significant reduced rate of DTOC from 2017/18.

3. Permanent admissions to residential care

FIGURE15: RATE OF PERMANENT ADMISSIONS TO RESIDENTIAL CARE



	Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Annual rate	334.7	395.3	415.0	407.7

Merton currently performs well compared our peer comparators for permanent admissions to residential care. With an ageing population and people requiring increasing levels of care, maintaining this rate will be a challenging target.

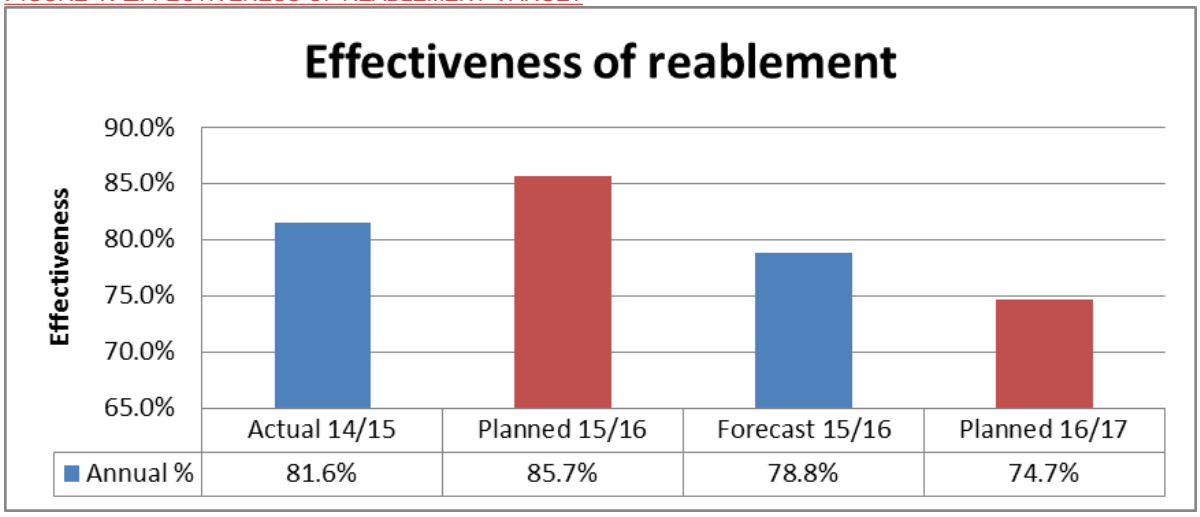
4. Effectiveness of Reablement

The HWB plan to offer more people reablement during 2016/17 through a combined health and social care offer. This means that a number of people with higher acuity will be supported and therefore the overall effectiveness of the service is forecast to decrease:

FIGURE 16: EFFECTIVENESS OF REABLEMENT CALCULATION

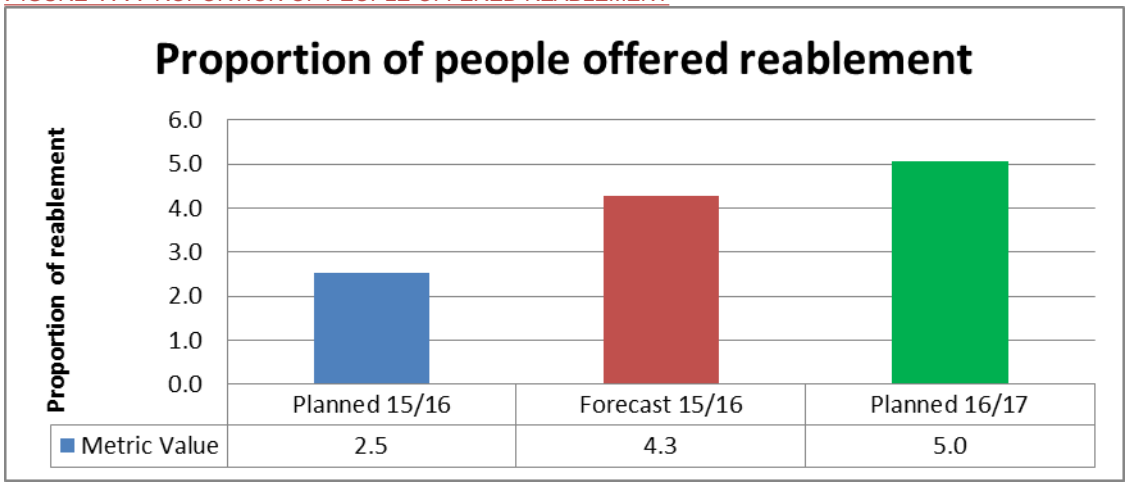
	Number of people at home 91 days after reablement	Number of people offered reablement	Effectiveness of reablement
Number of people offered reablement 2015/16	130	165	78.8%
Number of people offered reablement 2016/17 at same level of acuity as in 2015/16	130	165	78.8
Additional people offered reablement at increased acuity level 16/17	12	25	50%
Planned Reablement Total 2016/17	**142**	**190**	**74.7%**

FIGURE 1: EFFECTIVENESS OF REABLEMENT TARGET



5. Proportion of people offered Reablement

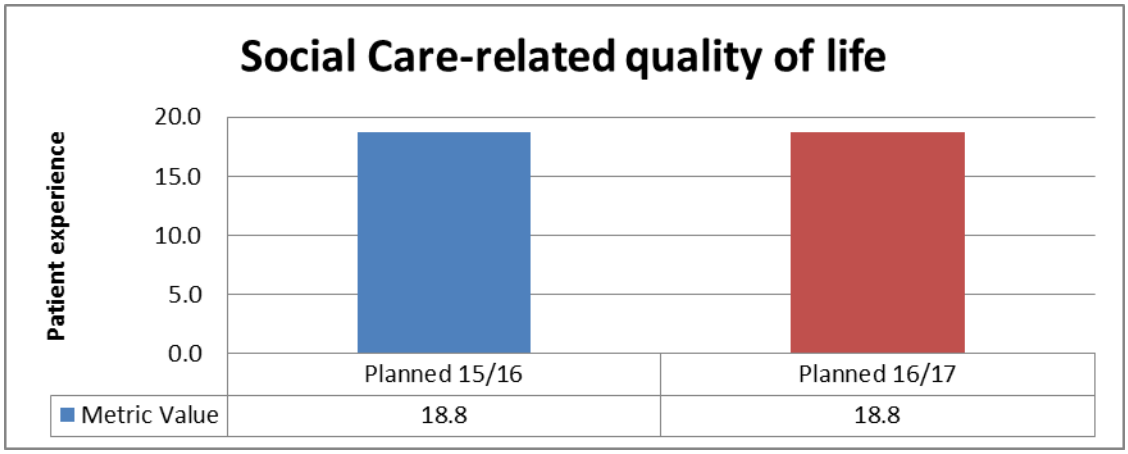
FIGURE 17: PROPORTION OF PEOPLE OFFERED REABLEMENT



During 2016/17 more people will be offered reablement through a combined health and social care reablement response that prevents admissions to hospital as well as facilitate earlier discharge.

6. Social care related quality of life

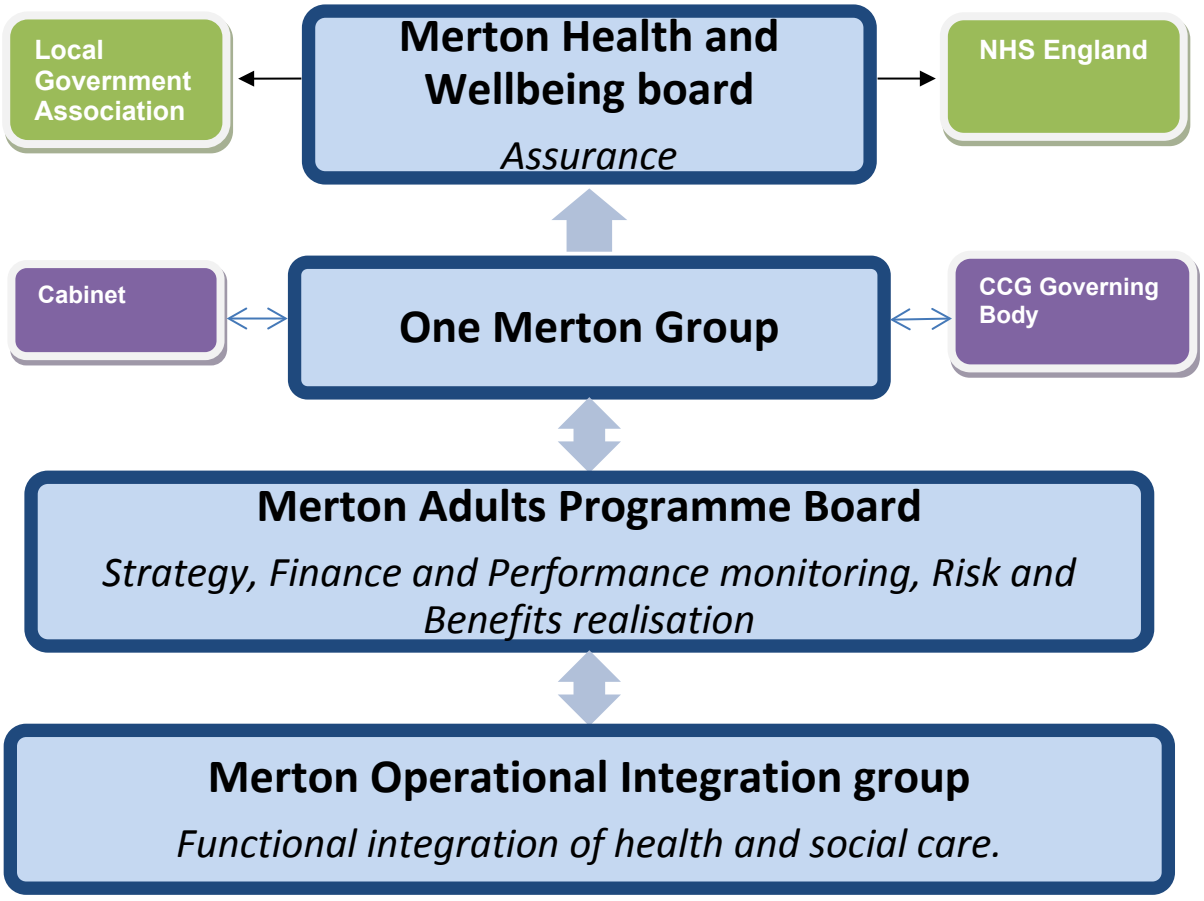
FIGURE 18: SOCIAL CARE-RELATED QUALITY OF LIFE



Merton currently compares well to our comparator peers. Maintaining current satisfaction levels will therefore be a challenging target with an ageing population and more people requiring support.

Programme Governance

The Merton Adults group has been established to act as the BCF Programme Board and will report to the CCG's Governing Body and the Council's Cabinet as set out in the diagram below.



The Merton Adults Programme Board is a newly established group which will take on the Merton BCF programme board responsibility. This group will be chaired by the Director of Adult Social Care and will meet monthly to provide strategic direction to the BCF programme, monitor implementation of the programme plan and monitor the impact and benefits of the programme.

The Merton Operational Integration group is re-constituted from the previous Merton Model group. The group and have responsibility for delivering the BCF projects and DTOC action plan. The group will be chaired by the Assistant Director of Integration, will meet monthly and will co-ordinate delivery of the various task and finish groups.

Risk Pool

There is currently a signed section 75 in place between the CCG and local authority. This will be updated to reflect amendments to the 2016/17 pooled budget and include a ring-fenced risk pool with supporting risk and gain sharing arrangement. The risk pool will be the same value of the Merton CCG QIPP for avoiding emergency admissions, currently £1,015k.

The CCGs non-elective plan has been calculated as follows and sets out the value of the NEL QIPP plan and therefore the required value of the Risk pool.

	Activity*	Cost **
NEL admissions 2015/16 FOT	23,225	30,415k
NEL admissions forecast growth 2016/17 (3%)	697	1,853k
NEL BCF QIPP	525	1,014k
CCG NEL operating plan target	23397	31,254k

*Activity forecasts at 18th March and subject to change prior to final CCG Operating plan submission on 24th April 2016
**Forecast costs and QIPP values based on 26th Feb 2016 CCG Operating plan submission and are subject to change prior to final CCG Operating plan submission on 24th April 2016

The CCG and local authority will ringfence an amount of £1,015k from the BCF pool and retain this as part of the risk share agreement. These funds will be retained and remain uncommitted with the terms of managing the fund set out in the Section 75 between the CCG and the Local Authority. These funds will be released at the end of the year, should the CCG meet the NEL QIPP target and spent as agreed by the Health and Wellbeing board.

However, if the CCG do not meet the NEL QIPP target, the fund will be used to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand.

Risk management and reporting

The Merton BCF programme will be managed as per recognised programme governance arrangements. Therefore a risk register will be maintained and reported to the BCF programme board on a monthly basis.

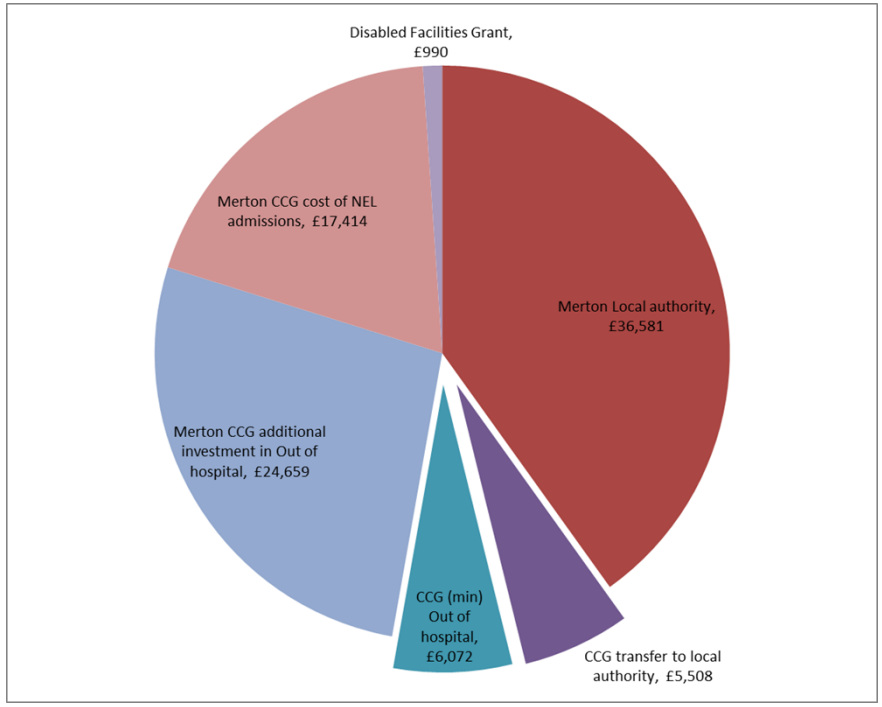
Appendix 1: 2016/17 Scheme level budget

Scheme Name	Investment categories	Area of Spend	Provider	Forecast outturn 2015/16	2016/17 Budget
Non-elective admissions for over 50s.	Non-elective Admissions	Acute	NHS Acute	£17,892,383	£17,414,310
Community Services contract	Integrated care teams	Community Health	NHS Community Provider	£16,098,000	£16,670,000
Community Services Contract performance payment	Integrated care teams	Community Health	NHS Community Provider	£0	£409,000
Merton integrated equipment store	Equipment	Community Health	Private Sector	£752,687	£776,950
13/14 underspend Merton Integrated equipment store	Equipment	Community Health	Private Sector	£0	£200,000
Ene of life care - local enhanced service	Integrated care teams	Primary Care	NHS Community Provider	£19,000	£19,209
Nursing - Marie Curie Cancer	Integrated care teams	Community Health	Charity/Voluntary Sector	£100,000	£101,100
Bereavement service	Integrated care teams	Mental Health	Charity/Voluntary Sector	£65,000	£65,715
Hospices	Integrated care teams	Community Health	Private Sector	£527,000	£532,797
Intermediate care beds	Integrated care teams	Community Health	Private Sector	£656,000	£594,216
Expert patient programme	Integrated care teams	Community Health	CCG	£80,000	£96,000
End of life support	Integrated care teams	Community Health	Private Sector	£105,500	£100,000
Data sharing	Project costs	Other	CCG	£0	£30,000
Continuing care placements	Personalised support or care	Continuing Care	Private Sector	£7,350,750	£8,526,870
Joint funded placements	Personalised support or care	Social Care	Private Sector	£559,000	£564,590
Funded nursing care	Personalised support or care	Social Care	Private Sector	£1,428,500	£1,657,060
Local Enhanced Services - Diabetes	Integrated care teams	Primary Care	NHS Community Provider	£15,000	£15,150
Local Enhanced Services - Care of older people	Integrated care teams	Primary Care	NHS Community Provider	£1,089,000	£1,099,890
Mascot	Assistive technologies	Other	Local Authority	£1,424,604	£1,444,920
Voluntary services grant - Ageing well	Integrated care teams	Community Health	Charity/Voluntary Sector	£807,131	£450,000
Reablement	Integrated care teams	Community Health	Local Authority	£2,467,053	£2,038,350
Placements Care Packages	Personalised support or care	Social Care	Private Sector	£41,302,841	£36,172,283
Carers support including respite	Carers support	Social Care	Private Sector	£417,200	£365,377
3 Health liaison officers	Integrated care teams	Social Care	Local Authority	£150,000	£150,000
Health liason 7 day working	Integrated care teams	Social Care	Local Authority	£500,000	£500,000
Hoist maintenance contract	Equipment	Social Care	Local Authority	£57,000	£57,000
Data sharing (NHS number cross reference)	Project costs	Social Care	Local Authority	£42,000	£42,000
Market management - packages of care	Project costs	Social Care	Local Authority	£15,000	£15,000
Project costs	Project costs	Social Care	Local Authority	£30,000	£30,000
Project costs - staff	Project costs	Other	CCG	£94,000	£94,000
Disabled Facilities Grant	Disabled Facilities	Social Care	Local Authority	£528,000	£989,719
				£94,572,649	**£91,221,506**

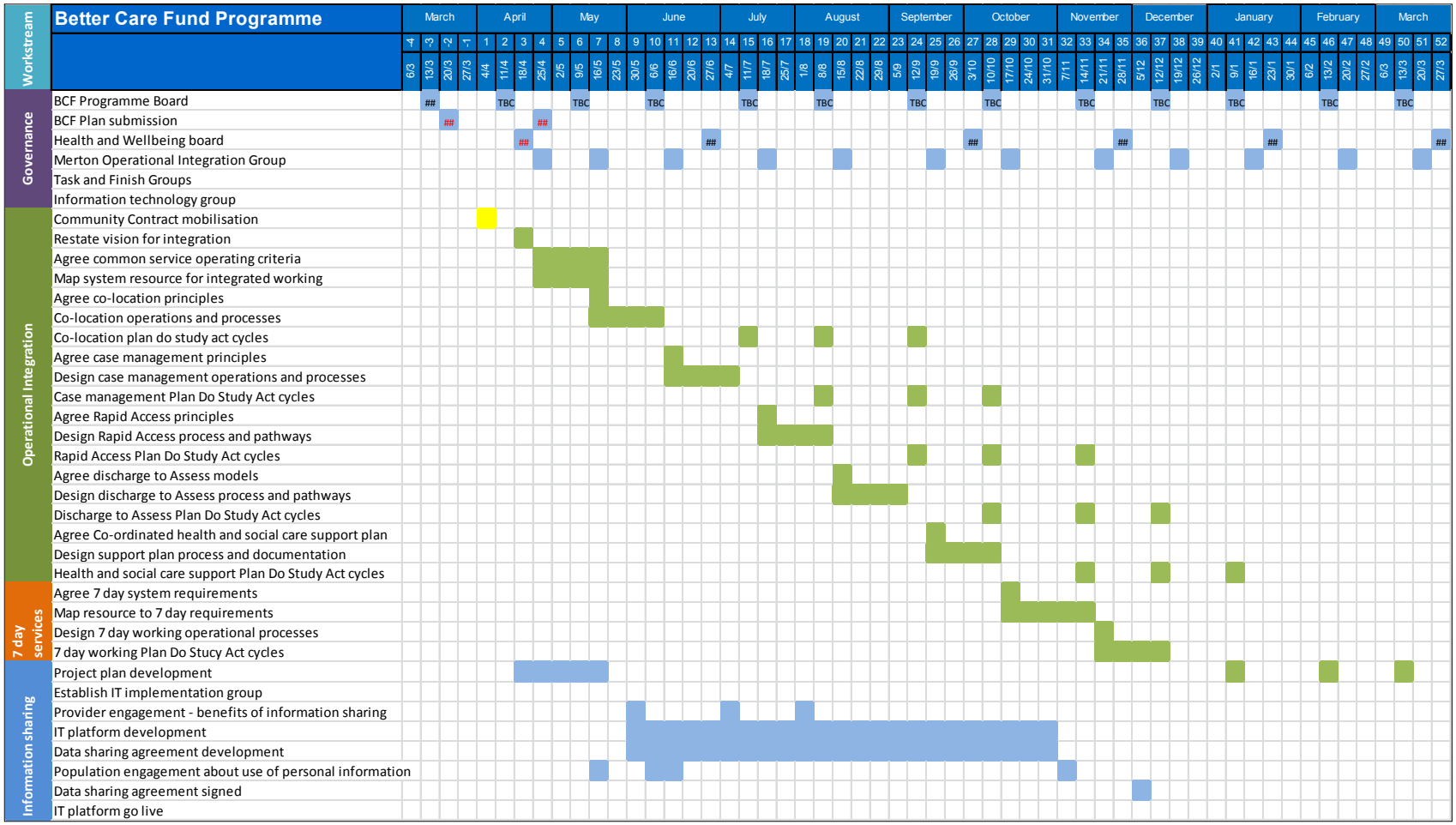
*At the time of writing, the CCG operating plan was not finalised. Therefore, the amounts in this table are subject to minor amendments.

Appendix 2: Merton 2016/17 BCF Funding Sources

Merton BCF HWBB Funding Sources	BCF budget (000)	Gross contribution (000)
Local Authority Contribution(s)		£ 36,581
Merton Local authority	£ 36,581	
CCG Minimum Contribution		£ 11,580
CCG transfer to local authority	£ 5,508	
CCG (min) Out of hospital	£ 6,072	
Additional CCG Contribution		£ 42,073
Merton CCG additional investment in Out of hospital	£ 24,659	
Merton CCG cost of NEL admissions	£ 17,414	
Capital Funding		£ 990
Disabled Facilities Grant	£ 990	



Appendix 3: 2016/17 BCF programme plan



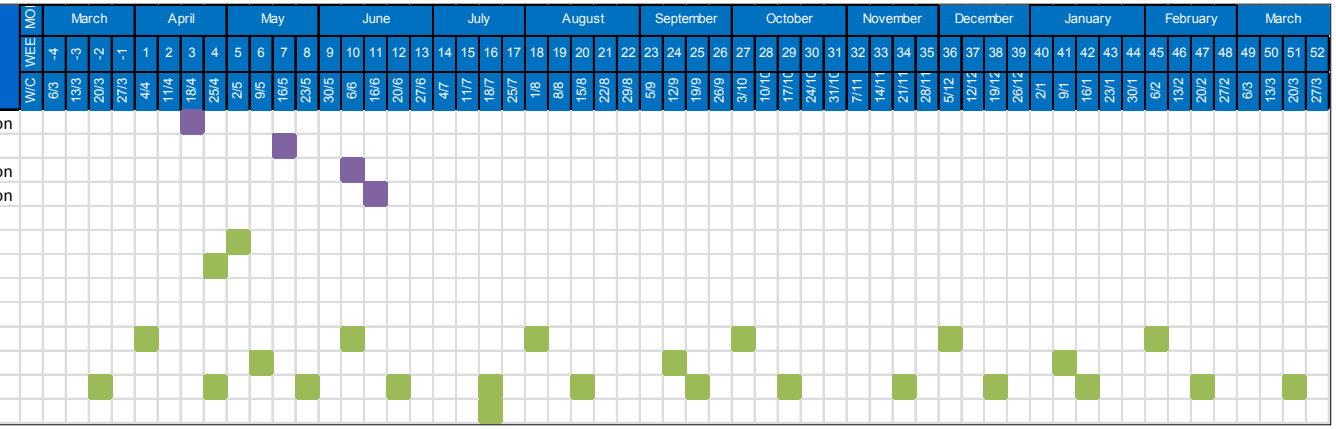
Appendix 4: DTOC Action plan

DTOC Action plan at 11/3/2016

Theme	Reason for delay	Issues	Required Action	Owner	Status
		Merton DTOC lower than Wandsworth	Establish what is different between Wandsworth and Merton provision	Simon	Open
Discharge planning process.	Awaiting Completion of assessment	Timings of issuing Section 2s and 5s	Local authority to present proposed timings of notifiying LA of discharges that need packages of care. To be presented for discussion and agreement at weekly Platinum command meeting. Jenny and Betty to agree proposed standards to be presented.	Jenny	Open
	Awaiting Completion of assessment	MDT assessment and recommendations for HNA etc (Assessments not complete or accurate)	Betty to present to Trust what the proposed standards and content of a HNA is and discuss via Platinum command meetings.	Betty	Open
	Awaiting Public Funding	Timing of notification of outcome of CHC panel	Health and Social Care to agree common pathway. James Holden, Jenny and Betty to meet to discuss	Jenny	Open
	Awaiting further NHS non acute care	Health input required post discharge (TTOs, Community services follow-up, GP follow-up, Mental Health follow-up)	Agreed that integrated health and social care response is required. Workshop - 3rd week of April.	Murrae	Open
	Awaiting further NHS non acute care	Mental Health input required to arrange discharge plan	Invite mental health representatives to hospital discharge meetings. MH team invited to Hospital Discharge Meeting on 21 March	Jenny	Complete
	Patient / family choice	Patients and family changing decisions due to information provision during in-patient spell.	Draft of information leaflet to be shared with key stakeholders, including St. Georges Hospital. Jenny to arrange review meeting and share output with Simon	Jenny	Open
	Disputes	DTOC counting not trustworthy	To continue raising at person level	Murrae	Open
		DTOC counting not trustworthy - no common audit trail of discharge process	Betty to discuss with Trust to investigate common audit process such as a discharge planning tracker.	Betty	Open
Care market	Awaiting Nursing Home	Timing and need for care homes to assess people in hospital	To negotiate with care homes to accept recommendations from Health and social care assessment	Jenny	Open
	Awaiting Nursing Home	Timing of discharge from hospital to care homes so that people have time to be settled before staff numbers reduce	No action identified		Open
	Awaiting Nursing Home	Providers not trusting recommendations for recommended level of care	To negotiate with care homes to accept recommendations from Health and social care assessment	Jenny	Open
	Awaiting Care Package / own Home	Market capacity for complex patients	Commissioning strategy for complex provision required	Head of Commissioning	Open
Advance planning	Housing: not covered by NHS and Community Care Act	People who are homeless	To agree process of dealing with cases that have no recourse to public funds. Meeting between Simon, Steve and Betty to be arranged	Simon	Open
	Patient / family choice	People refusing to accept family member home after admission	Negotiate with Trust to classify these cases as patient choice	Betty	Open
	Patient / family choice	People refusing to accept family member home after admission	Work with Trust to implement discharge policy	Betty	Open
	Patient / family choice	People refusing to accept family member home after admission	Investigate options for temporary placements	Jenny	Open
Crisis post discharge	Failed discharge	Insufficient care and support arranged at point of discharge - family going into crisis as not able to cope	Work with Trust and Voluntary sector to arrange: 1. Point of contact for people post discharge if require support 2. Work with voluntary sector to support people who have recently been discharged	Jenny	Open

Appendix 5: Stakeholder engagement plan

Better Care Fund Programme Stakeholder Engagement plan	Planned Start Date	Action by:
Merton Patient Engagement Group	26/04/2016	M. Wallington
Public data sharing workshop	TBC	M.Tolson
Mitcham Carnavall	11/06/2016	M. Wallington
Wiimbledon Village fair	18/06/2016	M. Wallington
Merton Senior's forum	Monthly meetings	M.Tolson
St. Georges SRG workshop	06/05/2016	A. Walker
Epsom and St. Helier SRG workshop	26/04/2016	A. Walker
Merton Centre for independent living	Monthly forums	K. Mahdi
Merton Involve	Quarterly forums	K. Mahdi
Merton CCG Clinical Transformation Committee	Bi-monthly	T. Foote
Merton CCG Clinical Reference Group	Monthly	T. Foote
Merton Adult Social Care managers meeting	Monthly	H. Begg
Merton CCG Annual General Meeting	14/06/2016	



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Template for BCF submission 2: due on 21 March 2016

Sheet: 2. Summary of Health and Well-Being Board 2016/17 Planning Template

Selected Health and Well Being Board:

Merton

Data Submission Period:

2016/17

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please enter the following information:
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition. The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

	Gross Contribution
Total Local Authority Contribution	£37,570,599
Total Minimum CCG Contribution	£11,580,371
Total Additional CCG Contribution	£42,073,232
Total BCF pooled budget for 2016-17	**£91,224,203**

Specific funding requirements for 2016-17	Select a response to the questions in column B
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes

4. HWB Expenditure Plan

Summary of BCF Expenditure

	Expenditure
Acute	£17,414,310
Mental Health	£65,715
Community Health	£22,475,413
Continuing Care	£10,748,520
Primary Care	£1,134,249
Social Care	£38,269,580
Other	£1,113,719
Total	**£91,221,506**

Please confirm the amount allocated for the protection of adult social care	
Expenditure	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.
£38,269,580	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

	Expenditure
Mental Health	£65,715
Community Health	£1,833,113
Continuing Care	£10,748,520
Primary Care	£1,134,249
Social Care	£0
Other	£30,000
Total	**£13,811,597**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share

	Fund
Local share of ring-fenced funding	£3,290,813
Total value of NHS commissioned out of hospital services spend from minimum pool	£13,811,597
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£1,014,000
Balance (+/-)	**£11,534,784**

5. HWB Metrics

5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	4,403	4,580	4,799	4,471	18,254
HWB Quarterly Additional Reduction Figure	0	0	0	0	0
HWB NEA Plan (after reduction)	4,403	4,580	4,799	4,471	18,254
Additional NEA reduction delivered through the BCF					£0

5.2 Residential Admissions

		Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	407.7

5.3 Reablement

		Planned 16/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual %	75%

5.4 Delayed Transfers of Care

		Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	635.3	571.3	889.0	637.9

5.5 Local performance metric (as described in your BCF 16/17 planning submission 1 return)

	Metric Value Planned 16/17
BCF 2: 2B(2) -Proportion of older people (65 and over) who were offered a Reablement or Intermediate Care Service during the period October to December	5.0

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 1 return)

		Metric Value Planned 16/17
1A (ASCOF) Social care-related quality of life	Enhancing quality of life for people with care and support needs	18.78831282

6. National Conditions

National Conditions For The Better Care Fund 2016-17	Please Select (Yes, No or No - plan in place)
1) Plans to be jointly agreed	Yes
2) Maintain provision of social care services (not spending)	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes
4) Better data sharing between health and social care, based on the NHS number	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes

Template for BCF submission 2: due on 21 March 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:

Merton

Data Submission Period:

2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:

- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

	Expenditure											
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Community Services contract	Integrated care teams		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£16,670,000	Existing	£16,098,000
Community services contract - performance incentrive	Other	Performance incentive	Community Health		CCG			Private Sector	CCG Minimum Contribution	£409,000	New	
Merton integrated equipment store	Other	Equipment	Community Health		Local Authority			Private Sector	CCG Minimum Contribution	£776,950	Existing	£752,687
End of life care - local enhanced service	Other	End of life	Primary Care		CCG			Private Sector	CCG Minimum Contribution	£19,209	Existing	£19,000
Nursing - Marie Curie Cancer	Other	End of life	Community Health		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	£101,100	Existing	£100,000
Bereavement service	Support for carers		Mental Health		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	£65,715	Existing	£65,000
Hospices	Other	End of life	Community Health		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	£532,797	Existing	£527,000
Intermediate care beds	Intermediate care services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£594,216	Existing	£656,000
Expert patient programme	Other	Self management	Community Health		CCG			CCG	CCG Minimum Contribution	£96,000	Existing	£80,000
End of life support	Personalised support/ care at home		Community Health		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	£100,000	Existing	£105,500
Data sharing	Other	Project costs	Other	Project costs	CCG			CCG	CCG Minimum Contribution	£30,000	Existing	£0
Continuing care placements	Personalised support/ care at home		Continuing Care		CCG			Private Sector	CCG Minimum Contribution	£8,526,870	Existing	£7,350,750
Joint funded placements	Personalised support/ care at home		Continuing Care		CCG			Private Sector	CCG Minimum Contribution	£564,590	Existing	£559,000
Funded nursing care	Personalised support/ care at home		Continuing Care		CCG			Private Sector	CCG Minimum Contribution	£1,657,060	Existing	£1,428,500
Local Enhanced Services - Diabetes	Integrated care teams		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	£15,150	Existing	£15,000
Local Enhanced Services - Care of older people	Integrated care teams		Primary Care		CCG			NHS Community Provider	CCG Minimum Contribution	£1,099,890	Existing	£1,089,000
Mascot	Assistive Technologies		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£1,444,920	Existing	£1,424,604
Voluntary services grant - Ageing well	Integrated care teams		Community Health		Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	£450,000	Existing	£807,131
Reablement	Reablement services		Community Health		Local Authority			Local Authority	CCG Minimum Contribution	£2,038,350	Existing	£2,467,053
Placements Care Packages	Personalised support/ care at home		Social Care		Local Authority			Private Sector	Local Authority Social Services	£36,172,283	Existing	£41,302,841
3 Health Officers	Integrated care teams		Community Health		Local Authority			Local Authority	CCG Minimum Contribution	£150,000	Existing	£150,000
Health liaison 7 day working	7 day working		Community Health		Local Authority			Local Authority	CCG Minimum Contribution	£500,000	Existing	£500,000
Hoist maintenance contract	Other	Equipment maintenance	Community Health		Local Authority			Private Sector	CCG Minimum Contribution	£57,000	Existing	£57,000
Data sharing (NHS number cross reference)	Other	Project costs	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£42,000	Existing	£42,000
Market development - packages of care	Other	Project costs	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£15,000	Existing	£15,000
Project costs	Other	Project costs	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£30,000	Existing	£30,000
Project costs - staff	Other	Project costs	Other	Tranformation	Local Authority			Local Authority	CCG Minimum Contribution	£94,000	Existing	£94,000
Carers support including respite	Support for carers		Social Care		Local Authority			Local Authority	Local Authority Social Services	£365,377	Existing	£417,200
Equipment underspend 14/15	Other	Risk Pool	Social Care		Local Authority			Local Authority	Local Authority Social Services	£200,000	New	
Cost of Non-elective Admissions for people over 50	Other	Acute Activity	Acute		CCG			CCG	Additional CCG Contribution	£17,414,310	Existing	£17,892,383
Disabled Facilities Grant	Other	Capital costs for disabled facilities	Other	Capital costs	Local Authority			Local Authority	Local Authority Social Services	£989,719	Existing	£528,000

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:

Merton

Data Submission Period:

2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has m
name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

Scheme Type	Description
Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages.
Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
Intermediate care services	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge.
Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions.
Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance.
Support for carers	Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance
7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
Assistive Technologies	Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care

Template for BCF submission 2: due on 21 March 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Merton

Data Submission Period:
2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

Contributing CCGs	% CCG registered population that has resident population in Merton	% Merton resident population that is in CCG registered population	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
			CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**
NHS Croydon CCG	0.5%	0.8%	8,864	43	8,962	44	8,962	44	8,768	43	35,556	174
NHS Kingston CCG	3.5%	3.0%	3,546	124	3,584	126	3,585	126	3,693	130	14,408	506
NHS Lambeth CCG	0.9%	1.4%	7,266	64	7,266	64	7,266	64	7,270	64	29,068	256
NHS Merton CCG	87.7%	81.5%	4,112	3,605	4,305	3,774	4,554	3,992	4,191	3,674	17,162	15,044
NHS Sutton CCG	3.4%	2.7%	4,498	154	4,547	155	4,547	155	4,448	152	18,040	616
NHS Wandsworth CCG	6.5%	10.5%	6,315	413	6,384	418	6,384	418	6,245	409	25,328	1,658
Totals		**100%**	**34,601**	**4,403**	**35,048**	**4,580**	**35,298**	**4,799**	**34,615**	**4,471**	**139,562**	**18,254**

Are you planning on any additional quarterly reductions?	No							
If yes, please complete HWB Quarterly Additional Reduction Figures								
HWB Quarterly Additional Reduction Figure								
HWB NEA Plan (after reduction)								
HWB Quarterly Plan Reduction %								

Are you putting in place a local risk sharing agreement on NEA?	No	
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£3,290,813	
Cost of NEA as used during 15/16 ****	£1,490	Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below.
Cost of NEA for 16/17 ****		

Additional NEA reduction delivered through the BCF								
HWB Plan Reduction %								

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 7th March 2016.

** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx

**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	336.9	395.3	415.0	407.7	Whilst the BCF plans prevented excessive growth for new long term residential and nursing care homes, The Merton forecast for 15-16 out-turn exceeds the current target of 100. However, during 16/17 the BCF programme commits to maintaining the current lvel of new placements.
	Numerator	83	100	105	105	
	Denominator	24,640	25,299	25,299	25,757	

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'. Any numerator less than 6 has been supressed in the published data and is therefore showing blank in the numerator and annual rate cells above. These cells will also be blank if an estimate has been used in the published data.

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16	Forecast 15/16	Planned 16/17	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	81.2%	85.7%	78.8%	74.7%	We offered more reablement services to our customers during 2014-15 which meant applying a lower admission criteria for reablement. This resulted in a perceived reduced effectiveness of the service. For 16/17 the intention is for more people to be seen through a combined health and social care reablement response, which will further reduce the admission criteria to the service and result in a greater perceived effectiveness of th e response. We anticipate maintaining the same rate of effectiveness for the current number of patients offered reablement (152 people at a 78.8% rate of effectivenss). However, for the additional people offered reablement we estimate a reduced recovery rate (27 people at a 50% recovery rate).
	Numerator	155	78	130	142	
	Denominator	190	91	165	190	

*****Any numerator or denominator less than 6 has been supressed in the published data and is therefore showing blank in the cells above. These cells will also be blank if an estimate has been used in the published data.

5.4 Delayed Transfers of Care

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1, Q2 & Q3) and forecast (Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	287.4	263.5	246.4	161.3	617.0	565.6	907.4	728.4	635.3	571.3	889.0	637.9	Whilst the BCF will implement a plan to address Delayed discharges of care, the impact of the plan will only be realised Q3 and 4.
	Numerator	470	431	403	267	1,009	925	1,484	1,206	1,052	946	1,472	1,068	
	Denominator	163,542	163,542	163,542	165,579	163,542	163,542	163,542	165,579	165,579	165,579	165,579	167,423	

5.5 Local performance metric (as described in your BCF 16/17 planning submission 1 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
BCF 2: 2B(2) -Proportion of older people (65 and over) who were offered a Reablement or Intermediate Care Service during the period October to December	Metric Value	2.5	5.0	For 16/17 the intention is for more people to be seen through a combined health and social care reablement response, which will further reduce the admission criteria and scope of the the reablement response.
	Numerator	91.0	190.0	
	Denominator	3,620.0	3,765.0	

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 1 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
1A (ASCOT) Social care-related quality of life Enhancing quality of life for people with care and support needs	Metric Value	18.8	18.8	This plan ensures maintenance of the current good satisfaction levels as well as continues to compare favourable to peer organisations.
	Numerator	36,307.5	36,307.5	
	Denominator	1,932.4	1,932.4	

STRATEGIC ITEM

Committee: Health and Wellbeing Board

Date: 19 April 2016

Wards: All

Subject: Voluntary and Community Sector Health & Wellbeing Priorities

Lead officer: Khadiru Mahdi

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

Contact officer: Khadiru Mahdi, MVSC 020 8685 1771

Recommendations: The Health and Wellbeing Board is being asked to:

A. Endorse the revival of the Adult Social Care Task Group with a revised Terms of Reference and membership, which includes the Clinical Commissioning Group (para. 3.4).

B. Pilot Social Prescribing as part of the East Merton Model of Health and Wellbeing, collaborating with MVSC, Healthwatch Merton and the voluntary and community sector (para. 3.8.)

C. Endorse a VCS State of the Sector Review 2016 and the development of combined VCS and Volunteering Strategy (para. 3.11).

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This paper provides a brief outline of MVSC's strategic priorities and key voluntary and community sector issues for discussion by the Health and Wellbeing Board.

2. BACKGROUND

MVSC's strategic priorities

2.1 MVSC is the main infrastructure/umbrella organisation for the voluntary and community sector (VCS) in Merton. The key strands of its work are organisational development, volunteering support, strategic representation and influence, and supporting local community action. It undertook a Strategic Review 2015-18 informed by the State of the Sector Report 2014 and views of stakeholders, including Merton Council and the Merton Strategic Partnership.

MVSC's Vision is "*A thriving Merton community where people's lives are enriched by voluntary and community action."*

Our Mission is "*To inspire and develop an excellent voluntary and community sector in Merton."*

Strategic Objectives

i) Provide support to voluntary, community, faith and social enterprise organisations
ii) Build social capital by supporting and developing volunteering and community action
iii) Identify changing and emerging need and respond with development
iv) Promote, support and develop liaison, advocacy, joint working and strategic partnership between sectors
v) Promote quality through standard setting

Ensure sustainability.

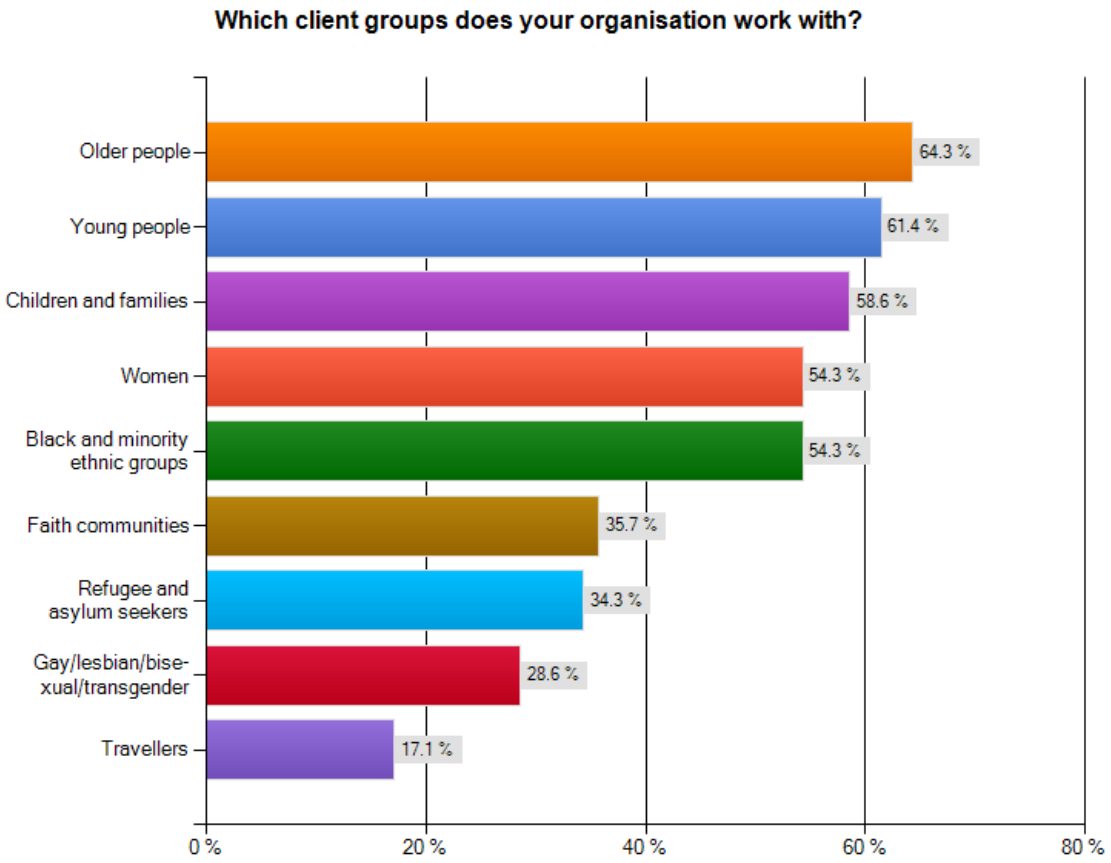
2.2 MVSC manages Healthwatch Merton, the consumer health champion. Its 2016 main areas include:

- East Merton Model of Health and Wellbeing
- Adult Social Care savings/cuts
- Development of Children and Young people work
- Social prescribing learning and strategy incl. pilot at the Nelson learning
- Progress of Healthwatch Merton Operational Committee role/functions
- Continuation on the integration agenda
- Enter and View.

These areas are in addition to the ongoing signposting, outreach and partnership work with the Voluntary and Community Sector, Merton Clinical Commissioning Group, Local Authority, Public Health and NHS across Health and Social Care.

The Voluntary and Community Sector

2.3 We have extensive contracts and links with over 990 voluntary, community, faith and social enterprise organisations, including very small groups in the east of the borough. These organisations provide a diverse range of services for Merton residents, many of which make direct contribution to residents' health, social care and wellbeing. The diagram below gives a snapshot from the State of the Sector Survey 2014.



Analysis of the survey results compared with data from the 2011 Census suggests that 58% of respondents work with children and families, children representing 19% of the population, 61% work with young people who represent 20% of the population and 64% work with older people who represent 12% of the population.

3. KEY ISSUES FOR THE VOLUNTARY AND COMMUNITY SECTOR

Health and Wellbeing Issues

3.1 The Council's Medium Term Financial Strategy and its budget setting process for 2016-17 throw into sharp relief the limited and dwindling funds allocated to health and social care services in Merton at a time when vulnerable residents need these services most because of austerity, welfare changes and projected increase in the ageing population.

3.2 The voluntary and community sector has been at the heart of health and social care service delivery over the years but the funding decisions for 2016-17 puts these services and the sustainability of many organisations providing them at risk. Anecdotal reports show current and potential effects on service beneficiaries. These require monitoring to gather data that will inform measures to mitigate these effects and future service planning.

3.3 More effective VCS engagement is one of the lessons learned from the Adult Social Services consultation on the savings proposals. This is required in order

for the sector to inform evidence based setting of priorities and allocation of resources. Linked to this would be co-production, funding and procurement processes. The Adult Social Task Group has facilitated some of these processes in the past and is a good template to apply in future.

3.4 **Recommendation:** To revive the Adult Social Care Task Group with a revised Terms of Reference a membership that included the Clinical Commissioning Group.

East Merton Model of Health and Wellbeing

3.5 The voluntary and community sector addresses the **wider determinants of health** though its varied services for local people, geographically and in communities of interests. They generate a high social value through their services and connectivity and these need to be harnessed effectively in order to realise the vision of a holistic people centred East Merton Model of Health and Wellbeing. The model provides an excellent opportunity for Health and wellbeing Board members and the VCS to adopt a co-production approach to social prescribing.

3.6 MVSC and Healthwatch Merton are committed to supporting the development of the East Merton Model of Health and Wellbeing. They are willing to play a key role in engaging the voluntary and community sector and individual residents respectively. The Community Navigator, jointly supervised by the HARI Service and Healthwatch, is already well placed to support and link residents to appropriate health and community services.

3.7 MVSC has a comprehensive database of VCS organisations. Its role in coordinating the voluntary and community sector providers through various networks, particularly the VCS Health and Social Care Forum and the INVOLVE Network could be pivotal in piloting a **social prescribing** model for Merton. This will include embedding **quality assurance** by exploring bespoke quality marks such as the '*Quality for Health*' developed by Voluntary Action Calderdale and Calderdale CCG.

3.8 **Recommendation:** That the Health and Wellbeing Board pilots Social Prescribing as part of the East Merton Model of Health and Wellbeing, collaborating with MVSC, Healthwatch Merton and the voluntary and community sector.

Merton VCS and Volunteering Strategy 2016-19

3.9 Merton's Voluntary Sector and Volunteering Strategies are both in need of updating. A report to the next Merton Partnership will propose an approach to developing a new and combined Voluntary Sector and Volunteering Strategy sponsored by the Merton Partnership.

3.10 Both the Merton Council's Third Sector Strategy and Merton's Volunteering Strategy were first published in 2008 and reviewed in 2011. Annual action plans

were development and implemented in subsequent years and progress reported to the Compact Board, the Overview and Scrutiny Commission and the Merton Partnership. The evident synergies between the Volunteering Strategy and Voluntary Sector Strategy provide a clear rationale for combining the two.

3.11 The new strategy is all the more relevant given the significant cuts in voluntary sector funding coupled with the increasing demands for its services from people with more complex needs. The process will allow input from VCS organisations as well as statutory and business partners. A State of the Sector Review 2016 would also enable MVSC and partners to gather comprehensive intelligence about various aspects of the sector in the borough including social value; governance and leadership; staff and volunteers; finance and services.

Recommendation:
It is recommended that the Health and Wellbeing Board endorses a VCS State of the Sector Review 2016 and the development of combined VCS and Volunteering Strategy.

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

None.

5. BACKGROUND PAPERS

None.

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STRATEGIC ITEM

Committee: Health and Wellbeing Board

Date: 19 April 2016

Agenda item: Sustainability and Transformation Plan

Wards: All

Subject: Sustainability and Transformation Plan

Lead officer: Adam Doyle, Chief Officer MCCG

Contact officer: Cynthia Cardozo, Director of Transformation

MCCG

Recommendations:

A. To note the Sustainability and Transformation Plan process

B. To be aware of the timelines for approval

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1 Purpose of report and executive summary

The NHS shared planning guidance 16/17 – 20/21 outlines a new approach to help ensure that health and care services are planned by place rather than around individual institutions.

As in previous years, NHS organisations are required to produce individual operational plans for 2016/17. In addition, every health and care system will work together to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision.

To do this, local health and care systems will come together in STP 'footprints'. The health and care organisations within these geographic footprints will work together to narrow the gaps in the quality of care, their population's health and wellbeing, and in NHS finances. Merton is part of the SWL STP footprint.

This update provides the Health and Wellbeing Board on the process to date.

2 Background

NHS England has published further guidance and has requested for an initial submission from each footprint, by 15th April, in order to check STP development.

Within this submission NHS England have asked us to set out:

- The leadership structure, decision making processes, and supporting resources we have put in place; and
- Major areas of focus and the key decisions we will need to take as a system to drive transformation, with a focus on three key issues –

improving health and wellbeing; improving care quality; and closing the finance / productivity gap

To have a realistic prospect of developing good plans by the summer, we were asked to have agreed three things for each of the STP footprints by Easter:

(i) the governance arrangements and processes needed to produce an agreed STP and then to implement it;

(ii) the scale of the challenge locally for each of the three gaps; and

(iii) key priorities identified to address each gap.

Each footprint has been asked to set out governance arrangements for agreeing and implementing a plan. This should include the nomination of a named person who will be responsible for overseeing and coordinating their STP process – a senior and credible leader who can command the trust and confidence of the system, such as a CCG Chief Officer, a provider Chief Executive or a Local Authority Chief Executive. In south west London we have agreed that Kathryn Magson, Chief Officer of Richmond CCG will take this role on. Kathryn will be responsible for convening and chairing system-wide meetings and facilitating open and honest conversations that will be necessary to secure sign-up to a shared vision and plan.

3. DETAILS

Strong STPs will set out a broader platform for transforming local health and care services. We will work with the footprints to help us develop the detailed requirements. However, as a minimum, it is expected that all plans will:

- describe a local cross-partner prevention plan, with particular action on national priorities of obesity and diabetes and locally identified priorities to reduce demand and improve the health of local people;
- increase investment in the out-of-hospital sector, including considering how to deliver primary care at scale;
- set out local ambitions to deliver seven day services. In particular: (i) improving access and better integrating 111, minor injuries, urgent care and out-of-hours GP services; (ii) improving access to primary care at weekends and evenings; and (iii) implementing the four priority clinical standards for hospital services every day of the week;
- support the accelerated delivery of new care models in existing Vanguard sites; or in systems without Vanguards, set out plans for implementing new models of care with partners;
- set out collective action on quality improvement, particularly where services are rated inadequate or are in special measures;
- set out collective action on key national clinical priorities such as improving cancer outcomes; increasing investment in mental health services and parity of esteem for mental health patients; transforming learning disabilities services; and improving maternity services;

- ensuring these and other changes return local systems to financial balance, together with the increased investment that will come on-stream as set out in NHS England's allocations to CCGs; and
- be underpinned by a strategic commitment to engagement at all levels, informed by the 'six principles'.

4. ALTERNATIVE OPTIONS

Nil of note

5. CONSULTATION UNDERTAKEN OR PROPOSED

STPs will need to be developed with, and based on the needs of, local patients and communities and command the support of clinicians, staff and wider partners. We therefore anticipate robust plans for genuine engagement as part of the decision making process. We are still finalising how the engagement programme will work across south west London.

6. TIMETABLE

What	Who	When
Further engagement and support on gap analysis and STP development	National bodies	w/c 29 February 2016
Gap analysis / data developed with each footprint	National bodies / Regional Directors / footprints	Throughout March 2016
Short return, including priorities, gap analysis and governance arrangements	Each footprint	11 April 2016
Outline STPs presented	Footprints to attend regional events to discuss emerging plans with peers and national bodies	w/c 22 April 2016
Each footprint area to develop plans and build support with their boards and partners	As set out in local governance arrangements	During April/May/early June 2016
Ongoing engagement and support from national policy experts and teams to support priority development	National policy teams and experts	During April and May 2016
Each footprint to submit their STP	To Regional Directors and then the 5YFV Board of national body Chief Executives	30 June 2016
Series of regional conversations between national teams and footprints	The NHS national body Chief Executives, National Directors, partners and footprints	Throughout July 2016

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

These will be considered in line with the STP implementation plan.

8. LEGAL AND STATUTORY IMPLICATIONS

These will be considered in line with the STP implementation plan.

9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

A full equality impact assessment will be completed as part of the process.

10. CRIME AND DISORDER IMPLICATIONS

Nil of note

11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

Nil of note

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

Nil of note

13. BACKGROUND PAPERS

Nil of note

Committee: Health and Wellbeing Board

Date: 19/04/16

Subject: Transforming Care

Wards: ALL

Subject:

Lead officer: Adam Doyle, Chief Officer, MCCG

Contact officer: James Holden (MCCG)

Recommendations:

A. Health and Wellbeing Board to confirm receipt of Transforming Care update

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to inform the Health and Wellbeing Board about the new requirements of Merton Clinical Commissioning Group (CCG) and its partners locally, and to outline the actions being taken to implement Transforming Care on behalf of people with learning disabilities in Merton.

1.2 There have been number of recent documents published nationally that describe the new requirements for CCG and local authority areas. “Building the Right Support” (October 2015) presents a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autistic spectrum disorder who display behaviour that challenges, including those with a mental health condition.

1.3 A new Transforming Care Partnership will bring together the commissioners responsible for funding health and social care for people with a learning disability and/or autism (CCGs, local authorities with their responsibilities for care and housing, NHS England specialised commissioning), with their budgets aligned or pooled as appropriate.

1.4 The report also updates the Health and Wellbeing Board on action undertaken against the Winterbourne View action plan. Regular reporting to the Board is a requirement of the new framework.

2.0 BACKGROUND

2.1 “Transforming Care” was published in 2012 as the Department of Health’s response to the Winterbourne View inquiry and outlined actions that must be taken by local authorities, clinical commissioning groups and other partners to ensure that people with learning disabilities who currently live in hospital settings have their care needs reviewed and are supported to move to community placements where appropriate.

2.2 "Building the Right Support" was published in October 2015 and presents a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. The document sets a challenging target for the reductions in the number of people in inpatient settings.

2.4 A new transforming care partnership will bring together the commissioners responsible for funding health and social care for people with a learning disability and/or autism (CCGs, local authorities with their responsibilities for care and housing, NHS England specialised commissioning), with their budgets aligned or pooled as appropriate. The partnerships must be established on a regional footprint, and so the South West London Transforming Care Partnership is made up of Croydon, Kingston, Merton, Richmond, Sutton, and Wandsworth.

2.5 In common with the other South West London CCGs, Merton has a very small inpatient population which is comprised of those people with learning disabilities whose mental health needs and/or challenging behaviour have not been successfully managed in the community. Further details are given in section 3.4 below.

3.0 DETAILS

SWL TRANSFORMATION DETAILS

3.1 Adam Doyle, Chief Officer, Merton CCG, is the nominated senior responsible officer for the newly formed South West London Transforming Care Partnership. The purpose of the South West London Transforming Care Partnership is to implement, monitor progress and provide assurance of the delivery of the Transforming Care Programme. A partnership board which meets monthly has been created which provides governance and leadership for all aspects of the Transforming Care Partnership to ensure programme targets are achieved. Assurance will be provided by:

- Monitoring progress against key milestones
- Ensuring quality of the programme deliverables
- Management of programme risks
- Overseeing the development and implementation of the transformation plan

3.2 As a Transforming care partnership we have based our plans on a strong understanding of: the population we are seeking to achieve better outcomes for (both current inpatients and those in the community at risk of admission without the right support); how much money CCGs, local authorities and NHS England Specialised commissioners are currently spending on health and care for that population; which providers are delivering what services for that spend; and how the system is currently performing.

3.3 Collaborative work with CCGs, Local authority, NHS England Specialised commissioning, users, their families and carers has been carried out to inform

and progress the final SWL Transformation Plan which has been submitted to NHS England on 11th April 2016.

MERTON DETAILS

3.4 Merton currently has four patients with learning disabilities or autistic spectrum disorders who are detained or placed in hospital settings, and so are reported nationally according to the Transforming Care requirements. All four patients are currently detained under Sec 3 or Sec 37 of the Mental Health Act 1983, for the purposes of treatment. None of the patients has been detained indefinitely and all are receiving active treatment.

3.5 London Borough of Merton leads on the case management of two of the patients, both of whom are allocated within the local authority's learning disability team. The other two patients are allocated within the Merton Mental Health Recovery and Support Teams based at The Wilson Hospital.

4.0 ALTERNATIVE OPTIONS

4.1 None at this time

5.0 CONSULTATION UNDERTAKEN OR PROPOSED

5.1 Review of current care arrangements are undertaken with all individuals and their informal support networks on a regular basis

6.0 TIMETABLE

6.1 Submission of Final Transforming Care Partnership Plan to NHS England is 8 April 2015

7.0 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1 NHS England's specialised commissioning budget for secure learning disability and autism services will be aligned with the new transforming care partnerships, and CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare.

7.2 The financial implications of commissioning appropriate community settings will have to be considered with the aim of identifying value for money, cost-effective community-based alternatives.

8.0 LEGAL AND STATUTORY IMPLICATIONS

8.1 The needs of the affected individuals will need to continue to be met within appropriate provision which takes into account the nature and intensity of their

challenging behaviour and does not put them or others at inappropriate levels of risk.

9.0 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1 These elements are intrinsic to the reviews already carried out with the individuals affected by this work and to the consideration of future placements appropriate to the level of their need and the assessment of risk to themselves and others.

10.0 CRIME AND DISORDER IMPLICATIONS

10.1 None

11.0 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1 Risk Assessments will be completed which will evaluate the health and safety implications and risk management considerations of the individuals leaving their current care settings and being accommodated within alternative care and support environments.

11.2 These risk assessments will need to include an appraisal of risks not only to the people who directly involved in such potential moves, but to others who may subsequently be affected by the challenging behaviour of these individuals in potential community placements

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

12.1 None

13.0 BACKGROUND PAPERS

13.1 Building the Right Support – A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges including those with a mental health condition

https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

BUSINESS ITEM

Committee: Health and Wellbeing Board

Date: 19 April 2016

Wards: All

Subject: Safeguarding Adults Annual Report 2014/15

Lead officer: Simon Williams, Director of Community and Housing

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

Contact officer: Melba Gomes, Safeguarding and DOLS Service Manager

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Recommendations:

A. To note the Merton Safeguarding Adults annual report 2014/15

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of the report is for the HWBB partners to be sighted on the Merton Safeguarding Adults Annual report 2014/15.

2. DETAILS

2.1 The Safeguarding Adults Annual Report is for 2014/15, under the previous Vulnerable Adults Safeguarding Team (VAST) and it should be noted that since then significant changes have come into place. The Care Act 2014 has now put adult safeguarding on a legal footing, from April 2015 each local authority is required to:

- set up a Safeguarding Adults Board (SAB) with core membership from the local authority, the Police and the NHS (specifically the local Clinical Commissioning Group/s) and the power to include other relevant bodies
- make enquiries, or ensure others do so, if it believes an adult is subject to, or at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them
- co-operate with each of its relevant partners in order to protect adults experiencing or at risk of abuse or neglect.

2.2 The most recent work in Merton will be more fully reflected in the annual report for 2015/16 when it is brought to the HWBB later this year. This will be a dedicated item for discussion by the Board and if possible link to the annual report of MSCB.

3. ALTERNATIVE OPTIONS

From April 2015 it is now statutory for all local authorities to have a Safeguarding Adults Board which makes an annual report.

4. CONSULTATION UNDERTAKEN OR PROPOSED

None for the purpose of this report.

5. TIMETABLE

It is planned that the SAB annual report 2015/16 will be reported to the Health and Wellbeing Board later this year.

6. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report

7. LEGAL AND STATUTORY IMPLICATIONS

It is a statutory requirement for all local authorities to have a Safeguarding Adults Board.

8. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Safeguarding Adults annual report is focused on safeguarding those who are vulnerable.

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 – Merton Safeguarding Adults Annual Report 2014-15

12. BACKGROUND PAPERS

N/A

Safeguarding Adults Partnership Board

MERTON SAFEGUARDING ADULTS PARTNERSHIP BOARD ANNUAL REPORT

1 April 2014 – 31 March 2015

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MESSAGE FROM THE CHAIR

The findings from Winterbourne View are now being embedded into National Policy and individual practice. The knowledge and profile of 'Safeguarding' continues to increase and this will continue to grow with the implementation of the Care Act in 2015. The Care Act places a duty for agencies to work together hence working in partnership has never been so important. The demands being placed upon those engaged in safeguarding adults continues to push the boundaries of our capacity to deliver a professional and caring service.

Within this operating environment I am immensely proud of the positive contributions to improving people's lives being made by all agencies. I am very aware of how the lives of carers and service users are affected each day when dealing with families and friends.

A key strand for Merton's Safeguarding Adults Partnership Board going forward will be to hear more of the voices of service users, families and their loved ones.

This Annual Report seeks to demonstrate how the Merton Safeguarding Adults Board is working to improve the lives of people who need our support most. This will be achieved by reinforcing our learning from the past, building stronger partnerships, building confidence in the service being delivered and building for the future.

Sue Redmond
Chair of Merton Safeguarding Adults Partnership Board

INTRODUCTION

This annual report is produced on behalf of Merton Safeguarding Adults Partnership Board and covers the period of 1st April 2014 to 31st March 2015. Each year we have been able to watch and report on the developments of the work carried out by Merton and its partners to safeguard our vulnerable residents from abuse.

This report outlines the progress made during the year April 2014 – March 2015 and how local and national developments have influenced this.

WHO WE ARE

The Safeguarding Adults Partnership Board is a group of people who meet four times a year to ensure that Adult Safeguarding is delivered effectively. The Board comprises of senior lead managers from all key partner agencies.

**Membership is detailed in Appendix 1 and The Terms of Reference for the board is attached in Appendix 2*

The role of Safeguarding Adults Partnership Board is to promote, inform and support the work of safeguarding adults in Merton. It does this by ensuring that safeguarding adults is a theme that is strategically driven, adequately represented across the borough and included in strategic thinking, documents and plans.

The board has been chaired by David Smith (Director of Adult Social Care) and more recently by Sue Redmond (acting Director of Adult Social Care) Royal Borough of Kingston Upon Thames since March 2013. The Director of Merton's Community and Housing department Simon Williams has chaired the Kingston Board. This arrangement with be reviewed in in the latter of 2015.

NATIONAL AND LOCAL PROGRESS

Safeguarding Adults at Risk National Policy Context

Over the past year there have been a number of changes within health and social care which change the landscape in protecting adults at risk. A principal change was the publication of the *Health and Social Care Act 2012*. One of the principles included in the Act is the responsibility for commissioning of health services. This now lies with *Clinical Commissioning Groups* (CCG). Equally, under the Health and Social Care Act 2012 the new National Commissioning Boards have responsibility for commissioning of primary care and some community and specialist health care services.

Local Authorities will retain the duty to improve the health of the people who live in their communities. Additionally, *Health and Wellbeing Boards* are established by law under the Health and Social Care Act. The role of the Health and Wellbeing Board is to formally consider matters affecting health and well-being, including all changes to local health services.

A further change has been the establishment of Health Watch which was developed to represent the views of service users within health and social care and other members of the public. Local Authorities were required to establish a local Health Watch organisation to ensure local people are involved in the commissioning, scrutiny and provision of health and social care services.

A further development has been the *Care and Support Bill* which sets out the government's intention for the future of Adult Social Care. It is proposed that the Care and Support Bill will give clarity of entitlements to care and support, give people a better understanding of what is available, help them plan for their future and ensure they know where to go for help when they need it.

The Bill provides a clearer legal framework for safeguarding adults with Safeguarding Adults Boards becoming statutory. Local Authorities, the NHS and the police will be core members of Safeguarding Adults Boards and are already key partners on Merton's Safeguarding Adult's Partnership Board.

Safeguarding Adults Partnership Boards will carry out Serious Case Reviews in certain circumstances and will be required to publish annual plans which reflect the agreed local priorities.

The Department of Health published the final report *Transforming care: A national response to Winterbourne View Hospital* in December 2013, setting out actions to improve care and support of vulnerable people with learning disabilities. The report lays out clear milestones for health and local authority commissioners to work together to ensure that commissioned services are safe and there is evidence that the service users and their families have been included in the decision making process. The aim is to reduce the number of people who are cared for long term in inpatient services for assessment and treatment. This work continues on into 2014-2015 with review of actions.

Lessons learned from inquiries such as *Mid Staffordshire Foundation Trust* have highlighted the need to make safeguarding integral to care. Commissioners have responsibilities to address failures of care and have a key role in managing the impact of enforcement action taken by the Care Quality Commission (CQC) by ensuring that the impact on the local health economy is minimal

LOCAL POLICY CONTEXT

In response to the number of concerns raised about adults who may be at risk and the concerns about hoarding, the Safeguarding Adults Partnership Board set up a short term group to look at implementing a multi-agency protocol for hoarding.

The Safeguarding Adults team in partnership with other agencies developed a multi-agency protocol identifying how the borough identifies, works with and manages people that hoard. The protocol includes a number of tools for practitioners' across all agencies to use and offers a practical, solution focused way of working that manages risk and assesses support needs.

The protocol was launched in the spring of 2014. The event was opened by Professor Lyn Drummond. The event was well attended by all agencies. The hoarding protocol is the first of its kind in London and Merton have been contacted by a number of agencies in other boroughs asking to use the protocol themselves. Merton and its partners are looking to put this forward as an example of positive multi agency working.

This protocol can be found on Merton website at:
www.merton.gov.uk/safeguardingvulnerableadults

SAFEGUARDING BOARD ACHIVEMENTS AND OBJECTIVES FOR 2013/14

- We said we would set up a short life multi agency group to look at developing a policy in response to hoarding. This was completed and launched in spring 2014.

- We said that we would look at including supervision of risk competencies for Safeguarding Adults and appraisal for staff at all levels. This is still to be completed and will be taken forward to this year.

- We said that we would look at developing service user feedback on safeguarding. We have presented Safeguarding Adults information to carers groups and service users groups. We developed questions as part of our annual survey.

- We said that we would ensure that quality assurance processes were robust and focused on quality of the work and recording. We have done this by developing an *Adult Quality Assurance Framework* for Merton social services which is underpinned by a *Quality Audit Tool* which the Safeguarding Adults team use. A sample of safeguarding cases is taken from all care groups and the audit is completed. The outcomes, areas of development and good practice are discussed with team managers in regular meetings and an action plan is produced.

- We said that we would carry out an independent audit of our Deprivation of Liberty Safeguarding (DoLS) assessment and ensure that Merton have a plan to train Best Interest Assessors (BIA) each year. This was prior to the Supreme Court Judgement which came out on the 19th March 2014. In response to the judgement we have developed a plan to have all eligible practitioners trained as Best Interest Assessors by 2017.

- We said we would develop a data capturing tool regarding safeguarding plans in line with *Pan London Process*. This has been completed as part of the interim changes to Care-first and our response to the ZBR process.

- We said that we would develop a process for capturing data in relation to Safeguarding Adults and Serious Untoward Incident (SUI) processes across Mental Health. The Mental Health Trust have implemented Ulysees as a data tool. This is being rolled out over 2014.

- We continue to raise the profile of Adult Safeguarding Partnership work through regular and annual reporting to Committees, Boards and relevant statutory and governance bodies of all partner agencies. The Safeguarding Adults team continues to represent Safeguarding Adults in Merton through regular attendance of various boards and reporting to committees such as Scrutiny and the Health and Well-being Board.

- We said that we would map out the Safeguarding Adults process in line with Pan London Procedures and look at opportunities to improve. This piece of work was completed by an independent worker and a report was written.

- The recommendations will be reviewed as part of the work in ensuring that processes are Care Act compliant during 2014/2015.

- We said that we would develop a consistent *Mental Capacity Assessment Form* for practitioners to use. This has now been developed and is now available for practitioners to use, complete with guidance on how to complete it.

Deprivation of Liberty Safeguards

- We have set up a professional forum for Best Interest Assessors who undertake the assessments for the Deprivation of Liberty Safeguards to ensure consistency and quality in assessment. This is chaired by an independent Chair who previously was involved in developing the *Deprivation of Liberty Code of Practice*.

- We continue to ensure that learning is embedded into processes and practice following lessons from serious case reviews. Our serious case review this year highlighted the need for further training around mental capacity assessments and this will be rolled out through 2014/2015. The mutli-agency case review held in March 2013 reflects on practice and discusses in a multi-agency forum what learning and development can be extrapolated.

- We said we will look at enhancing our strategic overview of safeguarding. We have used the NHS Tool and an overarching template for all partners. This template will be reviewed as part of the Safeguarding Adults Partnership Board away day.

- We will review the high risk service, with a view to developing a self-neglect panel, to facilitate regular discussions of cases of concern with partner agencies.

SAFEGUARDING BOARD OBJECTIVES FOR 2015/2016

The board have started work on the following objectives for this year. The away day being held in October 2015 will identify further objectives that the board need to take forward and this progress will be reported in the next annual report**.**

One of the key areas for the board will be responding to protecting adults at risk and the changes proposed in the Care Act 2014.

The board are keen to ensure that adults at risks are central to the safeguarding process. We have joined the project of *Making Safeguarding Personal* which started in September 2014 in order to review and look at a more proactive way of engaging customers in the safeguarding process.

The Care Act means that the current Pan London Multi Agency Procedures for Protecting Adults at Risk written in 2011 will no longer be fit for purpose. Merton are part of the working party looking at the revision of the Pan London Policy.

As a result of the Cheshire west judgement by the Supreme Court we will be looking at developing the Deprivation of liberties function of the safeguarding team.

We will be reviewing our deprivation of Liberties policy with Children's Social Care to reflect the changes as a result of the Cheshire west judgement.

We will be rolling out a comprehensive training programme for staff and partners on the Mental capacity Act and how this fits with practice and commissioning.

We will look at competencies for staff for those working with adults at risk and undertaking Best interest assessor roles in relation to the DoLS.

We will review the hoarding protocol with key agencies and collect examples of good practice to add to the policy to provide evidence of our successful approach.

The three year strategy will be reviewed on an annual basis and report our progress in the annual report.

QUALITY ASSURANCE

Merton Social Services introduced a quality assurance framework across adult social care. One of the key areas of the framework is safeguarding adults at risk. To support this we developed a *quality assurance audit tool* covering the process, decision-making and outcomes of safeguarding alerts and investigations.

The Safeguarding Adults quality officer's carry out the quality assurance audit process by selecting a random sample of audits across all care groups. This is presented in a quarterly report to the Safeguarding Adults Partnership Board. The report provides information to the board on numbers of audits undertaken for alerts and investigations and highlights areas of good practice and areas of development.

DETAILS OF THE AUDIT AND KEY FINDINGS

The safeguarding case audits are a two-part process whereby the safeguarding quality officer undertakes the safeguarding recording audit. The audits are then passed to the team

managers to complete the audit for decision making and outcomes. A Joint meeting then takes place between the quality officer in safeguarding and team manager to discuss issues or training needs that have been raised during the audit process. An action plan is kept to ensure follow up and the team manager feeds back to the individual practitioner or team.

REVIEW OF TRAINING

This year we have had a comprehensive training programme designed to provide skills and experience to practitioners across all agencies. The training programme has included basic safeguarding, investigators training and assessing the alert. This has ensured that staff at all levels across the social care sector were able to get the most up to date legislation and guidance on safeguarding practice. Coupled with the safeguarding training, a number of courses relating to domestic violence, forced marriage, Deprivation of Liberty, Risk Assessment and the Mental Capacity Act were run.

The Learning and Development manager continues to work very closely with the Corporate Training department to ensure that all training needs are taken into account and that we are aware of the most current issues affecting vulnerable adults in Merton.

For the coming year we have secured a wide variety of courses specifically aimed at Safeguarding Adults at risk.

SUMMARY OF COMPLETED SAFEGUARDING TRAINING COURSE 14/15

Course Title	Delegate Count
DOLs for Social Workers & Multi-disciplinary Professionals	48
Safeguarding for Investigating Officers	22
Safeguarding for Managers	4
Safeguarding - Material/Financial Abuse	29

We trained 104 delegates this year through our learning and development team safeguarding training. These delegates are Merton, provider services and partner agencies such as care homes.

In addition we offered safeguarding training on provider's sites according to need where whole teams were trained together, for example, at JMC and Mencap. This year we provided training to day centre staff at JMC. In general the feedback was good and the staff was happy with the training offered.

DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

The Mental Capacity Act (MCA) 2005 was amended to provide safeguards for people who lack capacity. Specifically, to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty. This is known as Deprivation of Liberty Safeguards (DoLS). These safeguards came into force on the 1st April 2009. The purpose of this was to provide a legal framework for acting and making decisions on behalf of these individuals. The safeguards cover a particular group of people; these are:

- People who are 18 years and above with significant Learning Disabilities, Dementia, Autism, Brain or Neurological injury/conditions.
- They apply to people who are in a care home (residential and nursing) and acute hospitals. DoLS does not apply to people detained under the Mental Health Act 1983.

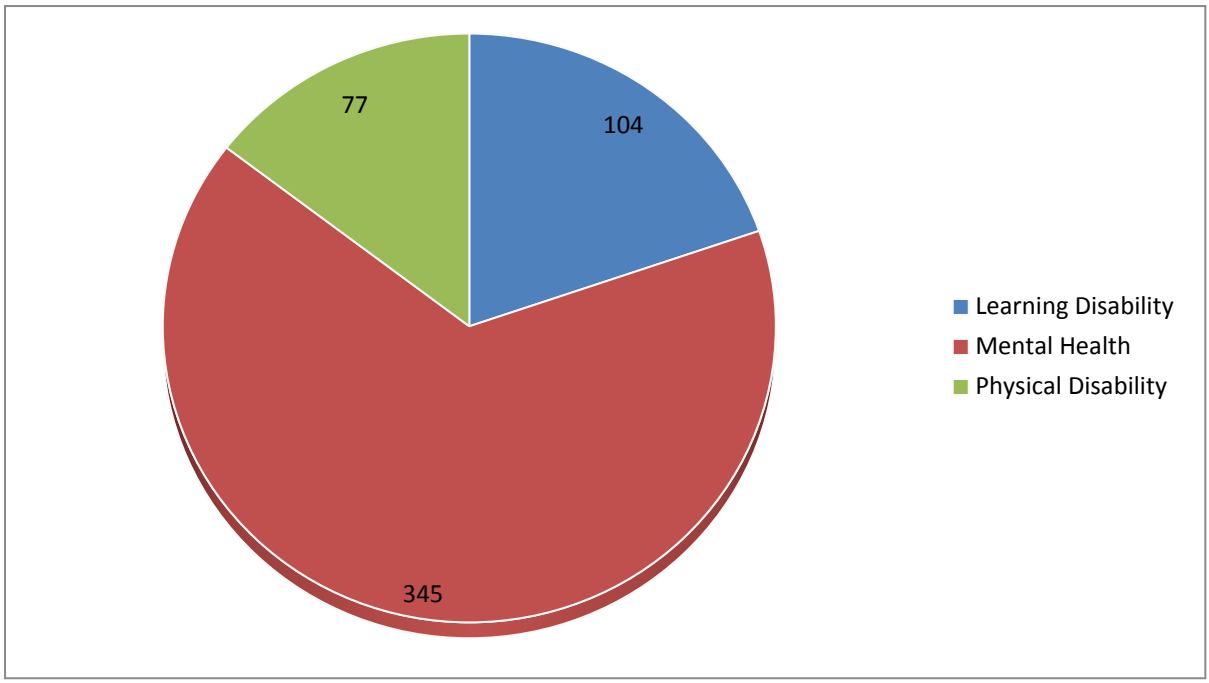
- The DoLS assessment incorporates the process for referral, allocation and monitoring which is undertaken by the safeguarding team.

In the period of April 1st 2014 – March 31st 2015 there were:

- 35 referrals from hospitals
- 20 referrals from All Saints Respite (local respite provision for customers with a learning disability)
- 472 referrals from care homes.

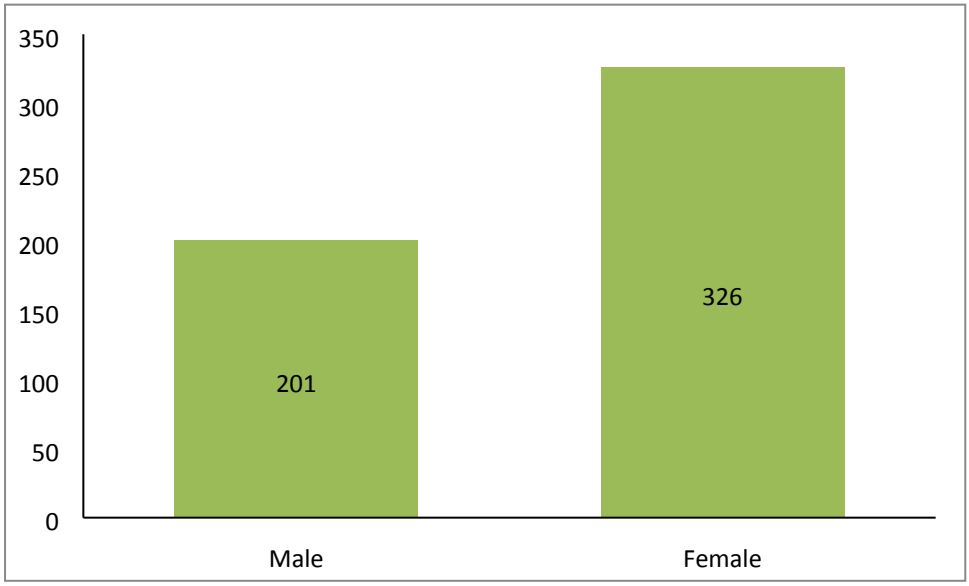
There is an increase in authorisation requests from respite services due to the Cheshire West ruling, this has provided the most challenging authorisation requests as the customers tend not to spend a long period of time in this setting and they will access other settings as part of their care plan which may mimick the care plan in other community settings. This has questioned whether these cases should be covered by the judicial DOLS process.

Number of DoLS requests by Care Group



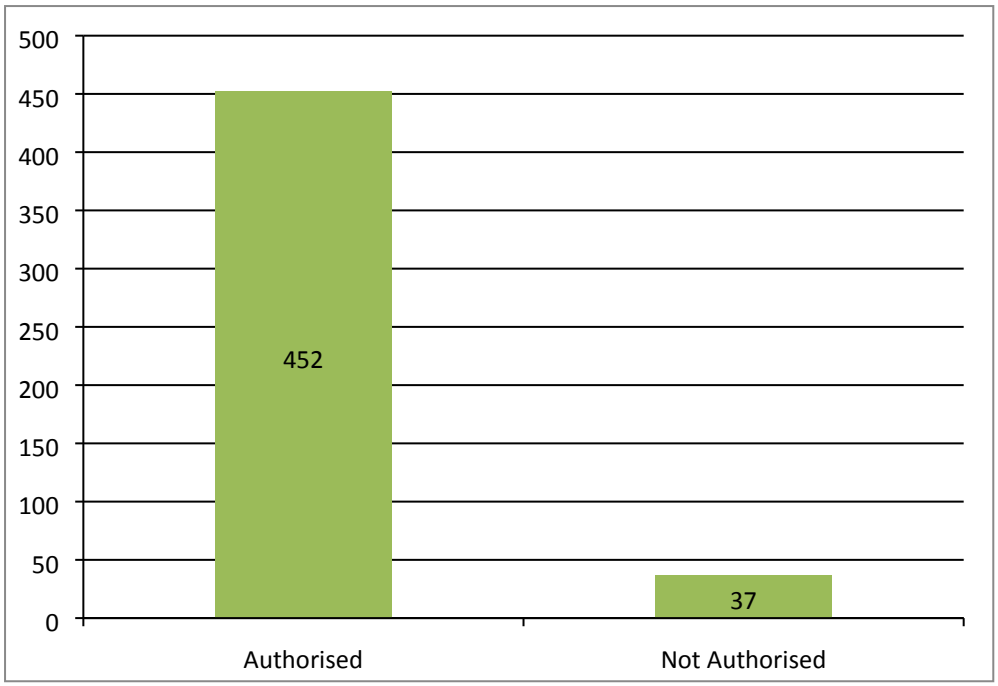
As can be seen above, the highest numbers of DoLS requests were for Mental Health (includes Dementia as category therefore incorporation of older people) and those with Mental Health Difficulties. In total, 526 DoLS requests were received this year.

Number of DoLS requests by Gender



The graph above shows that this year, there were significantly more DoLS requests for female customers in comparison to male customers There is a reason for this as previous years have shown the opposite.

Number of DoLS requests in relation to Authorisation



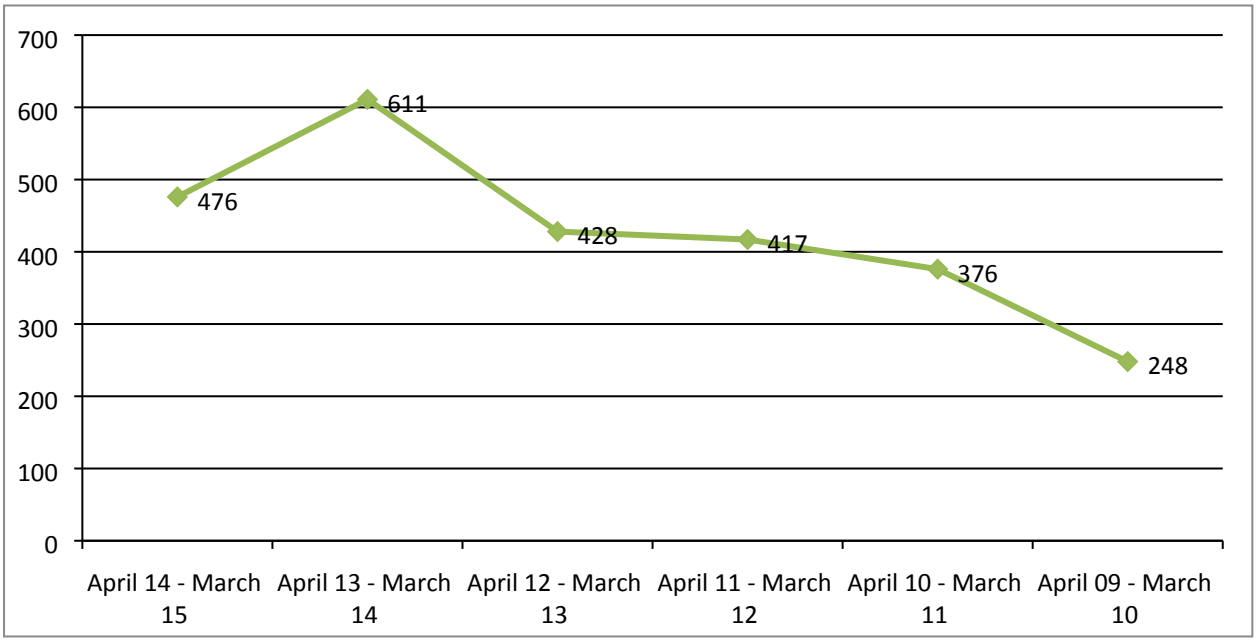
The vast majority of authorisation requests were authorised this year. Only a small number were not authorised, mainly due to the customer assessed as having mental capacity.

SUMMARY OF SAFEGUARDING ADULTS STATISTICS

During this year, Merton saw a decrease in the number of referrals received and in the number of referrals that progress through to investigation. This, we believe, can be attributed to the new system of logging safeguarding alerts. We suspect the received numbers would've been the same or even increased if we look at previous years patterns, but the system of logging these alerts was not effective in capturing the accurate number.

The following statistical information has been collated from our monitoring systems.

Table A The number of reported cases of adult abuse (alerts and including those that moved on into referral) for the last 6 years.



The number of referrals decreased to 476 this year. However it is still important to note that since 1st April 2009 cases reported have almost trebled, which is evidenced by the steep rise in reporting.

Table B. Number of cases by month

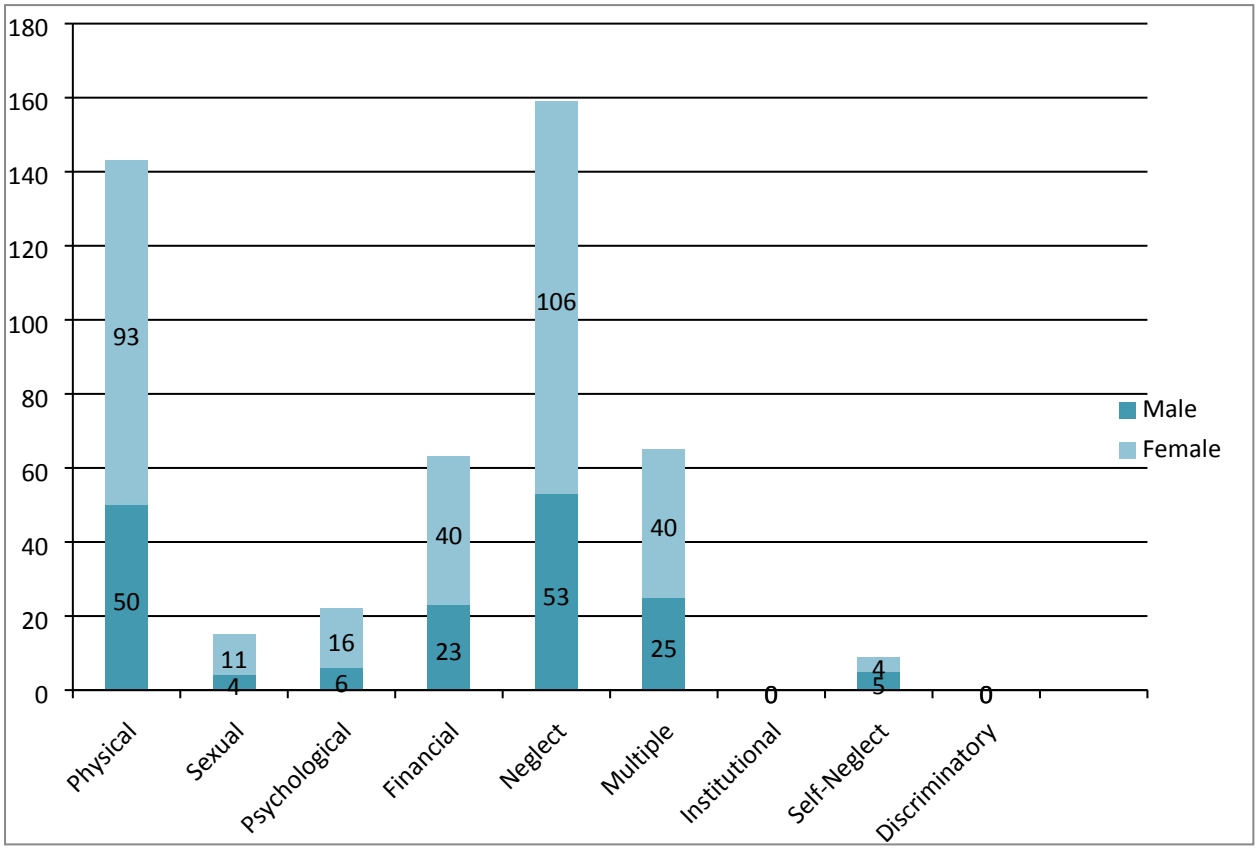
Number of cases by month remains constant with only 2 months of the year with lower cases than the others.

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014-2015	41	42	47	37	28	42	28	45	36	42	30	58
2013-2014	36	46	51	74	60	44	70	42	44	51	48	45
2012-2013	42	34	39	31	25	43	34	42	25	44	35	29
2011-2012	16	30	46	30	33	32	33	39	52	39	32	35
2010-2011	26	34	24	23	25	25	33	45	25	40	31	45

Figure C. Source of Referrals

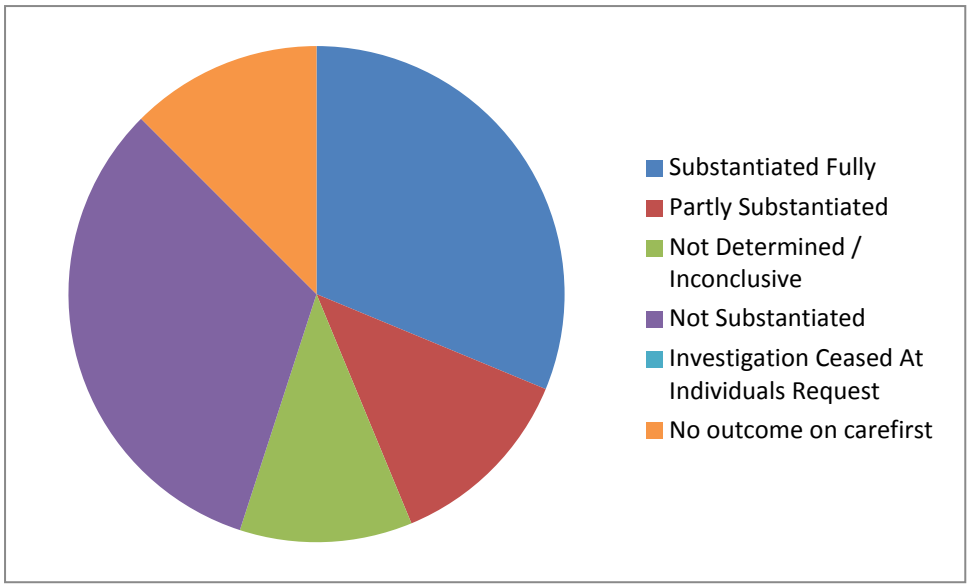
No data provided at time of report.

Graph D. Gender of Victims



Females, and in particular single people, are more likely to be abused. There has been a sharp increase in the number of females who have been victims of alleged abuse. This would be consistent with the increase in alerts relating to physical abuse and domestic violence issues. Self-neglect seems to affect men and women equally. Financial abuse is broadly similar between men and women and this is consistent with previous years.

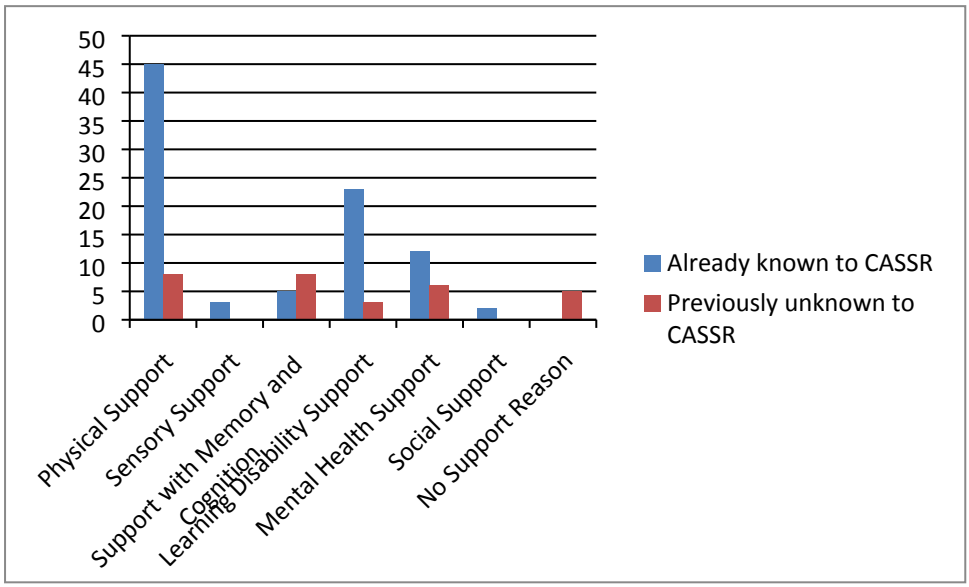
Graph E. Case conclusion for completed investigations



According to our safeguarding adults return, 188 reported safeguarding cases went on to investigation. Out of those, 63 were substantiated fully, whilst 51 were not substantiated. These figures show that cases that go on to investigation, the majority will be substantiated (inc. partly substantiated) which shows accurate screening of the alert and decision of which alerts should proceed to investigation.

It is important to note that a decision whether a case is substantiated or not is determined on the balance of probability and is a multi-agency decision by the strategy group following review of investigation. As safeguarding progresses on from the introduction of the Care Act 2014, the case conclusion will change focusing on customer outcomes from the Making Safeguarding Personal Agenda and decision based on risk to customer following the safeguarding adult's process.

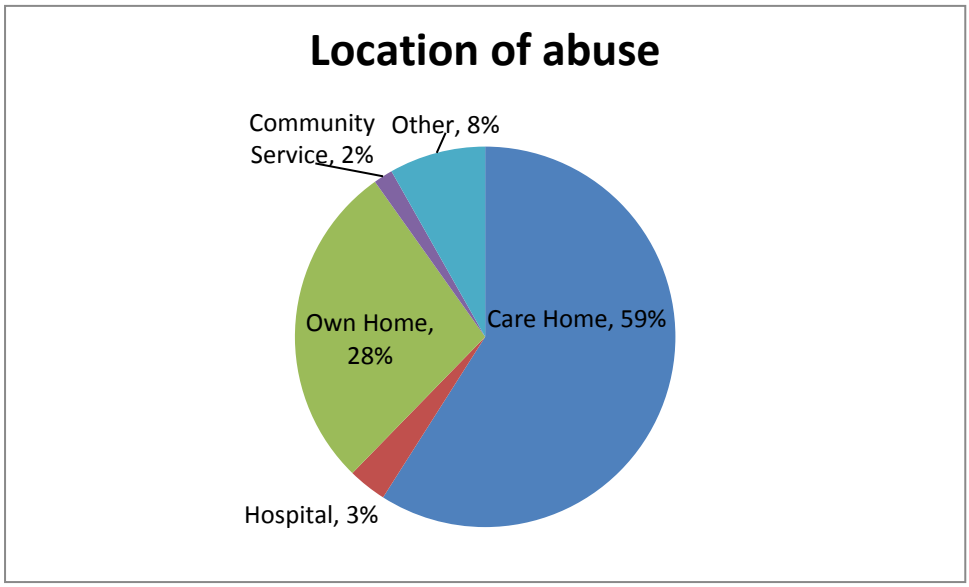
Graph F. Safeguarding referrals by client group



Those listed with physical support needs were where the most safeguarding referrals were received. Physical support also means those customers that are frail meaning older people or those that have a physical disability. This connects to the large number of alerts received

of people living in a care home as typically it will be older people that reside in care homes (and nursing).

Figure G. Location of abuse



Care Homes were the most where safeguarding cases were investigated. This year saw a rise in multiple alerts regarding customers in the same care home. These investigations contained more than 5 customers at times so this would inflate the location and evidence that the majority of safeguarding investigations were in care homes.

How has this data informed our work?

- Closer joint working with our contracts team, sharing responsibilities connected to the safeguarding adults investigations within care homes. This has helped sharing information between teams, understanding which team is most appropriate to lead an investigation and further effective liaison with our key agencies such as the Care Quality Commission.

- As this year reported a decrease in alerts, consideration has been given to what information should be obtained when receiving a safeguarding alert to determine when to log as a safeguarding alert and when this should proceed to investigation. As the introduction of the Care Act 2014 approaches into 2015, further emphasis on quality of information is key at point of referral in order to make an informed decision as to what is logged as a safeguarding alert.

- Consideration of response to domestic violence and abuse alerts. As the data evidences a sharp rise in females of have been victim of alleged abuse, safeguarding adults work need to ensure the involvement of key support services. For example, sharing services such as One Stop Shop and ensuring strong attendance at MARAC.

APPENDIX 1

Safeguarding Adult Partnership Board as of March 2014

Name	Title and Agency	Email
Simon Williams	Director of Community and Housing	simon.williams@merton.gov.uk
Sue Redmond	Chair of Adult Safeguarding Board	sue.redmond@kingston.gov.uk
Julie Phillips	Safeguarding Adults 7 Dols Manager	julie.phillips@merton.gov.uk
Jenny Rees	Service Manager Access and Assessment	jenny.rees@merton.gov.uk
Rahat Ahmed-Man	Head of Commissioning	rahat.ahmed-man@merton.gov.uk
Andy Ottaway-Searle	Head of Direct Provision	andy.ottaway-searle@merton.gov.uk
Lee Hopkins	Service Manager – Children School and Families	lee.hopkins@merton.gov.uk
Jonathan Brown	Service Manager, Learning Disabilities and complex needs	jonathan.brown@merton.gov.uk
Gemma Richardson	Safeguarding Adults Practitioner	Gemma.saunders-richardson@merton.gov.uk
Zoe Gallen	Strategic Lead for Victims and Witnesses Safer Merton	zoe.gallen@merton.gov.uk
Interim	Associate Director of Social Work – Mental Health	
Scott Pollock	Safeguarding Lead – The Royal Marsden	Scott.Pollock@rmh.nhs.uk
David Flood	Safeguarding Lead – St Georges Hospital	david.flood@stgeorges.nhs.uk
Jason Morris	Safeguarding Lead, London Ambulance Service	Jason.morris@lond-amb.nhs.uk
David Palmer	Metropolitan Police	david.palmer@met.pnn.police.uk
Jeff Lyle	Borough Commander – London Fire Brigade	jeff.lisle@london-fire.gov.uk
Dawn Helps	Neighbourhoods Manager – Merton Priory Homes	dawn.helps@circle.org.uk
Lynn Street	Merton CCG	lynn.street@mertonccg.nhs.uk
Zoe Wilson	London Probation Service	Zoe.wilson@london.probation.gsi.gov.uk
Emma-Louise Haran	Sutton & Merton Community Services	emma-louise.haran@smcs.nhs.uk
Georgina Lotinga	Voluntary Sector	Georgina.lotinga@vslondon.org

APPENDIX 2

Revised Terms of Reference 2013

Membership

- Director Of CCG and Adults Services Kingston (Chair)
- Community & Housing, Merton
- Safeguarding Adults Manager, Merton Social Services
- Lead Practitioner, Safeguarding Adults
- Administrator (minute taker)
- Safeguarding Lead, S.W London and St Georges Mental Health Trust
- Children's Safeguarding Representative, Merton
- Service Manager, Access and Assessment, Merton Social Services
- Head of Direct Provision, Merton
- Safeguarding Lead, St George's NHS Trust
- Detective Chief Inspector, Metropolitan Police.
- Head of Commissioning, Merton
- Borough Commander, London Fire Brigade
- Safeguarding Lead, Royal Marsden NHS foundation Trust
- Interim Associate Director of Social Work S.W. London and St Georges Mental Health NHS Trust
- Strategic Priority Lead, Safer Merton
- Head of Group HR for Adult Social Services, Sutton and Merton
- Health Watch
- London Probation Service

Terms of Reference

- To oversee the implementation and working of the Pan London policy and procedures, including publication, distribution and administration of the document.
- To agree a strategy and maintain a strategic overview of an inter-agency working protocol relevant to the implementation of the policy and procedures.
- To oversee the development of information systems that supports the gathering of information necessary to carry out the evaluation of policy and practice.
- To oversee the monitoring and reporting of safeguarding concerns and investigations and to undertake a full review annually.
- To agree revisions and changes necessary to the procedures, which are identified as a result of the monitoring process completed by Audit Review And monitoring (ARM).
- To maintain a strategic overview of safeguarding adult training.
- To oversee promotion of the policy and procedures through formal events or information campaigns to ensure a wider professional and public understanding of adult abuse.
- To identify sources of funding required to implement all of the strategies associated with the policy and procedures and to monitor the use of these resources.
- To agree and maintain links with relevant corporate management groups.
- To create and discontinue task groups in line with development needs.
- To commission and oversee the work of the task groups.
- To accept and consider recommendations from the task groups.
- To ensure that agreed multi-agency strategies are implemented within individual agencies.

Frequency of Meetings: Bimonthly

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