Merton Council
Health and Wellbeing Board

Date: **20 June 2017**

Time: **3.00 pm**

Venue: **Committee rooms D & E - 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 - 4
4	HWB Strategy Indicators and Priorities	5 - 12
5	Healthwatch - Verbal Update	
6	Joint Strategic Framework for Prevention of Substance Misuse and related harm	13 - 36
7	Wilson Health and Wellbeing Campus: progress report	37 - 86
8	Health in all Policies Action Plan	87 - 102
9	Better Care Fund	103 - 108
10	Local Account 2013-2017 THIS REPORT WILL FOLLOW IN A SUPPLEMENTARY AGENDA	
11	Adult Social Care Budget 2017/18	109 - 112

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

- Tobin Byers (Chair)
- Gilli Lewis-Lavender
- Katy Neep

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
28 MARCH 2017

(3.00 pm - 5.10 pm)

PRESENT Councillor Tobin Byers (Chair), Dr Andrew Murray, Councillor Gilli Lewis-Lavender, Councillor Katy Neep, Dr Karen Worthington, Khadiru Mahdi, Chris Lee, Yvette Stanley, Simon Williams, Dr Dagmar Zeuner, Dr Doug Hing, Brian Dillon and Dave Curtis

ALSO PRESENT Andrew Moore –CCG, Annette Bunka-CCG
Sue Rimmer - South Thames College
Lisa Jewell – Democratic Services

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for absence where received from Melanie Monaghan.

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

No declarations of interest were received.

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The minutes of the previous meeting held on 29 November 2016 were agreed as a correct record

4 CCG COMMISSIONING INTENTIONS (Agenda Item 4)

Andrew Moore, the Director of Commissioning Operations, Merton CCG, presented his report on Merton CCG's Commissioning Intentions. He asked the Board to note that the most significant elements of the CCG's plans are contained within the STP. He highlighted; the challenging financial situation and the need for the CCG to make £11 million savings to achieve a balanced budget in 2017/18, and the importance of partnership working to achieve savings whilst maintaining services.

The Board noted that there would be increased working across the STP footprint, and there should not be any 'postcode lottery' for standards of care.

The Board noted that target of 28% of children with diagnosable mental illness to receive care in 2017/18 and challenged if this figure was ambitious enough. The board noted that there were discussions with the provider regarding their current performance and that careful consideration is being given to improving this with discussion taking place on the detail at the CAMHS partnership. In response to a question from the DCSF the CCG confirmed that the providers proposed changes would be delayed to enable resolution of some key issues.

RESOLVED

The Board noted the Report on CCG Commissioning Intentions

5 UPDATE ON MERTON CCG'S PRIMARY CARE STRATEGY (Agenda Item 5)

Dr Karen Worthington, Clinical Director Primary Care Transformation Merton CCG presented her update report on Merton CCG's Primary Care Strategy.

The Director of Public Health thanked Dr Worthington for her report and presentation and emphasised that she wanted the messages about primary care to be communicated as widely as possible. She also welcomed the move by CLCH into Merton Civic Centre as a positive step in the integration of primary care services

The Director of Community and Housing welcomed the report and the increased opening hours but asked what was being done about access to emergency appointments and also what was being done to support Nursing Homes. Dr Worthington explained that each GP practice did try to ensure, in its own way, that there was provision for same day emergency appointments. Dr Worthington said that Nursing Homes were not addressed specifically by the report but the Board noted that there had been vanguard work carried out in a neighbouring borough and Merton could use this work to move forwards.

Sue Rimmer, Principal & Chief Executive of South Thames College, spoke about how she could promote the primary care strategy within the college and how the structure of their courses would be linked to careers. The Board noted her concerns on the drop in applicant numbers to the College's Access to Nursing Course, and noted that the age profile of nurses in the borough was increasing.

The Director of Children, Schools and Families welcomed the additional funding for Children's Safeguarding and said that there was work to be done and that she was looking forward to discussing this with Dr Worthington and Dr Zeuner and identifying the locality leads.

Councillor Katy Neep spoke about access to primary care for young people, and how alternative locations to the GP surgery may be more appropriate. Following her conversations with Young Peoples Forums and the Merton Youth Parliament she said would bring a report to the next HWBB

The Director of Environment and Regeneration spoke about Estates regeneration and healthier neighbourhoods, and said he would bring a report to a future HWBB about this work.

The Chair asked about the communications necessary to ensure that residents know about the Hubs and go there rather than A&E. Dr Worthington replied that GPs would promote this and there was also a communication Strategy that she would send the Chair, Councillor Lewis-Lavender and the Chair of Healthwatch so that they could help disseminate the information on Hubs.

The Chair thanked Dr Karen Worthington for her work and the report

RESOLVED

The Board noted the achievements and work in progress presented in the report

6 WILSON DEVELOPMENT: PROGRESS REPORT (Agenda Item 6)

The Director of Public Health presented the progress report on the Wilson Development. The Board welcomed the community conversations as presented in the appendix to the report and agreed that these should be shared with all who participated and as widely as possible with all who have an interest.

The Director of Environment and Regeneration spoke about the One Public Estate (OPE) and how OPE will present opportunities for the Wilson re-development to optimise the utilisation of public sector assets and as a vehicle for integrating and transforming services.

The Board noted the program timetable in the report, and how important it was to keep to this timescale, whilst also truly involving the community in discussions. The Board discussed the importance of finding the correct balance between clinical and non-clinical activities on the site.

The Chair thanked Mari Davies for her work on the Community Conversations

RESOLVED

That the Board:

A. Noted, welcomed and help share the completed write up of the Community Conversations on the Wilson and the engagement done to date.
B. considered the progress, including the strengthened governance and accountability mechanisms.

7 ANNUAL PUBLIC HEALTH REPORT ON CHILDHOOD OBESITY AND CHILD HEALTHY WEIGHT ACTION PLAN PROGRESS UPDATE (Agenda Item 7)

The Director of Public Health presented the Annual Public Health Report and explained that she had decided that this report should concentrate on the theme of ‘Tackling Childhood Obesity Together’, and form a resource that can be used by all.

Councillor Lewis-Lavender asked if anything could be done to reduce the cost of using the boroughs leisure facilities to encourage families to exercise. The Director of Environment and Regeneration said that he could discuss this further with the Director of Public Health.

Dr Andrew Murray said that he thought that ‘Tackling Childhood Obesity’ was a fantastic document that was fully endorsed by the CCG, and that the CCG would champion.

Dr Zeuner said that there were further in-depth conversations to be had with BME communities around issues of childhood obesity, and further consideration of the links with children’s mental health.

RESOLVED

1. To receive the independent Annual Public Health Report (APHR) 2016/17.
2. To help disseminate and promote key messages and resources set out in the Annual Public Health Report 2016-17among stakeholders and residents.
3. To endorse and champion the Child Healthy Weight Action Plan 2016 – 18
4. To consider how Health and Wellbeing Board members can champion strategic priorities and actions that make healthy eating and being active easy choices for children and families, identifying opportunities to embed within every day business

8 BETTER CARE FUND UPDATE (Agenda Item 8)

Annette Bunka, Senior Commissioning Manager for Merton CCG, presented her report that gave an update on health and Social Care integration through the Better Care Fund and asked the Board to note that national guidance for BCF has not yet been published
The Director of Community and Housing said that this report provided a comprehensive summary of the current situation, he noted the progress and hoped that there will be an opportunity to move forward faster.

RESOLVED

The Board noted the report

DATES OF FUTURE MEETINGS

The Board noted the dates of future meetings, as tabled at the meeting. All dates are Tuesdays at 3pm:

20 June 2017
19 September 2017
28 November 2017
30 January 2018
27 March 2018

STRATEGIC ITEM

Committee: Health and Wellbeing Board

Date: 20 June 2017

Agenda item:

Wards: All

Subject: **Health & Wellbeing Strategy 2015-18: Update Monitoring Report**

Lead officer: Dr Dagmar Zeuner, Director of Public Health

Lead member: Cllr Tobin Byers, Adult Social Care & Health

Forward Plan reference number:

Contact officer: Dr Amanda Killoran, Public health consultant

---

Recommendations:

A. To consider the update on outcome indicators measuring progress on the Health & Wellbeing Strategy 2015-18.

B. To consider the progress on Childhood Obesity and Social prescribing priorities (2016/17), and to continue to champion actions in these areas.

---

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The H&WB Board considered the Annual Progress Report 2016 on implementation of the Health & Wellbeing Strategy 2015-18 at its November 2016 meeting.

This paper provides an update on outcome indicators; specifically trends in life expectancy, and also the three indicators with *Red* status in the Annual Progress Report (immunisation, childhood obesity, and fuel poverty). This responds to the request of the Board at the November meeting.

This paper also reports on the H&WB priorities for 2016/17- childhood obesity and social prescribing.

1.2 Life expectancy is the strategic overarching indicator used to measure and monitor differences in health & wellbeing between different communities within the borough.

In summary, our analysis shows that the trend for women is positive-the difference in female life expectancy between the most deprived and least deprived wards reduced over the period 2005-2014. In contrast, the difference in male life expectancy between the most deprived and least deprived wards increased slightly. This year's Annual Public Health Report will examine the trends in health equalities within the borough in more detail.

1.3 The target for increasing the uptake of MMR immunisation at 5 years of age remains unlikely to be met by 2018. Although there have been some improvements from baseline, the most recent data shows that progress remains difficult. NHS England (the commissioner for immunisation) reported performance and actions to the Healthier Communities Overview & Scrutiny Panel in March 2017.

1.4 Targets for reducing inequalities in childhood obesity have been revised (downwards) through the development of Child Healthy Weight Strategy 2016-18. The new targets remain ambitious but recognise the scale of the challenge.

1.5 Promotion of energy switching to reduce residents' energy bills has proved not to be an effective way to address fuel poverty because of the limited reach of scheme. It is clear that a more comprehensive approach is required. We plan to undertake a further review of the problem and the opportunities for actions taking account of resource constraints.

1.6 In addition, the Annual Progress Report rated reduction in waiting times for CAMHS through effective integrated CAMHS pathways as *Amber*. Members are asked to note that the reduction of waiting times specifically for Autistic Spectrum Disorder Assessment/Diagnosis remains problematic. Commissioners are working with the provider (SW London & St George's NHS Mental Health Trust) on actions to secure improvements in the short term, while a more systematic review of the pathway is planned to ensure a solution for the longer term.

1.7 The Health & Wellbeing Board considered the new Child Healthy Weight Strategy 2016-18 at its March meeting, and further progress on implementation has been made to date.

1.8 The social prescribing pilot went live in January 2017 in two volunteer practices in East Merton. By the end of May 2017, 84 new patients had been seen by the Social Prescribing Coordinator with issues relating to social isolation and mental health, and subsequently patients are accessing community services including volunteering opportunities.

Health & Wellbeing Strategy 2015-18: Update Monitoring Report

1. Purpose

This is an update paper following the Health & Wellbeing Board's consideration of the Annual Progress Report 2016 on implementation of the H&WB Strategy 2015-18 at its November 2016 meeting.

The purpose is:

- To report on the overarching aim of the strategy-the reduction in health inequalities within borough (as measured by life expectancy)

- As requested by the Board, to update on the three areas identified as 'red' in the H&WB Strategy Annual Progress Report 2016:
    - Immunisation
    - Childhood obesity
    - Fuel poverty & energy switching

- To update on the Health & Wellbeing Board 2016/17 priorities
    - Childhood obesity
    - Social prescribing.

2. Trends in life expectancy between different areas in Merton

The Health & Wellbeing Strategy has the broad goal of *achieving a fair share of opportunities for health and wellbeing for all Merton residents* as measured by trends in life expectancy within Merton.

Measuring trends at sub-borough level over time poses methodological difficulties. We have developed a working methodology that examines the differences in life expectancy between the most deprived wards and least deprived wards within the borough over time.

The initial findings are set out below.

In summary the trend for women is positive- the difference in female life expectancy between the most deprived and least deprived wards in the borough has reduced.

In contrast, the difference in male life expectancy between the most deprived and least deprived wards has increased slightly.

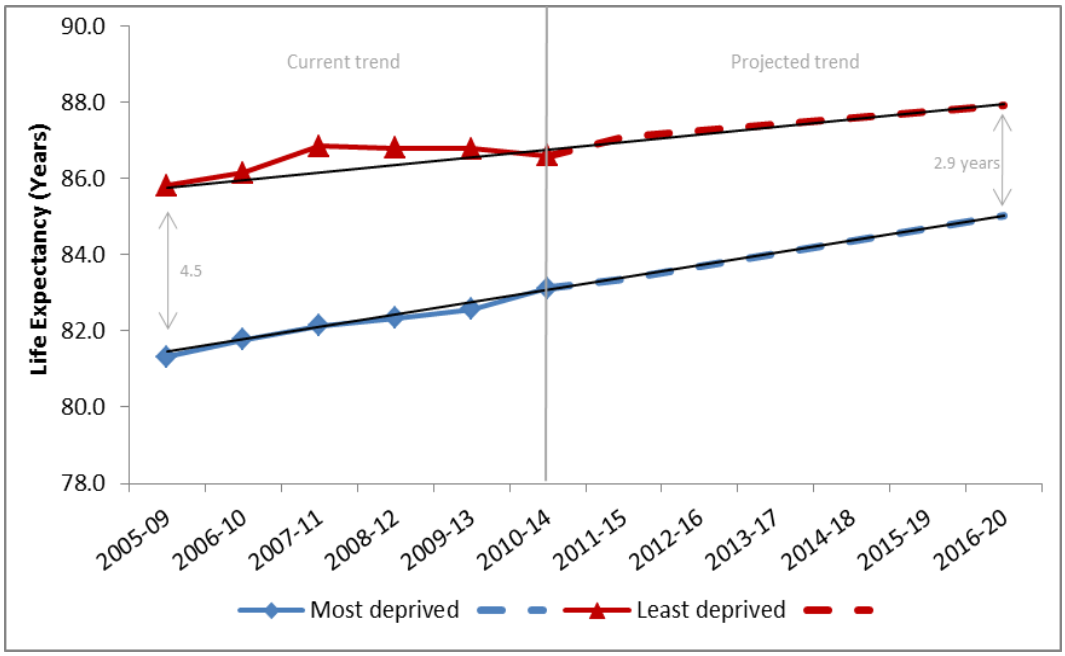
The Public Health Annual Report for 2017/18 will focus health inequalities. The intended aim is to describe and analyse the trends in health inequalities between different communities in Merton and thereby define the nature of the challenge and the potential for closing the gap.

Female life expectancy

Female life expectancy for most deprived wards has increased by almost 2 years at a rate of 0.4% over a 9 year period (2005-2014) from 81.3 years to 83.1 years. In least deprived wards female life expectancy has increased by 0.8 years from 85.8 years to 86.6 years, at a rate of 0.2%.

The gap in female life expectancy at birth between the most deprived and least deprived wards in Merton has **decreased** over a 9 year period (2005-2014) from 4.5 years to 3.5 years. Projections of this trend to 2020 this shows a **narrowing** of the gap of 2.9 years.

Female Life Expectancy at birth

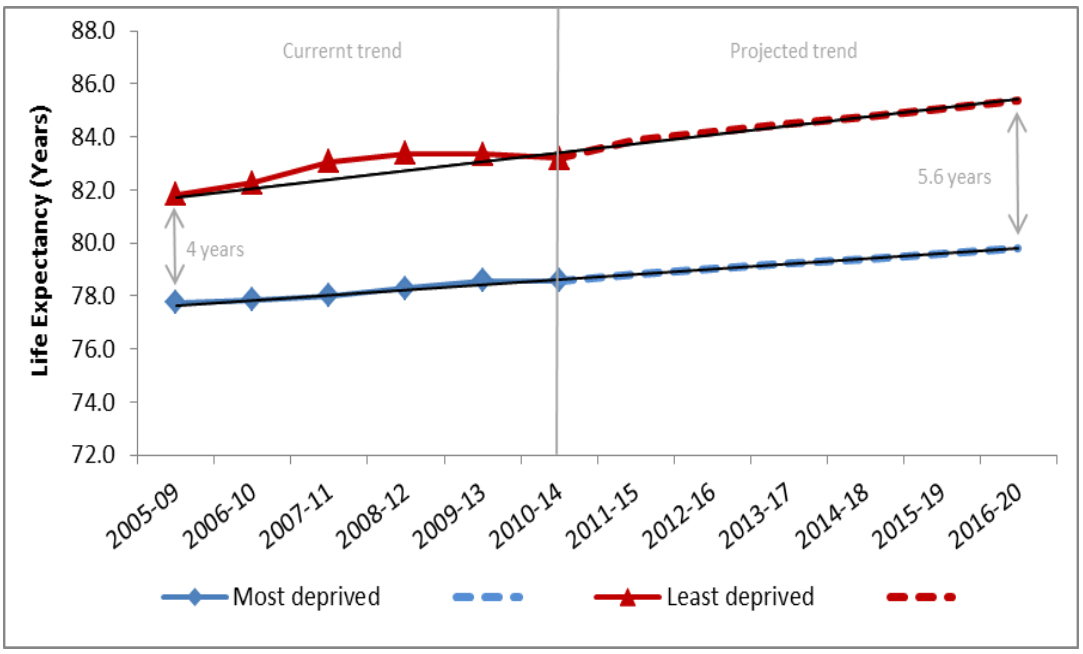


Male life expectancy

Male life expectancy for most deprived wards has increased by only 0.8 years at a rate of 0.2% over a 9 year period (2005-2014) from 77.8 years to 78.6 years. In least deprived wards male life expectancy has increased by 1.4 years from 81.8 years to 83.2 years, at a rate of 0.4% which is double the rate compared to females.

The gap in male life expectancy at birth between the most and least deprived wards in Merton has **increased** over a 9 year period (2005-2014) from 4 years to 4.6 years. Projection of this trend to 2020 this shows a **widening** of the gap of 5.6 years.

Male life expectancy



2. Areas at risk of not achieving target outcomes for 2017/18

2.1 Uptake of child immunisation is increased

The target of achieving 87.6% MMR uptake at aged 5 by 2018 will be challenging

Although the uptake rate has improved from the baseline to above 80.4% (2014/15), the most recent data (79.8% at Q3 2016/17) shows that sustaining the improvement is difficult.

The Healthier Communities and Older People Overview & Scrutiny Panel considered *Childhood Immunisations* at its March 2017 meeting. A paper prepared by NHS England (NHSE) reported performance and set out the action plan for improvements.

The MMR uptake at age 5 in Merton remains significantly lower than England but similar to London.

The Merton Childhood Immunisation Steering Group (with NHS England, MCCG, Public Health and providers) is working to take forward the actions to improve immunisation uptake. These actions have included:

- NHS England visiting GP practices and providing advice on improving performance on childhood immunisations and child flu uptake.
- PHE and NHSE providing training on changes to the immunisations schedule,
- Health visitors promoting immunisations and signposting families
- Continued promotion of childhood immunisations e.g. through '*My Merton'*

The H&WB Board will need to continue to monitor performance.

Outcome Indicator	Baseline	Current	Target	RAG rating	Commentary
Immunisation - MMR2 at 5 years	72.2% 2013/14	80.4% (2014/15) 80% (2015/16) 79.8% (Q3 2016/17)	87.6% (2018) National target 95%	R	MMR2 has increased from 72.2% baseline in 2013/14. However the recent data shows a slight decline in performance.

2.2 Inequality in childhood obesity is reduced

The marked inequality in childhood obesity between east and west Merton is increasing, while for the borough as a whole, the level of excess weight in children has reduced (and met the H&WB strategy target).

The Child Healthy Weight Strategy 2016-18 was approved by Cabinet in January 2017. The Annual Public Health Report 2017/18 focused on childhood obesity- and demonstrated the scale of challenge. Trends and projections show a widening gap in childhood obesity.

New targets to reduce inequalities have been agreed through this process of strategy development, specifically

- To halt the widening gap in the proportion of obese 10-11 year olds between east & west Merton –target –not to excess 2015/16 gap of 9.2%
- To reduce the gap in proportion of obese 10-11 year olds between east & west Merton –target 8% by 2016/17-18/19 (three year aggregate figures)

Outcome Indicator	Baseline	Current	Target	RAG rating	Commentary
Gap between % of 10-11 year olds with **obesity** weight between east and west Merton	6.2% 2010/11-2012/13 (rolling aggregated 3 years data)	7.8% 2011/12-2013/14 -	8% 2016/17-2018/19 New target Original target 6%	R	The gap has widened since the HWBB baseline. New targets set in the Child Healthy Weight Strategy

2.3 Fuel poverty is reduced through collective energy switching

Fuel poverty is an issue of inequality**.** In the east of the borough 10.8% of households are fuel poor this is above both the London (10.6%) and national (10.6%) while in the west of the borough the rate is 10.4%. An estimated 8,400 residents in total are living in fuel poverty (source Department for Energy and Climate Change 2014).

In Merton the aim has been to promote the Big London Energy Switch to enable residents to access collective energy switching programmes as a way of reducing energy bills.

This indicator is rated red as the number of residents switching remains small (although latest figures show improvement), and the approach has proved not to be the most effective way for the council to tackle the issue of fuel poverty, or more importantly help people living who are fuel poor for the following reasons:

- People who are in debt to their energy supplier may be prevented from switching
- The offers for residents with pre-paid meters were not always very attractive
- Accessibility was an issue – the process was primarily an online procedure (although offline registration was available by phone) so online users were more likely to register
- Energy switching is more attractive to people who are able to pay their energy bills

It is clear that a combination of measures are required to address more systematically this issue. A number of other London boroughs including Sutton and Tower Hamlets have developed Fuel Poverty Action Plans- as a focus for mapping and coordinating actions.

We will undertake a further review of the problem and current activities (spanning adult social services, Public Health, Environmental Health and Future Merton) to identify opportunities for tackling fuel poverty (and related issues of winter warmth) more systematically and taking account of the limited resources available.

Potential interventions include Retrofit schemes-that improve the performance of domestic energy use, with community organisations being funded through Carbon Offset payment arrangements. The Climate Change team is currently exploring the establishment of a ‘Community energy fund’ as the means to manage Carbon Offset payments, with the potential to support such schemes.

Outcome Indicator	Baseline	Current	Target	RAG rating	Commentary
Promote & facilitate the London Energy Switch in Merton	2013/14 Total registrations: 1103 Total switchers: 117	2014/15 Total registrations: 302 Total switchers: 88 (-24% on 2013/14) 2015/16 Total registrations: 385 Total switchers: 74 (-15% on 2013/14) 2016/17 Total registrations: 254 Total switchers: 147 (25% + on 2013/14)	Increased participation of 10% annually	R	Although 2016/17 show improved performance, numbers are small ; vulnerable groups - possibly with debt & prepaid meters have difficulty switching

2.4 Waiting times for CAMHS are reduced through putting in place integrated pathways

The Annual Progress Report rated reduction in waiting times for CAMHS through effective integrated CAMHS pathways as *Amber*.

Members are asked to note that the reduction of waiting times specifically for Autistic Spectrum Disorder Assessment/Diagnosis remains problematic.

- In autumn 2016 CCG Commissioners provided approximately £634k to reduce the current waiting list backlog but indicated that no additional recurrent funding will be available in 2017/18. Alongside this, SWLStG NHS Mental Health Trust (the provider) has found efficiencies. This has achieved some increase in numbers of assessments undertaken.
- The provider (at request of commissioners) reviewed eligibility criteria for this service and made proposals that reduce the number of children and young people who are able to access a full diagnostic assessment from the Trust (focusing on those children and young people that have mental health needs and/or ADHD as well as social and communication disorder). This potentially will achieve improvements for the short term.
- A full systematic review of the pathway will be carried out over the next 12 months (across the sector) to re-engineer the ASD Pathway, to ensure sufficient capacity, and to ensure families can access the NICE compliant assessment and support they need, within acceptable timescales.

The Merton Autism Strategy 2017-2022 is currently being drafted, with *Referral and Diagnostic Assessment* as a priority theme. This will be considered by the H&WB Board at a future meeting.

3. Health & Wellbeing Board 2016/17 Priorities

3.1 Childhood Obesity

The Health & Wellbeing Board discussed the new Child Healthy Weight Strategy 2016-18 at its March meeting. Childhood obesity is now part of the Council's agreed Health in All Policies Programme.

The Child Healthy Weight Action Plan is being implemented and achievements include:

- Engagement and conversations with the local community through for example the London Great Weight Debate and now a Merton Great Weight Debate focusing on engaging residents in the east of the borough, BAME communities, children and young people to shape Merton's approach further.
- Engaging local partners such as All England Lawn Tennis Club, Sustainable Merton, schools clusters and Merton School Sports Partnership to help increase physical activity and improve food environment e.g. promoting the 'daily mile' for schools, Early Years Activation Pilot and developing a food poverty action plan.
- Developing and expanding the Healthy Catering Commitment for businesses in the east of the borough to improve the food environment e.g. through working with fast food outlets to offer healthier options and make smaller portion sizes available.
- Work to make the Wilson an exemplar in healthy weight environment combining design expertise with ideas from the community about what promotes healthy living.
- Taking actions around schools to improve air quality, as part of the Merton draft Air Quality Action Plan, and including promotion of active travel and physical activity.

3.2 Social Prescribing

Social prescribing is an important element of the East Merton Model of Health & Wellbeing – the planned blue print Merton wide service transformation. 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.

The Social Prescribing Implementation Group is managing delivery of the Social Prescribing one year pilot- with representation from Public Health, CCG commissioning, General Practice, MVSC, Health Watch and CLCH.

Key features and achievements:

- The pilot is based on Wide Way and Tamworth GP practices (population 17,400). A Social Prescribing Coordinator was appointed and is based in the practices (and hosted by MVSC).
- The total budget is £105,000-from Council Voluntary Grants, Public Health, CCG, and including £25,000 from SW London Health Innovation Network for the evaluation.
- The pilot became operational from January 2017. Patients eligible for the service are those with issues relating to social isolation, low level mental health problems and frequently presenting at general practice. By the end of May 84 new referrals were seen by the SP Coordinator, and these patients are accessing a range of community services, and also being referred to IAPT services.
- The intention is that the pilot will be expanded to a number of neighbouring practices over the next few months.
- The evaluation project has been commissioned and about to start, with a baseline report being produced in July.
- A learning event is planned for early July-bringing together experiences from a number of related navigator /case management projects in the borough.
- A funding plan is being prepared and a Big Lottery funding bid will be made in June/July to secure funding to cover the scaling up of the service to all practices in 2018.

Committee: Health and Wellbeing Board

Date: 20 June 2017

Agenda item:

Wards: All

Subject: **Merton's Joint Strategic Framework for Prevention of Substance Misuse and related harm 2017-2021**

Lead officers: Chris Lee, Director Environment & Regeneration, Dagmar Zeuner, Director of Public Health

Lead member: Tobin Byers, Adult Social Care & Health

Forward Plan reference number:

Contact officer: Amanda Killoran, Public Health Consultant

Recommendations:

Board members are asked:

A. To consider the Merton Joint Strategic Framework (LBM & MCCG) for Prevention of Substance Misuse and related harm 2017-21.

B. To endorse the whole systems perspective as the means of achieving shared outcomes and maximising the impact of limited resources, and specifically recognising that the current re-procurement of the Adult Substance Misuse Treatment Service is an important 'invest to save' measure –helping to reduce costs to health, social care, welfare and criminal justice.

C. To note that the Safer Stronger Executive Board has oversight of the implementation of Substance Misuse Strategic Framework Action Plan- to ensure cross council, CCG and partners' ownership and commitment.

D. To consider opportunities for Health & Wellbeing Board members to champion the SM strategic objectives and actions as systems leaders.

---

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to set out the Merton Joint Strategic Framework (LBM & MCCG) for Prevention of Substance Misuse and related harm 2017-21.

The overall aim of the Strategic Framework is to reduce the significant harm caused by alcohol and drug misuse to individuals, families and communities in Merton.

The Framework takes forward specific objectives of the Health and Wellbeing Strategy 2015/18, Children and Young People's Plan, and CCG Whole Merton Vision & Strategy, and contributes to the implementation of the Safer Stronger Merton priorities (including domestic violence). Tackling alcohol and drug misuse will also help close the gap in health inequalities between the west and east of the borough.

The Strategic Framework is a whole systems response to the problems relating to alcohol and drug misuse, and to achieving desired outcomes (reduced levels of substance misuse, and alcohol-related hospital admissions and crime)[1].

The Framework is designed to enable decisions about resources and savings to focus on achieving the shared intended outcomes spanning health, social care, welfare and community safety and criminal justice. Investment in prevention, early intervention and treatment represent invest to save measures –helping to reduce costs to the system.

The Framework specifically informs the current redesign and re-procurement of the Adult Substance Misuse Treatment Service, and decisions about investment and the potential for savings. The aim is to establish a more integrated recovery-based service model to improve successful treatment rates and help reduce costs elsewhere.

To date, within the Council and CCG, the prevention of substance misuse and related harm has not had a strategic profile. The Safer Stronger Executive Board will now take oversight for the implementation of the Strategic Framework Action Plan.

The Health & Wellbeing Board is asked to consider and endorse the Strategic Framework. Members are also asked to consider the opportunities for championing the strategic objectives and actions as systems leaders.

2 DETAILS

The Merton Joint Strategic Framework for Prevention of Substance Misuse and related harm 2017-2021 is presented in appendix 1.

2.1. The health, social and economic costs relating to substance misuse to individuals, families and communities in Merton are substantial.

- In Merton, an estimated 1,800 adults have some level of alcohol dependence in need of specialist assessment and treatment[2].
- There were a total of 2,900 alcohol-related hospital admissions in 2014/15.
- The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income groups and those experiencing the highest levels of deprivation.
- Around 620 adults are in contact with specialist substance misuse treatment services annually. Alcohol is the primary presenting problem (53% of the treatment population).
- Around 60% of children and young people subject to a single assessment have one, two or all three of the 'toxic trio' risk factors- exposure to parental mental health, substance misuse and domestic abuse.

2.2. The future desired outcomes are reduced levels of alcohol and drug misuse, alcohol related hospital admissions and alcohol related crime[3].

---

[1] As measured by Public Health England national indicators and data sets.

[2] Public Health England new estimates of Alcohol Dependency in England, published March 2017

[3] New data set is due to be published by the end of 2017 for alcohol- attributable crime (for total crime, violence against the person, sexual offences and public order offences) based on a PHE methodological review of crime indicators 2016.

2.3. The Action Plan seeks to align the contributions (commitment and resources) across the council, CCG and other partners to achieve shared improvements in health, social care and community safety outcomes. It is designed to maximise the impact of the resource available and take account of severe financial constraints.

2.4. The redesign of the Adult Substance Treatment Service through the current re-procurement process is an important element of the Framework. The aim is to establish a more recovery focused service model. Research demonstrates that effective treatment has a high return on investment[4].

The total Public Health Substance Misuse 2017/18 budget is £1,461,630 (including inpatient detox service). The budget includes savings of £140,000 (£80,000 detox service plus £60,000 from the main contract with SW London & St George's NHS Mental Health Trust).

Considerable work has been undertaken to engage specialist substance misuse providers (mental health NHS Trusts and large voluntary organisations) to ensure a competitive positive response to the tender in June/July. The award of the contract is due in November 2017.

The Substance Misuse Strategic Framework is planned to be received and endorsed by the Cabinet and CCG Governing Body in November/December 2017, following formal consultation. The timing is also linked to the approval by Cabinet of the Substance Misuse Treatment contract award decision in November/December.

2.5. The overall strategic objectives and actions cover the following five areas:

- *Leadership commitment through strategic governance* –the Safer Stronger Executive Board and Health and Wellbeing Board

- *Increased focus on prevention and early intervention* -using licensing powers to secure responsible alcohol retailing, training of front line staff on alcohol awareness and brief intervention (Making Every Contact Count), and access for individuals to digital IBA (identification and brief advice).

- *Redesign & delivery of a recovery orientated drug & alcohol treatment service*- with improved access to specialist services and stronger pathways between services (primary care, mental health, and criminal justice); and stronger routes to housing, education, employment, volunteering and mutual support.

- *Reducing the harm to families, children and young people* based on clear pathways between substance misuse, domestic violence and activities to prevent violence against women and girls; as well as early identification through public health children's prevention programmes.

- *Tackling crime & antisocial behaviour relating to substance misuse* – through implementation of the Local Alcohol Action Area project, and sustained collaborative working across agencies on community safety, offender management and rehabilitation.

[4] Studies have shown that the benefits of drug treatment far outweigh the costs, with a benefit-cost ratio of 2.5:1 ie for every £1 spend on treatment £2.50 savings are achieved in the system (PHE 2017)

3 ALTERNATIVE OPTIONS

3.1. N/A

4 CONSULTATION UNDERTAKEN OR PROPOSED

The development of the Framework is based on a review process involving extensive engagement with stakeholders (colleagues across community safety, licensing, CCG, police, probation, Children, Schools and Families, and specialist providers and service users).

We plan to work with HealthWatch in undertaking a formal public consultation as a next stage.

5 TIMETABLE

The Safer Stronger Executive Board is now taking the responsibility for oversight of the SM Strategic Framework and implementation of the Action Plan.

A new Merton Substance Misuse Partnership Board has been established to coordinate implementation of the Action Plan, monitor and report progress.

The intention is that the SM Strategic Framework will be received and endorsed by the Cabinet and CCG Governing body at the end of 2017, following formal consultation. This timing is also linked with Cabinet decision on the contract award for the Adult Substance Misuse Treatment Service.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. Given the financial pressures, implementation of the Action Plan will be linked primarily to related plans and commissioning investments

6.2. The total Public Health budget for adult substance misuse treatment services 2017/18 is £1.462m (including for the Adult Substance Misuse Treatment Service inpatient detox service). The total includes a planned savings release of £140,000.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. N/A

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. Tackling drug and alcohol misuse and related harm contributes to reducing health inequalities.

9 CRIME AND DISORDER IMPLICATIONS

The Strategic Framework objectives and desired outcomes cover issues of community safety and crime reduction.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. N/A

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

11.1. Merton's Joint strategic framework for prevention of substance misuse & related harm 2017-2021 (LBM & MCCG).

This page is intentionally left blank

Appendix 1

Merton's Joint strategic framework for prevention of substance misuse & related harm 2017-2021

1. Introduction

This joint strategic framework between Merton Council and Merton Clinical Commissioning Group sets out a comprehensive programme of actions to prevent substance misuse & related harm.

The framework describes:

- The scale of the problem
- The Merton response – desired outcomes and the challenges and issues that need to be addressed
- Strategic objectives and
- Action plans

2. The scale of the problem relating to alcohol and drug misuse in Merton

Substance misuse is associated with a wide range of harmful social and health impacts and costs for the individual, families and communities.

Level of alcohol and drug use in Merton

In Merton, significant numbers are drinking at levels potentially harmful to health

- An estimated 1,800 adults have some level of alcohol dependence in need of specialist assessment and treatment (based on Public Health England (PHE) borough level estimates 2017).

Alcohol is a causal factor in a significant number of medical conditions including liver disease, heart disease, depression and stroke.

- Although Merton alcohol-related hospital admission rates are below the national average, numbers are substantial –equating to 2,900 alcohol-related hospital admissions in 2014/15.
- There has been a marked increase in alcohol-specific morality rates since 2008 (from 6.9 per 100,000 population in 2008/9 to 10.2 in 2013/14).

Co-morbidity of drug and alcohol problems and mental illness is frequent. Approximately 40% of people with psychiatric disorders, misuse substances at some point in their lifetime, at least double the rate seen in the general population.

Health inequalities

The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income groups and those experiencing the highest levels of deprivation. This pattern exists despite the data showing that lower income groups do not tend to consume more alcohol than people from higher income groups.

- This pattern of inequality is marked between the East and West of the borough, with a higher rate of alcohol-related admissions in the more deprived East compared to the West.
- Those groups most at risk of harm relating to both alcohol and drug misuse include families with children in care or those excluded from school, those in contact with criminal justice or mental health services and homeless people.

Harm to children and families

Parental substance misuse, together with mental health and domestic abuse ('toxic trio') are the major risk factors that impact negatively on a child's health and wellbeing both immediately and longer term.

- Parental substance dependency is a common feature in social work cases.
- PHE is due to publish shortly borough level estimates of the number of children likely to be negatively affected by parental alcohol dependency.
- 20% of new alcohol presentations are parents living with children (2015/16) vis 24% nationally

Crime and anti-social behaviour

Availability and affordability of alcohol are the most significant factors influencing levels of alcohol consumption. The volume of alcohol sold in Merton through off licenses is similar to the national average, although higher than the London average- with Merton ranking the tenth highest in London. The two Cumulative Impact Zones (CIZs) in Merton are vital measures regulating alcohol outlet density and availability, together with sustained use of licensing powers

Alcohol is associated with a wide range of criminal and anti social behaviour, particularly public drunkenness and street drinking, violence, domestic violence, injury and deaths and casualties due to road traffic accidents.

- Merton's participation in the Home Office/ DH initiative Local Alcohol Action Areas is providing a focus for strengthening agencies' collaborative response to problems in Wimbledon and Mitcham Town Centres.

Specialist substance misuse treatment services

617 adults were in contact with specialist substance misuse treatment services in 2015/16. 290 (47%) were treated for drug misuse, and 327 (53%) for alcohol. The treatment profile in Merton is distinct compared to other London boroughs with a much greater proportion of alcohol clients. Alcohol is the dominant condition in new presentations to substance misuse services, representing 64% of all presentations (2015/16).

Evidence suggests that Merton has comparatively lower service 'reach' for drug treatment. Only 25% of estimated numbers of opiate users are accessing specialist services compared to 50% nationally. Also waiting times for alcohol are higher than the national average.

Overall outcomes are comparatively positive as measured by rates of successful completion of treatment, (except for opiates) (2016/17). 60.2% of alcohol clients completed treatment successfully, a rate higher than the national average (39.2%). The rate of successful treatment completion for opiate users was 9.4%. This is a continuous decline over previous years (similar to the national trend). However Merton's ranking has declined continuously against 'comparator' boroughs.

Around 20% of substance misuse clients were treated concurrently for mental illness.

3. Merton response: a partnership (whole system) approach to the problem

Policy and evidence define clearly what actions are effective in reducing misuse of alcohol and drugs and associated harm. A model based on prevention, early intervention and recovery is known to be highly cost effective, in combination with wider community safety, licencing and enforcement measures.

Desired outcomes[1] are:

- More people access and benefit from alcohol and drug prevention and early intervention services
- More people successfully recover from drug and alcohol problems and are engaged in education and employment and are not offending
- Fewer people admitted to hospital with alcohol and drug related conditions
- More children and young people are protected from the harm related to parental substance misuse, including domestic violence
- Fewer young people report drinking alcohol or using illicit drugs
- Fewer people engage in alcohol and drug related antisocial behaviour and crime[2]

[1] As measured by Public Health England national indicators and data sets

[2] New data set is due to be published by the end of 2017 for alcohol- attributable crime (for total crime, violence against the person, sexual offences and public order offences) based on a PHE methodological review of crime indicators 2016.

Prevention and intervention services are ‘invest to save’ measures –avoiding the significant costs to the health and local authority budgets. Without this sustained strategic investment the harm and associated financial costs are likely to increase.

Review of current approaches and services has been undertaken over the last six months through engagement with partners, and benchmarking against evidence base practice, and taking account of financial constraints.

Engagement activities have included multi-agency workshop events (including with service users), discussions with CCG clinical leads, and also service users’ focus group work.

Key issues and challenges are:

- Overall low strategic profile of drug and alcohol and lack of overview of coherence of activities across sectors and agencies.
- Availability and affordability of alcohol particularly of high strength beers, and need to sustain and use all prevention opportunities relating to the licensing system measures
- Prevention and early intervention activities for adults underdeveloped, including limited identification and brief advice within all key front line services.
- Individuals and families dealing with alcohol dependency report lack of information about the range of services available–with difficulties in accessing and navigating different services, issues of stigma and discrimination, and limited access to mutual support –viewed as vital to recovery
- Comparative low ‘reach’ of the specialist treatment services among drug users, and need for specialist services to respond to changes in pattern of drug use- including increasing problematic use of some prescription and over the counter medicines.
- Variable relationship between primary care and specialist substance misuse services –including need for better communication and a collaborative approach to case management of clients in recovery.
- Underdeveloped routes to recovery-housing, education and employment and mutual support services.
- Gaps in the criminal justice pathway for treatment and recovery of drug and alcohol problems, including difficulties relating to organisational changes in probation and community rehabilitation services (NPS and CRC)

4. Strategic objectives

Objectives

- To embed efforts to prevent substance misuse and related harm within council strategic governance and partnership arrangements (particularly through establishment of Substance Misuse Strategic Partnership Board accountable to the Safer Stronger Executive Board)

- To increase and improve the effectiveness of alcohol and drug prevention and early intervention services, including access to and uptake of alcohol screening and brief interventions across all appropriate health, social care, youth, criminal justice and community settings.

- To improve the effectiveness of specialist treatment services for substance misuse with the focus on recovery goals of education, housing, employment and family and social networks.

- To strengthen effective partnership arrangements, pathways and protocols to protect and promote the health and wellbeing of children and young people affected by parental substance misuse

- To ensure effective joint working between specialist services for adult and young people specialist services for alcohol and drug problems, including transition between young people and adult specialist treatment services.

- To reduce the negative impact of substance misuse (alcohol and drugs) on levels of crime and anti-social behaviour and the fear of crime on residents.

Action Plan

Theme 1: Governance, Partnerships and Communication				
Objectives	**Tasks**	**Who/lead**	**When completed**	**Expected outcomes/benefits**
To strengthen strategic governance arrangements for the substance misuse agenda within Merton.	• Agree oversight for the SM Strategic Framework by the Safer Stronger Executive Board, with link to HWB Board • Establish a Substance Misuse Partnership Board (SMPB). Membership to included: o CCG o Mental health o CSF (incl safeguarding) o Service user/Carer representation o Public Health o Adult Social care o MVSC o CRC/NPS/YOT o Police o Community Safety o Housing o PH England	Public Health (PH)	06/2017	• Defined accountability for the conduct of the substance misuse agenda • Improved outcomes across a range of agendas : o Treatment o Domestic Violence /VAWG o Health o Mental Health o Crime/ASB o Children's and Adult Safeguarding
To develop a shared awareness and commitment across Council of priorities related to substance misuse and its impact across other service areas		PH	06/2017	
Reduced inequalities in access and outcomes for those under represented within services	• Equality Audit completed for the Adults and YP Substance misuse services at appropriate points e.g. procurement and annual basis.	PH Community	11/2017	• Ensure and improve access to treatment for groups and individuals underrepresented within services.

	• Equality Audit completed for LAAA.	safety (CS)/PH	07/2017	
To ensure community and service user participation in the design and delivery of substance misuse treatment services.	• Establish a service user council to facilitate a 'voice' for service users in treatment • Include service user voice in SMPB • User voice within commissioning process – tender, monitoring, training, review and design.	PH	12/2017 06/2017	• Contribute to the development of relevant, person centred substance misuse services • Improved 'recovery capital' in service users that choose to engage
To strengthen operational partnership arrangements between stakeholders.	• Identify operational partners, services and stakeholders in delivery of substance misuse. • Explore opportunities for a Substance Misuse operational delivery group (SMODG) meeting.	PH PH	06/2017 07/2017	• Maximising impact and use of resources • A shared understanding among stakeholders of the priorities/issues related to drug and alcohol and there impact on Merton residents • An improved 'client journey' for those accessing substance misuse treatment services • Improved recovery outcomes for those with comorbidity.
To effectively embed key messages associated with Substance Misuse within related work streams, to develop a shared understanding, increase awareness, minimise duplication.	• Ensure Substance misuse has profile in other relevant strategies including: o Mental Health o Sexual Health o Community Safety o Teenage Pregnancy and Substance Misuse strategy	PH	03/2020	
To ensure that Social Value is realised as part of the adult substance misuse procurement, and pilot the process, with a view to roll out across Public Health/Council.	• Develop and pilot an approach to social value as part of the method statements in the substance misuse contract. • Refine approach for roll out in other procurements across Public Health/council.	PH Commercial & Procuremen	12/2017 03/2018	• The roll out across the Council of Social value through procurement • Improved social, economic, and environmental well-being for Merton residents as a consequence of procurement activity.

		t (CP)		
To ensure that all contracts that the council has, incorporates prevention (Health in All Policies).	• Explore opportunities as part of HIAP to incorporate prevention e.g. supporting key campaigns including substance misuse.	PH/CP	03/2020	• Improved accountability for prevention throughout Council contracts • Improved life chances for people at risk • Improved preventative health outcomes for Merton residents
Theme 2: Prevention and early intervention of alcohol and drug related problems				
Objectives	**Tasks**	**Who/lead**	**When completed**	**Expected outcomes/benefits**
To raise awareness of the harms associated with drugs and alcohol use amongst those that live and/or work in Merton.	• Make Every Contact Count and develop training for front line staff in Drug & Alcohol Awareness and Identification and Brief Advice (IBA). (including use of over the counter/prescription medications) • Targeted and coordinated social marketing, linked to national messages, to raise awareness on alcohol and encourage responsible drinking behaviour. • Improve the promotion and awareness of substance misuse treatment advice and services and what they have to offer. • Develop and/or signpost to up to date alcohol and other drug information available in public places.	PH PH PH PH	03/2018 03/2020 06/2018 03/2018	• Earlier intervention in parental substance misuse • Reduction in drug & alcohol related crime and ASB. • Reduction in drug & alcohol related health harms. • Merton residents are able to make informed choices regarding drug and alcohol use • Reduction in harmful and hazardous drinking behaviour • Fewer people will experience the harm relating to drug and alcohol misuse • Reduce the financially impact on the adult Social care (Residential Care)

To identify and actively engage with populations at high risk of alcohol and drug harms.	• Identify key groups and communities at risk of substance misuse and use segmentation to inform assertive outreach and engagement. • Link service information and advice to GIO website	PH	03/2018	• Greater understanding of drug and alcohol use among hard to reach communities • Reduction of health harms among older Merton residents • Reduction in Accident and Emergency presentations • Reduction in alcohol related hospital admissions • Reduction in the instances of street drinking • Prevention of drug related deaths and infection by Blood Borne Viruses
To increase the identification of increasing and high risk drinkers.	• Embed digital IBA into the One You Merton service. • Develop the promotion and delivery of IBA in healthcare and other settings e.g. workplaces. • Explore opportunities for alcohol screening through CQUINs. • Include alcohol prevention measures within QUIP programme • Explore opportunities for supporting healthy ageing.	PH PH PH/CCG PH/Adult social Care (AS) To be Confirmed	06/2017 09/2018 12/2018 03/2019	
To reduce the instances of Drug & Alcohol health harms.	• More targeted work within Accident & Emergency settings, with robust pathways into community drug & alcohol treatment services, to reduce and prevent drug and alcohol attributable hospital representations. • Increase the use of ambulatory alcohol detoxification initiated within the hospital setting.	PH/Adult Treatment Provider (ATP)/CCG PH/Adult Treatment Provider	09/2018 09/2018	

		(ATP)		
To reduce the availability of high strength (over 6% abv) beers in Merton.	• Work in partnership with Responsible Authorities to continue to improve the approach to challenging high risk licence applications.	Licencing (LI)	03/2020	• Reduction in Alcohol related Health Harms • Reduction in Alcohol related crime and ASB
To prevent drug and alcohol use among young people.	• Work with colleagues in CSF to work closely on their action plan linked to Young Peoples service. • Combat alcohol sales to underage drinkers	PH/ Children's Commissioner (CC) CS	12/2017	
To support partners in Primary Care to have confidence around tackling substance misuse and be able to identify, engage and signpost/refer their patients to appropriate services and tools.	• Attend Practice Led Training for Primary Care to raise awareness of substance misuse pathways. • Support closer working between primary care and substance misuse services.	PH PH/CCG	03/2019 03/2019	• Primary care services competent to support those with substance misuse issues.
Theme 3: Recovery orientated drug and alcohol specialist treatment				
Objectives	**Tasks**	**Who/lead**	**When completed**	**Expected outcomes/benefits**
To carry out a procurement of a recovery outcome based Integrated Drug and Alcohol Treatment System	• Engage with potential providers to establish interest within the market • Work with potential providers to upskill market on social value requirements • Engage with the market place to	PH/ CP	12/2017	• Recovery outcome based treatment service delivering on Merton substance misuse vision • Those with substance misuse will achieve sustained recovery from drug and alcohol problems.

	develop specification and priorities			• Reduction of the impact of drugs and alcohol on families. • Reduction in A&E and hospital admissions
To communicate an ambition for recovery in all aspects of drug and alcohol service delivery.	• To develop current workforce to enable delivery of evidence based recovery focused interventions including: o Carry out a Training Needs Assessment (TNA) among current staff to identify training needs with regard to recovery focused delivery of services o Support provider to develop a training and development plan for current and future staff	PH/ATP	03/2018	
To fully integrate a recovery-based approach within the whole treatment community.	• To carry out a recovery audit of current provision including: o Mapping of current recovery support available to clients and families. o Audit current provision against the recommendations of 'Medicines in Recovery', and develop an action plan is in place to address gaps in provision.	PH/APT	03/2018	• Improved outcomes for those accessing services • Improved access to treatment opportunities for those accessing services
To improve outcomes for those accessing the treatment system.	• Implement the outcome star model across treatment services. • Effectively monitor service delivery through robust contract monitoring.	PH/ATP PH/ATP	03/2018	• Freedom from dependence on drugs or alcohol • Improvement in mental and physical wellbeing

	• Adult Treatment Provider to be develop approaches to attract treatment naïve drug users. To include: o Engagement with diverse community groups o Developing outreach opportunities with establish street agencies	PH/ATP PH/ATP	Ongoing 03/2019	• Prevention of drug related deaths and infection by Blood Borne Viruses • Reduction in crime and re-offending • Sustained employment • Access to and sustained suitable accommodation • Improved relationships e.g. family members, partners and friends • Effective and caring parenting
To facilitate the development of recovery capital among service users by improving pathways into ETE, work opportunities and housing.	• Community substance misuse service to develop links with local ETE providers. • Community substance misuse service to develop links with housing providers. • Community substance misuse team to have a named housing champion among workforce.	ATP ATP ATP	06/2018 06/2018 06/2018	
To develop a visible recovery community in Merton.	• Identify named Recovery Champions within the recovery community. • Ensure mutual aid representation within the SMPB. • To develop a register/directory of Mutual Aid opportunities within Merton. • Support Mutual aid organisations access to Council events.	ATP PH PH Community Engagement (CE) To be Confirmed	06/2018 06/2017 12/2017 Ongoing	• Sustained recovery among those exiting services
To strengthen pathways between substance misuse services and key clinical services such as Drug	• To formalise pathways between clinical services and the community substance misuse team.	ATP	06/2018	• Improved outcomes for those with comorbidity • Improved outcomes for children

and Alcohol Liaison, Maternity, IAPT and Psychiatry liaison.	• Ensure clinical services representation on the SMODG • Community substance misuse team to adopt an assertive outreach approach for service users who access alcohol liaison services • Develop, alongside secondary services a frequent attender strategy for A&E. • Review the model for joint working (between mental heath/IAPT and SM services) on dual diagnosis	PH ATP	07/2017 06/2018	impacted on by parental substance misuse • Reduce the impact of substance misuse on A&E and hospital beds.
To ensure effective links are in place between the substance misuse services and other specialist mental health services to improve outcomes for clients with comorbid mental health and drug and alcohol problems		CCG To be Confirmed	06/2018	• Improved outcomes for those with severe and enduring mental ill health
Develop the role of Primary care to support the delivery of drug and alcohol/drugs prevention & treatment, including the effectiveness of the pathway between Primary care and the Adult Treatment Service	• Raise profile of substance misuse services among primary care practitioners by development of a communication plan • Carry out a training needs assessment among primary care practitioners (GPs and Pharmacists) to establish training needs around substance misuse • Support General Practice role through appropriate training • Improve pathway between primary care and the community substance misuse team by ensuring LPC and LMC engagement with the SMPB/SMODG.	PH CCG To be Confirmed CCG To be Confirmed	06/2018 03/2018 Ongoing	• Increased competence of primary care in alcohol and drugs • Improved physical health outcomes for those with substance misuse

	• Improve communication between primary care and specialist SM treatment service regarding referrals, case management & recovery • Develop a liaison function between General practice & Adult Treatment Service for effective case management & recovery	PH/ATP/PC	07/2017	
Understand local trends in alcohol/ drug consumption to inform targeted work.	• Analyse NDTMS data on a quarterly basis and report to SMPB. • Review the use of New Psychoactive Substances (NPS) and Image and Performance Enhancing Drugs (IPED) among the Merton population • Consider problems relating over the counter and prescription medication • Develop strategies to respond to immerging threats • Carry out survey of current service users.	PH PH PH ATP	Ongoing 03/2018 Ongoing 06/2018	• More targeted approach to commissioning of drug and alcohol services. • Reduction in health and Crime/ASB harms
Improved pathways between treatment and internal statutory services such as Adult social Care and CSF.	• Ensure that Adult social Care (ASC) and Children, Schools and Families (CSF) have representation on the SMPB and SMODG. • Ensure the provider develops robust working relationship with statutory services.	PH ATP	06/2017 06/2018	• Maximising impact and use of resources • Improve children's and adult safeguarding. • Improve outcomes for Children and families.

Theme 4: Families, children and young people				
Objectives	**Tasks**	**Who/lead**	**When completed**	**Expected outcomes/benefits**
Embed 'Think Family' across all aspects of substance misuse strategy and delivery.	• Provider to fully engage with the Family Drug and Alcohol Court (FDAC) • Review the alignment of substance misuse delivery against CSF and Teenage pregnancy Board (or future equivalent) activity	CSF/PH/ATP	06/2018	• Improvement in children's and adult safeguarding. • Improve outcomes for Children and families. • Earlier identification of children at risk
Work with whole families and other agencies to assess and regularly review the family's interrelated strengths, resources, needs and risks using a 'whole family' or holistic approach.	• Ensure that family work is integrated into current provision and is specified within future service provision. • Signs of Safety training and/or brief intervention training for providers • Access to MSCB training for providers	PH/ATP	06/2018	
Increased identification of parental substance misuse and early referrals of children and young people to appropriate support services (Hidden harm).	• Increased use of CAF by treatment services • Increased referrals between social services and treatment services • Develop reciprocal in reach between CSF and substance misuses services	ATP/children, Family Services (CSF) **To be Confirmed** ATP/CSF	09/2018 09/2018	

		PR/CSF	12/2018	
Identify drug and alcohol misuse among Looked after Children (LAC) and those young people leaving care	• Ensure that substance misuse during assessment and review of LAC and those leaving Care	CSF	03/2018	• Improved outcomes for LAC and those Leaving care.
To improve pathways between adults and young people services for those in transition (18 – 24).	• Strengthen the transition between young people and adults services.	ATP/RR	06/2018	
To improve communication and pathways between Substance misuse, domestic violence and VAWG.	• Establish pathways between substance misuse, domestic violence and VAWG • Ensure domestic violence and VAWG representation on the SMODG • Arrange reciprocal training between agencies to ensure shared understanding of the cohort.	VAWG Coordinator(VC) ATP/RR/VC	06/2018 07/2017 09/2018	• Reduction in violent crime among those using drugs and/or alcohol • Improved relationships • Effective and caring parenting

Theme 5: Tackling crime and anti-social behaviour relating to substance misuse				
Objectives	**Tasks**	**Who/lead**	**When completed**	**Expected outcomes/benefits**
To utilise and develop existing CSP and police interventions and resources to reduce alcohol related violence against the person offences.	• Police to utilise: o Closure powers o Criminal Behaviour orders • Local authority to utilise: o Community protection orders (CPO) o Closure powers o Injunctions	CS/Police (MPS) CS	03/2020 03/2020	• Supports the discharge of the Council's statutory functions in relation to Public Safety, Protection and Wellbeing. • Reduction of Alcohol related violent crime. • Reducing the risk to children and families. • Reduction in Accident and Emergency presentations • Reduction in alcohol related hospital admissions
To utilise and develop existing CSP and police interventions and resources to reduce alcohol related Anti Social Behaviour (ASB).	• Develop a legal framework to be in a position to implement Public Spaces Protection Orders (PSPO) where necessary	CS	03/2018	
To continue to make effective use of existing and new licensing and policing powers.	• To carry out regular licence reviews • To keep abreast of changing /developing legislation and guidance.	LI CS/LI	Ongoing Ongoing	
Continue a rigorous approach to enforcement of licensing legislation.	• Strengthen licensing, representations, awareness and partnerships. consider link of business crime radio scheme as a condition of license	CS/LI	03/2018	
Improve intelligence by information sharing to manage risk.	• Improve intelligence sharing, linked to engagement of substance misuse partnership.	PH/CS	12/2018	

	• Import good practice from the MOPAC Business Crime reduction Partnership (BCRP) such as use of Radio Scheme.	CS	06/2018	
Improve outcomes for those Merton residents with substance misuse problems released from prison.	• Community substance misuse team to attend the Continuity of Care meeting in both the male and female prison establishments. • The community team to adopt the use of peer/volunteer escorts from prison to the community team • The community team to develop pathways with the Community rehabilitation Company (CRC) 'through the gate' service • CRC to attend the SMODG	PH/ATP ATP ATP PH	06/2017 09/2018 09/2018 07/2018	• Reducing reoffending among Merton residents released from prison. • Reduction in drug related death among this high risk cohort
Improve engagement and outcomes for those subject to Offender management	• Community provider, CRC and IOM coordinator to develop pathways for Merton residents subject to Offender management. • CRC and community provider to consider co-location opportunities or the establishment of a virtual offender management team.	IOM Coordinator (IOM) IOM	06/2018 06/2018	• Reduction of reoffending

Committee: Health and Wellbeing Board

Date: 20 June 2017

Subject: Wilson Health and Wellbeing Campus: progress report

Lead officer: Andrew Murray, Chair, MCCG / Dagmar Zeuner, Director of Public Health, LBM

Lead member: Cllr Tobin Byers

Contact officer(s): Douglas Hing, MCCG Clinical Director of the East Merton Model of Health and Wellbeing; Anjan Ghosh, Public Health Consultant, LBM

Recommendations:

A. To note the progress of the Wilson development and the reporting and accountability systems that have commenced.

B. To note the Wilson Health and Wellbeing Campus Development PID (Project Initiation Document) and consider ways to support and facilitate the progress.

C. To consider and make recommendations on the most appropriate method of engagement with the public and communities, identifying the key messages for this stage of the programme.

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The report describes the PID, some of the achievements to date, the issues and challenges being faced, and the next steps.

2 BACKGROUND

2.1. This paper follows on from the last report presented at the HWB meeting on 28th March 2017.

2.2. This cover paper reflects the contents of the Wilson Health and Wellbeing Campus Development PID presented to the Wilson Programme Board (WPB) on 8th June 2017. The full report is in the appendix.

3 DETAILS

3.1. The PID in the appendix is a key document that outlines a continuous reporting process and reflects the development of the Wilson Programme Office, the role of the Wilson Programme Director (Sue Howson), and the development of the two main work streams (Community Development, and Service Design and Commissioning – the “clinical design” work stream) and the OPE project. It also describes the other work streams and the scope of their work.

3.2. The PID describes the case for change, programme aims and objectives, the scope of the programme, expected benefits, constraints, dependencies and governance arrangements.

3.3. The individual work streams submit their highlight reports to the Programme Office, based on which the overall highlight report is drafted. This is then presented to the Wilson Programme Board every month.

3.4. While much progress has been made and both the community and the clinical design have moved forward since the last HWB meeting, some difficulties have been experienced in gaining activity information in respect of the services identified to be located on the Wilson site.

3.5. The service design for the clinical (health) facility has been substantially agreed. Areas that are being explored further are: the primary care offer, and child development services.

3.6. At the WPB in May an approach was agreed for taking the work forward on the community (wellbeing) facility, in order to narrow down the long-list of the wellbeing services/ components to a realistic and feasible set of options that the initial wellbeing model and the “build” could be based on. The WPB approved a set of criteria to evaluate the options in order to come up with this short-list.

3.7. A template was developed and agreed, and leads in various areas helped to complete the templates for the long-list of options.

3.8. Based on the learning from visits to the Bromley By Bow Centre, and our own experience with the building of the Nelson Health Centre, the thinking is that while it will be challenging (but not impossible) to raise the necessary capital for the Community Facility (based on a set of assumptions in relation to NHS Properties), the main challenge will lie in sustaining the services and projects through sustainable revenue streams. These are anticipated to be primarily through commissioning routes and funding streams in the Council and the NHS.

3.9. Therefore the worked up of options have particularly examined feasibility in the light of sustainable revenue streams through existing contracts for commissioned services.

3.10. As with the clinical facility, the community facility need to articulate the space requirements and “build” footprint for the Post PID Options Appraisal (PPOA) and this is an urgent priority. However much of this information is not easily obtainable without the services the options relate to, being involved. This has considerable sensitivities around it and there needs to be a clear approach towards such engagement and involvement. We are looking to work with proxies and “best guesses” as a mitigating approach should this information not be forthcoming in the next couple of weeks.

3.11. The work with OPE is also going ahead at a good pace, with an interactive map of public assets having been developed (available via email from mailto:katharine.thomas@merton.go.uk).

3.12. **Key next steps:**

3.12.1 Prepare demand and capacity model for health and wellbeing services

3.12.2 Community Development Project Initiation Document

3.12.3 Commence PPOA – source benchmark data for economic appraisal

3.12.4 Children's Services workshop scheduled for 21st June

3.12.5 Initiate Communication and Engagement work stream

3.12.6 Initiate Young Health Inspectors Programme

3.12.7 Plan Nelson Lessons Learnt process

3.12.8 Plan Primary Care workshop for July (date to be confirmed)

4 ALTERNATIVE OPTIONS

4.1. Not applicable.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. Community conversations were undertaken in 2016 in August and September.

5.2. Workshops have been undertaken with commissioners, providers and clinicians. Further workshops for children's services and primary care are planned. Children's work shop is scheduled for 21st June and primary care for 26th July.

5.3. In order to develop the model and the functions and services in the new campus, there will be reference groups aligned with the community facility design and the clinical design work streams. These will have stakeholders from community groups, voluntary and statutory sectors.

5.4. Further consultations will be undertaken as necessary for specific service areas.

6 TIMETABLE

Please see page 20 of the Programme Initiation Documents at Appendix A.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. The clinical facility is likely to be funded through NHS LIFT, with Merton CCG as the lead organisation. This will be confirmed on the completion of the Post PID Options Appraisal (PPOA)

7.2. The community facility will be funded through different approaches and channels.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. To be determined.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. This programme is being created to address the specific needs and challenges in East Merton, taking into account the inequalities and access issues that exist in that part of Merton.

9.2. East Merton has a diverse, more deprived, younger and mobile population compared with West Merton. It has relatively poorer health and social care outcomes and more unwarranted variation.

9.3. The Campus design is meant to better integrate health and wellbeing components and contribute to the physical, mental, emotional and social wellbeing of all Merton residents, and strengthen communities.

9.4. There will be specific emphasis to ensure that the design, approaches and services are sensitive and reactive to the needs of specific groups such as those from BAME communities, children and young people, older adults, people with mental ill-health &/or substance misuse issues, people with disabilities, people with special needs and people who feel otherwise disengaged from services.

9.5. The campus will be co-produced, co-owned and co-delivered with the East Merton community, and we hope to improve health outcomes and quality of life, decrease health and social inequalities, enhance the local economy, and create opportunities for training, volunteering, enterprise and employment.

10 CRIME AND DISORDER IMPLICATIONS

10.1. None.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. The approach to risk management is documented within the PID and the Risk Management Strategy is attached to the PID at Appendix C .

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

Please include any information not essential to the cover report in Appendices.

Appendix A. Wilson Health and Wellbeing Campus Project Initiation Document (PID)

13 BACKGROUND PAPERS

None.

Appendix A: ***Wilson Health and Wellbeing Campus Project Initiation Document (PID), 08 June 2017***

This page is intentionally left blank

MERTON COUNCIL

NHS Merton Clinical Commissioning Group

Wilson Health and Wellbeing Campus Development

Programme Initiation Document

Stage One Business Case

08 June 2017

Version 0.2

right care
right place
right time
right outcome

Document Control

Version Control

Version	Date	Issued to:	Author(s)
0.1	08/06/2017	Wilson Programme Board	Sue Howson
0.2	08/06/2017	Andy McMylor, Dagmar Zeuner and Anjan Ghosh	Sue Howson

Change Control

Version	Changes:	Author(s)
0.2	Amendments following Programme Board review	Sue Howson

Contents

Appendices

1 Introduction and Background

1.1 Introduction

1.1.1 This Programme Initiation Document (PID) sets out the details of the next stage of the project to redevelop the Wilson Hospital site in Mitcham.

1.1.2 In preparing this document the assumption has been made, that due to the value of the capital investment that the procurement of the healthcare element of the scheme will proceed on the basis of a NHS Local Finance Investment Trust (LIFT). The funding, procurement and contractual route will be decided following an appraisal carried out by the two NHS property companies, Community Health Partnerships (CHP) and NHS Property Services (NHSPS).

1.1.3 The wellbeing and community elements of the campus is likely to follow an alternative procurement and funding pathway, the development of the ownership and funding models are included within the scope of this programme.

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

1.2 Background

1.2.1 Following the approval of the Strategic Outline Case for the development of a new healthcare facility in Mitcham an options appraisal was undertaken to identify a preferred option for the development. The outcome of this appraisal was that the Wilson Hospital site was the most economically advantageous option, housing all the required services on one site and offering up surplus NHS owned land for disposal. MCCG Governing Body approved this “Economic Case” in January 2015.

1.2.2 Since then, at the instigation of the Health and Well Being Board, further detailed work has been undertaken to develop a joint vision for a new sustainable model of community health and well being in East Merton. The ambition is for the Wilson site to be designed on a campus model providing a location for an integrated health and well being hub in Mitcham, co-designed and co-managed by the community and local clinicians.

1.3 The Case for Change

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

- A younger, more ethnically diverse population;
- In general, the most deprived areas in Merton; and

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

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

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

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

1.3.5 The case for change for the investment in new facilities for East Merton is multifaceted. The high level objectives specific to this investment decision are to:

- Improve the range, integration and quality of health and wellbeing services accessible locally and by doing so improve health and social outcomes for residents;
- Modernise the facilities in the East Merton locality thus avoiding safety and financial risks due to the deteriorating condition of the existing buildings;
- Develop modern, fit for purpose facilities that will facilitate the delivery of more services locally and promote service integration across sectors and organisations; and
- Provide an opportunity to rationalise the community estate and dispose of properties surplus to requirements.

1.4 Programme Aims and Objectives

1.4.1 The development and implementation of the East Merton Model of Health and Wellbeing aims to provide:

- A more locally focussed, person-centred model of care rooted in prevention, health improvement, self care and earlier low cost interventions;
- A preventative approach, integrating health and social care and using community assets as part of the support options;

- An extended health and community campus co-designed and co-managed by the local community and clinicians; and
- A model aligned to the Primary Care Strategy and Sustainable Transformation Programme (STP).

1.4.2 Through a series of workshops held in 2016 a set of principles were developed to inform the development of the services and the site.

- Be adaptive, evolutionary and flexible to deal with the changing nature of our population; with mutuality at the core of the development
- For the community to influence the overall design of the Wilson campus to look for best ways to manage the community offering on the Wilson campus and to explore options and feasibility of ownership models.
- Taking the strength of the community and empowering it to lead and to do more to develop itself
- Enhancing people's independence – financially, mentally and physically
- Rapid and easy access to same day primary care when needed
- Access that is certainly 7 days a week
- To have a community feel and to be seen as a destination in its own right
- Not building a white elephant – deliverability including affordability

Objectives

1.4.3 Detailed objectives for the programme reflect the aims and principles and are divided into six categories: health promotion, clinical, design, sustainability, community and workforce.

Prevention objectives

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

Clinical objectives

- By careful consideration of current and required service provision, design and facilitate the development of integrated services and care pathways that put patients' needs foremost;
- Provide a comprehensive range of clinically appropriate services that can be safely and economically delivered in a primary/community setting;

- Introduce innovative service provision that embraces technology and new ways of working facilitating the delivery of high quality, accessible services;
- Provide an efficient and effective working environment for all staff that acts as an enabler for multidisciplinary working practices and service integration; and
- Ensure that the configuration of services has a strategic and clinical fit within the wider network of health and social care in East Merton.

Design objectives

- Provide purpose built modern facilities that are fit for purpose and provide flexibility to meet the changing health, wellbeing and social care needs of the local population in the short, medium and long-term;
- Design efficiency into the building maximising utilisation and minimising unused space (gross:net ratio);
- Through design facilitate the introduction of innovative service provision that embraces technology and supports new ways of working;
- Reflect best practice in design of healthcare buildings embracing principles set down by the Commission for Architecture and the Built Environment (CABE), design guidance published by the Department of Health and NICE guidance for buildings;
- Reflect the vision of modern health, wellbeing and social care services and also provide a positive and sensitive response to the local environment;
- Embrace the principles of Access for All; and
- Actively facilitate the development of the surplus NHS owned land to provide the most economically beneficial return for the NHS.

Sustainability objectives

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

Community objectives

- Provide a resource to the community that delivers an holistic service embracing both the prevention and treatment of ill health and promotes social well being by offering advice and support in partnership with statutory and voluntary organisations;
- Provide a centre which is integral to the local community by encouraging residents and service users to contribute to the development and evolution of the site and on-going use, for example,

by improving employment opportunities and work experience, supporting community interests e.g. local community group meetings, exhibiting local works of art etc.; and

- Be a 'good neighbour' to the surrounding properties and wider community.

Workforce objectives

- Create employment opportunities for the local population;
- Improve the ability to attract and retain good quality staff;
- Enable 'cross fertilisation' of ideas and practice;
- Improve integration between professions and providers leading to more flexible use of staff; and
- Provide opportunities for broadening the range of skills, expertise and knowledge of staff.
- Create opportunities for volunteering, training and apprenticeships, linked to the wellbeing facilities.

2 Project Definition and Scope

2.1 Introduction

2.1.1 The overall aim of the programme is to deliver a modern campus style development on the Wilson site that facilitates the delivery of a new health and well being model designed to meet the needs of the local population.

2.1.2 This section of the document sets out the scope of the programme and the outputs to be delivered that will ensure successful delivery of this stage of the programme, initiation and stage one business case.

2.1.3 The following sections of the document refer to the governance arrangements and controls that will need to be in place to monitor progress and to manage any risks that impact on successful delivery. Whilst this sets out the scope and deliverables of the joint programme team (MCCG, LBM, CHP, NHSPS and SLHP) it must be remembered that the success of the project is reliant upon the partnership working between all stakeholders.

2.2 Project Scope

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

In Scope

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

- Agreement of the service configuration for the site. This includes the health, wellbeing and community components;
- Production of the Post PID Option Appraisal, confirming the preferred site for the health and wellbeing development and any further development opportunities including disposals;
- Agreement of the funding, procurement approach and contractual arrangements to be adopted for the delivery of the built assets;
- Establishing the ownership model for the wellbeing and community elements of the campus;
- Agreement and establishment of the preferred funding mechanism for the community development of the site;
- Development of either LIFT Stage 1 or an Outline Business Case (OBC) depending on the agreed procurement route;
- Development of the detailed building design;
- Successful completion of the planning process for the new building(s); and
- Submission and approval of the Stage 1 Business Case.

2.2.3 The development of the East Merton Model of Health and Wellbeing, the design, specification and procurement is included within the scope of the programme. As such this will facilitate a close alignment between the development of the services and that of the buildings to ensure that both are developed with common objectives and will reach operational readiness in a timely manner.

Out of Scope

2.2.4 The preparation of business cases for the disposal of any surplus land is outside the scope of this programme and will be the responsibility of the land owner. However, this does not preclude the utilisation of capital receipts in the scheme to improve affordability.

2.3 Expected Benefits

2.3.1 The benefits anticipated from the successful development of a new health and wellbeing campus in East Merton are:

- Reduced health inequalities by enabling greater access to health and wellbeing services for the entire population of East Merton;
- Improved access to specialist services for the population of East Merton;
- Improved self management and independent living;
- Improved health and wellbeing of the population of East Merton;
- Improved quality and scope of care available locally in East Merton;
- Greater value for money from the delivery of health, wellbeing and social care services;

- Improved partnership between health and social care providers, voluntary organisations and agencies in East Merton;
- Greater integration of health and wellbeing services and care pathways that put patients' needs first;
- A modern estate which is cost effective to operate;
- The realisation of revenue savings generated from the disposal of surplus sites and rationalisation of the estate:
- The generation of capital receipts as a result of the disposal of surplus NHS-owned land and the local reinvestment of these funds to improve affordability.

2.4 Constraints

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

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

2.4.3 There is limited continuous funding for ongoing programme management. Alternative solutions are being explored to cash flow this funding.

2.5 Dependencies

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

Internal

2.5.2 The progress of the Land and Property workstream is dependent upon the timely outputs from the Clinical Design and Commissioning and Community Development workstreams. Without the abiity to develop a capacity model for the site they will be unable to proceed with the PPOA.

External

2.5.3 There is a requirement for the service strategy and service demand to be agreed. Without this information being readily available the programme is unable to proceed. The CCG are dependent upon the service providers to source this information.

2.5.4 There is a dependency on Merton Community Services and Mental Health providers to develop an office accommodation strategy so that the Wilson

Hospital site can be vacated within a timetable that will enable development to start.

2.5.5 The retention of any capital money, realised through the disposal of NHS property as a consequence of the programme, is at the discretion of DH.

3 Governance Arrangements

3.1 Introduction

3.1.1 This chapter sets out the programme and project management structure and processes that will be put in place to ensure that the programme is appropriately managed to deliver the anticipated benefits to be realised through the investment in establishing a health and wellbeing campus on the Wilson site.

3.1.2 It sets out the necessary project management controls and the arrangements for management of risk.

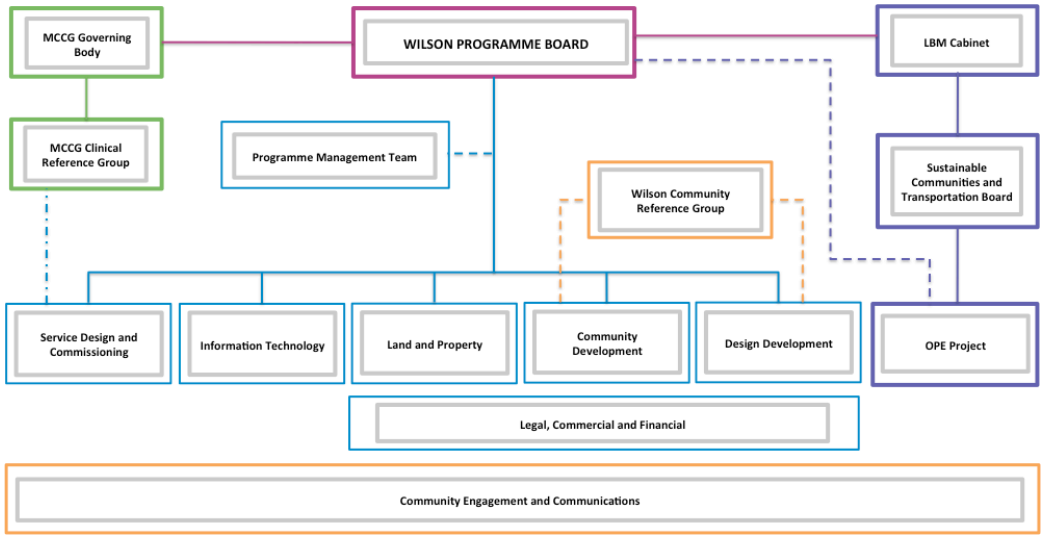
3.1.3 The ultimate decision making forum for decisions within the remit of the CCG will be the MCCG Governing Body and the Cabinet for the London Borough of Merton Council.

3.2 Programme Management Structure

3.2.1 The principles of Managing Successful Programmes (MSP) have been applied to the development of the governance structure for the Wilson Programme.

3.2.2 The figure below provides and overview of the governance structure with a detailed diagram provided at **Appendix A**, which gives an overview of the function of each group.

Figure 1. Programme Structure



Wilson Programme Board

3.2.3 The Wilson Programme Board will take responsibility for overseeing the delivery of the Wilson Health and Wellbeing Campus. It will report to the MCCG Governing Body and LBM Cabinet. Where specific scrutiny is required the MCCG Governing Body may ask that the Programme Board refers to specific sub-committees prior to presentation to the Governing Body e.g. Finance Committee, Clinical Transformation Board.

3.2.4 The Programme Board also reports to the Health and Wellbeing Board on a regular basis.

3.2.5 The Programme Board membership has been drawn from senior executive managers from MCCG, LBM, CHP and NHSPS thus facilitating timely decision making to prevent delays the programme. A scheme of delegation will be agreed to set the parameters within which the Programme Board can operate.

3.2.6 The Programme Board will take responsibility for the strategic direction and overseeing the programme management of all aspects of the projects involved in the development of a health and well being campus on the Wilson Hospital site in Mitcham.

3.2.7 The Wilson Programme Board will have delegated authority from the respective organisations to oversee and ensure delivery of the programme in line with the agreed specification and timescales. Its role is to ensure that resources are made available to deliver the programme and that the programme management arrangements are robust. It will form the main decision making forum and provide direction and advice to the Programme Director on issues outside their level of authority.

3.2.8 The Programme Board will monitor progress against time, budget and quality and authorise actions to address any deviation from the agreed plan. The membership of the Programme Board will be kept under review to ensure that the constitution of the Board is appropriate for the stage of the programme.

3.2.9 . The Programme Board Terms of Reference are attached at **Appendix B**.

Programme Management Team

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

3.2.11 The Programme Director will provide an aggregated progress report to the Programme Board on a monthly basis (Highlight report).

Page 34

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

Work-streams

3.2.13 The Programme Management Team will delegate the responsibility for key deliverables to work-streams specifically constituted for this purpose. Membership of these work-streams will be chosen specifically to ensure that the requisite expertise is present to deliver the required quality of output.

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

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

3.2.16 **Service Design and Commissioning**. This workstream is responsible for establishing the proposed service configuration for the health services to be provided from the site. This output will inform the development of the Participant's Requirements, which will initiate the commencement of the project.

3.2.17 Once the service configuration is agreed the workstream will be responsible for working with commissioners and providers to design the detail of the service provision, exploring opportunities for the implementation of new models of care and promoting integration and new ways of working. A close working relationship will be required with the Community development workstream to ensure that the health and wellbeing services are designed together and not as separate entities.

3.2.18 It is expected that this group will also work closely with the Information Technology workstream to ensure that IT systems facilitate these new ways of working and that IT does not became a barrier to change.

3.2.19 This workstream will be responsible for ensuring that service specifications are updated to reflect any changes and that this is communicated to commissioning and financial leads as part of the contracting process.

3.2.20 **Information Technology**. This work stream will have the responsibility for the development of the IT Strategy for the site. It will work closely with the Clinical Design and Commissioning and Community Development workstreams to ensure that their requirements for interoperability are planned in from the start.

3.2.21 The group will be responsible for the planning and implementation of the IT systems on the site. This will need to be supported by the preparation of a business case to access the required funds.

3.2.22 Once the development partner has been appointed the workstream will work closely with the developer to ensure that the infrastructure is adequately specified and that installation programmes are aligned.

3.2.23 **Land and Property**. This work-stream will be responsible for developing the plans for the moving of existing staff and services out of their existing accommodation into either the new building or alternative accommodation, as appropriate. The work-stream will also be responsible for the decommissioning and disposal of existing sites as appropriate.

3.2.24 **Community Development**. This workstream is responsible for designing the wellbeing and community aspects of the Wilson campus. This will be achieved through a robust, inclusive engagement plan that seeks the input and expertise of the local community.

3.2.25 This group will also be responsible for identifying and setting up the business model to support the implementation and ongoing funding of the scheme. This will include any initial capital investment and ongoing revenue.

3.2.26 **Design Development**. This work-stream will be responsible for the development of the design of the new building and have as its main deliverables the schedule of accommodation and the full set of 1:50 design drawings. This work-stream will also take the lead on the planning application for the new buildings.

3.2.27 The workstream will be responsible for establishing the engagement mechanisms to ensure appropriate input into the design. This will include users, staff, local community and technical advisers.

3.2.28 They will also be responsible for the development of the equipment schedule, including ICT equipment, identifying equipment for transfer to the new facility, if any, and a definitive list of equipment to be procured.

3.2.29 **Legal, Commercial and Financial**. This work-stream will be responsible for putting together the legal framework within which any new buildings will be developed, including briefing and working with the external legal advisors to be appointed to support the scheme.

3.2.30 It will offer support in the development of a funding model to support the implementation and ongoing funding of the community and voluntary elements of the programme.

3.2.31 It will be responsible for ensuring that the financial aspects of the business cases are completed and are consistent with the CCG's financial strategy and plans. It will also be responsible for putting together the commercial framework within which the new building will be developed, including

briefing and working with the external advisors to be appointed to support the scheme.

3.2.32 **Land and Property**. This work-stream will be responsible for all aspects of the programme relating to the land and property currently in the ownership of NHSPS.

3.2.33 It will develop the plans for the move of existing staff and services out of their current accommodation into either temporary accommodation or alternative permanent locations.

3.2.34 The workstream will be responsible for the development of the Post PID Options Appraisal (PPOA) identifying the most economically advantageous option for the development of the scheme..

3.2.35 The work-stream will also be responsible for ensuring that the site is ready for development. This will include the decommissioning of existing buildings and the disconnection of services to the site.

3.2.36 The disposal of land is outside the remit of this group.

3.2.37 **Community Engagement and Communications**. This work-stream will be responsible for overseeing communications and engagement with key stakeholders and the community as a whole. Its key deliverable will be the development and execution of a Communications strategy and Plan that will provide guidance to the programme as a whole, ensuring that the community development engagement is consistent with the Programme Communication Strategy and Plan.

3.2.38 The work-stream will work with the Programme Management Team to ensure that the content of communications are appropriate, timely and that the most appropriate medium is used. The Group will provide editorial input to all written communications prior to Programme Board sign off.

3.3 Roles and Responsibilities

Senior Responsible Officer – Andrew McMylor

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

3.3.2 The SRO is responsible for ensuring that the project meets its objectives and delivers the anticipated benefits. The SRO is owner of the overall business change and risk management process. The SRO is responsible for ensuring that the programme and the individual projects within it are managed effectively in the context of a clear business focus in terms of

meeting the partner's aims and objectives within the agreed resource and financial parameters.

Programme Director – Sue Howson

3.3.3 The Wilson Programme Director will cover three roles; CHP Project Director, the CCG Project Director, a joint appointment, and the overall Programme Director. The Programme Director will be responsible for:

- Planning and designing the programme in accordance with the programme plan and proactively managing its overall progress:
- Ensuring that programme and project controls are in place to monitor and manage progress against plan, budgets and risks;
- Facilitating the appointment of individuals to the project delivery team;
- Ensuring that there is efficient allocation of resources and skills;
- Initiating additional activities and other management interventions wherever gaps in the programme are identified or issues arise;
- Reporting to the Programme Board on progress and any issues that would be considered detrimental to successful programme delivery.
- The development, and editorial control, of the Stage One and Stage Two business cases sourcing the relevant technical advice and input as required;
- Managing stakeholder relationships and communications (in accordance with the agreed Communication Strategy and Plan);
- Leading on the commercial negotiations for CHP and managing the inputs of external consultants for time, quality and cost;
- The production of the relevant reports for approval at key project milestones; and
- Leading the process to Financial Close for CHP and the CCG, including all approvals.

3.3.4 The Programme Director will report directly to the SRO. They will also report to a director within CHP.

Programme Manager – Caron Hart

3.3.5 The Programme Manager reports to the Programme Director and is responsible for the day to day running of the Programme. This role will also take on the Project Management responsibilities for key aspects of the NHS LIFT development. They will:

- Take responsibility for the management of specific work streams within the programme structure;
- Ensure that all outputs are delivered in line with the agreed project plan;
- Ensure that all programme and project controls are implemented as per protocol;

- Provide regular reports to the Programme Director on progress highlighting any areas for concern;
- Be responsible for ensuring that any decant programmes are robust and receive commissioner and provider sign off;
- Organise and manage the design development process from the client's perspective; and
- Produce documentation, as required to support the development of the business cases and contract schedules at Financial Close.

Finance Lead – Ian Winning

3.3.6 Reports to the Programme Director and is responsible for:

- The collation and interpretation of current CCG commissioning finances;
- Establishing the cost of new commissioning models;
- Analysing and documenting the current costs of occupation and identifying any variances with the proposed costs of the new facility;
- Designing and running the affordability analysis; and
- Supporting commissioners in the development of business cases to support new services or new models of care.

Programme Administration – Kofi Monney

3.3.7 To be responsible for:

- Maintaining a logical electronic filing system for all project documentation;
- Organising meetings, sending invites and ensuring venues are booked and are fit for purpose;
- Assembly and distribution of agendas and papers for all programme and project meetings;
- Taking minutes / action notes as requested;
- Maintaining the Programme Board Action Log.

Communications Officer – Michelle Wallington

The Communications Officer will report to the Programme Director taking responsibility for:

- Development of the Communications Strategy and Plan, and ensuring adherence;
- To deal with all media enquiries;
- The drafting and design of internal and external programme communication; and

- The organising and advertising of any public events specific to the Programme.

3.3.8 In addition to the roles identified above workstream leads will provide project management input and focus to areas of the project where subject matter knowledge and experience is necessary.

3.4 Programme Controls

3.4.1 Programme controls will be established primarily around a comprehensive, regular and effective reporting system. The following table outlines the key areas of project control.

Figure 2 Programme Controls

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

Risk Management

3.4.2 Risk management is an integral part of programme management and is guided by the Wilson Risk Management Strategy, a copy of which is attached at **Appendix C**. The programme will hold its own risk workshop at the start of each stage of the programme to inform the development of a programme specific risk and issues register.

3.4.3 Reporting of significant risks will be managed through the programme reporting mechanisms and will be a standing item on all programme and workstream agendas. If the Programme Board cannot deal with the risk, they will ensure that it is escalated to the appropriate body to manage the risk and provide instruction to the Programme Board.

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

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

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

Reporting

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

Figure 3. Reporting schedule

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

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

Programme

3.4.8 A detailed programme plan will be developed at the outset of the programme and further refined as partners come onboard.

3.4.9 The table below presents a provisional outline timetable for the development of the healthcare scheme from initiation to operation, assuming the procurement route is NHS LIFT. At this stage the programme is indicative and based on a standard timeline produced by CHP. As the programme progresses and development parties are appointed this will be subject to refinement and change.

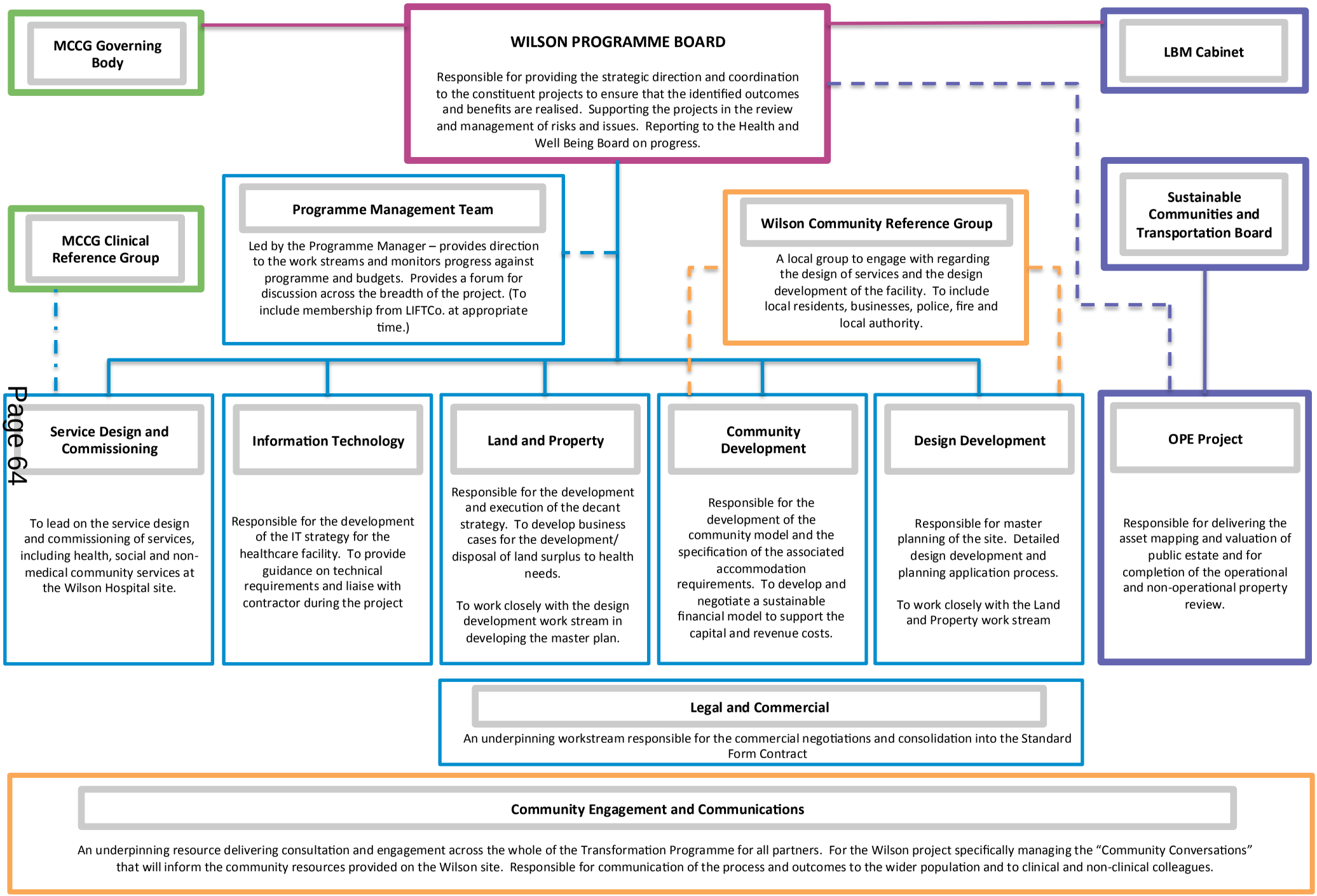
Figure 4. Outline Timetable

Milestone	Timeline
Sign off health and wellbeing service provision	July 2017
Sign off Participant's Requirements	July 2017
Post PID Options Appraisal (PPOA)	August 2017
Instruct New Project	November 2017
Planning Application approved	June 2018
Stage 1 Business Case approved	August 2018
Stage 2 Business Case approved	February 2019
Financial Close	March 2019
Practical Completion and Handover	September 2020
Services Operational	March - April 2021

3.4.10 At this stage we do not have a programme for the community development project as this will be dependent upon the scope of the provision which is currently under consideration. Once established a joint programme will be developed to ensure that milestones are aligned and that operational readiness is achieved to meet the go-live date.

APPENDIX A

Programme Structure


MCCG Governing Body
WILSON PROGRAMME BOARD
Responsible for providing the strategic direction and coordination to the constituent projects to ensure that the identified outcomes and benefits are realised. Supporting the projects in the review and management of risks and issues. Reporting to the Health and Well Being Board on progress.
LBM Cabinet
MCCG Clinical Reference Group
Programme Management Team
Led by the Programme Manager – provides direction to the work streams and monitors progress against programme and budgets. Provides a forum for discussion across the breadth of the project. (To include membership from LIFTCo. at appropriate time.)
Wilson Community Reference Group
A local group to engage with regarding the design of services and the design development of the facility. To include local residents, businesses, police, fire and local authority.
Sustainable Communities and Transportation Board
Service Design and Commissioning
To lead on the service design and commissioning of services, including health, social and non-medical community services at the Wilson Hospital site.
Information Technology
Responsible for the development of the IT strategy for the healthcare facility. To provide guidance on technical requirements and liaise with contractor during the project
Land and Property
Responsible for the development and execution of the decant strategy. To develop business cases for the development/ disposal of land surplus to health needs.
To work closely with the design development work stream in developing the master plan.
Community Development
Responsible for the development of the community model and the specification of the associated accommodation requirements. To develop and negotiate a sustainable financial model to support the capital and revenue costs.
Design Development
Responsible for master planning of the site. Detailed design development and planning application process.
To work closely with the Land and Property work stream
OPE Project
Responsible for delivering the asset mapping and valuation of public estate and for completion of the operational and non-operational property review.
Legal and Commercial
An underpinning workstream responsible for the commercial negotiations and consolidation into the Standard Form Contract
Community Engagement and Communications
An underpinning resource delivering consultation and engagement across the whole of the Transformation Programme for all partners. For the Wilson project specifically managing the "Community Conversations" that will inform the community resources provided on the Wilson site. Responsible for communication of the process and outcomes to the wider population and to clinical and non-clinical colleagues.

APPENDIX B

Programme Board Terms of Reference

Wilson Programme Board

Terms of Reference

Programme Initiation date:

Version No. 3

Date approved by Programme Board: 8 June 2017

Review Date: At Financial Close

Document Control:

The controlled copy of this document is maintained XXXXX. Any copies of this document held outside this environment, in any format, are considered to have passed out of control and should be checked for currency and validity.

1 Introduction

The case for the redevelopment of the Wilson Hospital site was established with the production and approval of a Strategic Outline Case in April 2014. This document set out the health needs of the people of east Merton and used this as a basis to establish the need for a new facility within Mitcham. The aim was to establish local services, tailored to the needs of the population that would not only improve the treatment of ill health but also promote activities that prevent ill health by helping people with lifestyle choices.

Following the approval of the strategic case an appraisal of the development options was undertaken, which concluded that the Wilson Hospital site was the preferred location for the new development.

At the instigation of the Health and Well Being Board further work has been undertaken to develop a joint vision for a new sustainable model of community health and well being in east Merton. The ambition is for the Wilson Centre to be a transformative, innovative and integrated health well being hub in Mitcham, co-designed, co-managed and co-owned by the community and local clinicians.

The local authority have been successful in their bid to join the One Public Estate Programme (OPE) and have been awarded funds to support the Programme and to undertake a wider review of the use of public land and property. The outputs from the work funded by OPE also fall within the remit of this Programme.

2 Authority and Accountability

The Director of Primary Care Transformation has been appointed as the Senior Responsible Officer (SRO) for the Programme.

The Programme Board will be co-chaired by a MCCG non-executive director and the Clinical Lead for the programme.

The Programme Board reports to:

MCCG Clinical Transformation Board on all matters clinical;

MCCG Finance Committee on all matters relating to finance; and

LBM Cabinet

3 Responsibilities of the Programme Board

The role of the Programme Board is to take responsibility for the strategic direction and overseeing the programme management of all aspects of the projects involved in the development of a health and well being hub on the Wilson Hospital site in Mitcham.

The Programme Board is responsible for:

- Providing leadership to the Programme and to actively promote the benefits of the Programme to ensure stakeholder support is secured;

- Ensuring that the strategic integrity of the Programme is maintained and that it remains consistent with the wider strategic intentions at a regional and local level;
- Agreeing the programme objectives and defining the outcomes and benefits to be realised through the successful delivery of the Programme;
- Ensuring that due consideration is given to securing best value with regard to the overall use or disposal of Public land and property;
- Ensuring that effective programme and project management arrangements and controls are in place to promote successful delivery of the Programme;
- To set the scheme of delegation and ensure compliance within the agreed parameters;
- Approving the programme and constituent project budgets;
- Ensuring that there is a system of cost control in place and to receive regular reports on existing and planned expenditure;
- Signing off the project and programme plans and monitoring progress against plan;
- Keeping the Programme scope under control as emergent issues force changes to be considered;
- Reviewing requests for significant variations to scope, programme or expenditure and making the decision whether to accept or reject;
- Ensuring that a robust risk management process is in place and to receive regular reports, escalating to the appropriate authority where necessary;
- Arbitrating on any conflicts within the programme;
- Addressing any issues that have major implications for successful delivery;
- Ensuring that there is a Communication Strategy and Plan in place to promote robust stakeholder engagement and management;
- Signing off the completion of project stages and key deliverables; and
- Ensure that a robust post-project evaluation process is agreed and implemented.

The Programme Board will be responsible for the review and approval of key project documentation. To include, but not limited to:

- Participant's Requirements
- Outline and Full Business Cases for the Community development
- Documents generated in support of the planning application
- NHS LIFT Stage One Business Case
- NHS LIFT Stage Two Business Case
- Specific Schedules with the NHS LIFT Land Retained Agreement (The contract)

4 Membership

The membership of the Programme Board should be as follows:

- MCCG Non-Executive Director – Co-Chair
- MCCG Wilson Clinical Lead – Co-Chair
- MCCG Director of Primary Care Transformation - SRO;
- LB Merton Director of Public Health;
- LB Merton Director of Community and Housing
- MCCG Director of Finance;
- LB Merton Head of Sustainable Communities;
- Merton Voluntary Sector Council Chief Executive
- CHP Developments Director;
- NHSPS Strategic Lead
- Wilson Programme Director;

In attendance

- Wilson Programme Manager
- OPE Regional Programme Manager
- MCCG Finance Lead

5 Attendance and Responsibilities

It is important that there is continuity of attendance at the Programme Board. It is expected that members will attend personally. Deputies may only attend by advance agreement with the Co-Chairs, and should be fully briefed prior to attendance to allow full participation in discussions and decision-making.

The meeting will be deemed quorate when four of the members are present, including one of the co-chairs, the LB Merton Director of Public Health, or appointed deputy, and one MCCG executive.

5.1 Declaration of Interests

Members of the Programme Board must declare if they have any interests, whether pecuniary or non-pecuniary which relates to the matters being discussed. Individuals will declare any such interest that they have to the Chair as soon as they are aware of it, and in any event no later than 28 days after becoming aware.

Should any such interest be declared, the Chair of the Programme Board should exercise discretion as to whether to disqualify that member (voting or non-voting) from taking any further part, or in any way influencing by proxy or otherwise, discussion and/or voting on that matter.

5.2 Confidentiality

Members will be responsible for ensuring the strict confidentiality of all commercially sensitive information.

6 Frequency of Meetings

The Programme Board will meet every six weeks with each meeting scheduled for duration of 90 minutes. A schedule of meeting dates will be provided on an annual basis.

Extraordinary meetings may be called at key milestones when decision-making or sign-off is critical to prevent delays to the programme.

“Virtual” meetings may replace scheduled meetings when it is deemed that there is no benefit in a face-to-face meeting, this will be at the discretion of the Co-chairs.

All agenda items must be forwarded to the Programme Manager seven working days prior to the meeting.

It is assumed that members will have read the papers in advance of the meeting, to allow direct discussion at the meetings.

7 Administration

The Programme Management Office will provide the administrative support to the Programme Board. The duties undertaken will include:

- Agreement of the agenda with the Chairman and ensuring the production and collation of papers.
- Circulation of the agenda and papers no less than five working days in advance of the meeting.
- Taking the minutes and maintaining an action log.
- Gaining sign off of the draft minutes by the Chairman and circulating within five working days of the meeting.
- Ensuring that agreed actions are progressed prior to the next meeting.

8 Review

The membership of the Programme Board will be monitored on an on going basis and amendments made if the membership does not provide adequate breadth of knowledge or experience or if the level of attendance by members is not deemed acceptable.

A formal review of the Programme Board will be instigated at Financial Close in readiness for the construction, mobilisation and operational stages.

APPENDIX C

Risk Management Strategy

MERTON COUNCIL

NHS
Merton
Clinical Commissioning Group

Wilson Programme

Risk Management Strategy

01 June 2017

Version 0.2

1 Introduction

The purpose of this document is to provide a consistent process for the management of risks across the Wilson Campus Development programme. It defines risk management in respect of the standards, processes and procedures to be employed in the identification, analysis, quantification, mitigation, escalation and documentation of risks.

This document describes the process for resolving:

- ***Project Risks*** - risks that can be resolved within a project team.
- ***Programme Board Risks*** - risks that are either of a strategic nature, have a major impact on service operations or project milestones, or require senior stakeholder direction or action.
- ***Programme Risks*** - risks that cannot be managed at the project level or affect multiple projects within a programme

The audience for this document is members of the Wilson Programme Board, Project Team members and all participants in the project work streams.

2 Risk Management Framework

2.1 The Aims

The aim of risk management is to improve the likelihood of the Project or Programme achieving its stated objectives.

The risk management process is designed to:

- Focus the Programme Board and senior management team on the major risks that threaten project delivery and objectives;
- Provide a clear picture of the major risks facing the programme, their nature, potential impact and likelihood;
- Establish a shared and unambiguous understanding of what risks will be tolerated;
- Actively involve all those responsible for planning and delivery of the programme's key deliverables and benefits;
- Embed risk awareness and management in planning and decision making processes; and
- Enable and empower managers to manage those risks within their area of responsibility.

2.2 The Objectives

The objectives of a risk management system is to ensure:

- Early identification and management of risks;
- Proper analysis, evaluation and quantification;
- Clear and consistent assignment of ownership and management;
- Comprehensive identification, definition and evaluation of appropriate mitigation routes;
- Clearly defined policy, standards, processes and procedures; and
- Robust documentation for audit purposes.

A common problem when identifying and scoring risks is the confusion between what is a risk and what is an issue. The following definitions should assist with clarification.

- A risk is something that might happen and needs a mitigation/management plan to either avoid it materialising or minimising the impact.
- An issue is something that has happened and needs to be managed with immediate effect.

3 Risk Management Process

Risk analysis and management are on-going processes incorporated throughout the life of a programme or project and are the responsibility of **all** staff involved with a project or programme. The responsible managers will keep stakeholders informed of risks identified, action taken where appropriate and the success of those actions.

There are three parts to the risk management process:

1. ***Analysis*** - identification, definition, and assessment of probability and impact.
2. ***Management*** - risk mitigation strategy and plan, monitoring and control of actions employed to deal with the threat, and problems identified in analysis.
3. ***Reporting*** - all risks raised will be recorded on the project risk register and will be owned by the Programme Director. Reporting of risks will be carried out on a regular basis in accordance with the agreed Governance structure and terms of reference.

3.1 Risk Analysis

Identification of risks is an ongoing process but gets the best results when done on a group basis at key intervals – such as the initial business case development stage, and again during Project Initiation. The process involves:

- Identification of potential risks that could adversely affect the impact and efficient delivery of project and programme objectives and benefits.
- Assessment of the importance, probability and the impact of each risk
- A decision as to whether the level of risk is acceptable
- Identifying courses of possible actions to be taken to reduce the probability or impact of the risk materialising.

3.2 Mitigation strategy and monitoring

Based upon the level of concern and controllability for each risk, the Risk Owner will decide on the risk mitigation strategy and associated actions i.e. whether to accept, treat, or transfer the risk, and ensure those actions are carried out as required. The Risk Owner at least monthly (more frequently for red and amber/red risks), will review and monitor progress and consider the effect on the overall risk rating and report to the Programme Director so that those changes and updates are reflected in the risk register.

3.3 Contingency planning

Where the risk has a high risk rating (Red) contingency plans will need to be developed to address the consequences of the risk materialising.

3.4 Escalation

Risks will need to be escalated to the next level of seniority (i.e. individual or group) and the escalation recorded in the risk register where:

- The risk is of significant concern (red) – escalate to the Wilson Programme Board or CCG Governing Body;
- The risk is outside the authority, responsibility or control of the risk owner;
- The risk relates to more then one managers area of responsibility; or
- Actions to manage the risk require additional resources or the action requires approval elsewhere

The escalation or transfer of the risk will be authorised by the Programme Board. If action is required in between Programme Board meetings the SRO will take on that responsibility.

3.5 Transfer

When the risk actually happens it becomes an issue and should be transferred to the 'Issues' log. If a risk affects the project but is outside the remit of the Project team or Programme Board it should be transferred to the most appropriate corporate governance body and managed therein. A watching brief within the programme or project will be required.

3.6 Reporting

Up to date risk reports are provided for the Project Team and Programme Board meetings on a timely basis for review with a focus on amber and red/amber risks within the Project Team and amber/red and red risks at the Programme Board.

4 Risk Assessment

4.1 Risk Categories

The risks identified within the risk register are categorised by the type of risk that they pose. In categorising the risks it is important to identify the main cause of the risk, not the impact. For example a design risk around the fit out of the x-ray department is what triggers the risk to be placed on the register, the impact may be financial and affordability but is not the causative factor.

The categories currently utilised are:

- ***Strategic and Political*** – likely to be external to the organisation and difficult to mitigate/manage
- ***Information Technology*** – a risk with the technical aspects of software/hardware compatibility, delivery or equipment
- ***Design and Planning*** – having an impact on the design of the facility or planning approvals with the potential knock on impact on cost or programme.
- ***Procurement*** – mainly related to the timescales for the procurement of services, equipment or property
- ***Funding/Financial/Affordability*** – lack of available funding, increased costs leading to an unaffordable scheme
- ***Capability and Capacity*** – risks associate with the lack of a skilled resource or limited resource.
- ***Construction*** – has an impact on the timescale and potentially cost of the construction of the facility
- ***Clinical Commissioning*** – related to the commissioning of clinical services to be provided within the centre

4.2 Assessment Matrix

The assessment matrix provides a framework for assessing and measuring identified risks, which will be reviewed at various points within the governance structure to ensure appropriate priority and visibility is assigned to it

Whilst risks will occur from various diverse routes, it is essential that the standards for assessing the probability and impact of occurrence of each risk should be subject to the same criteria across the whole project/programme. This will allow the risks to be managed consistently, at the appropriate level and given the appropriate attention and visibility.

Risk evaluation and quantification comprises of scores of three types:

- ***Impact*** – the level of impact on project objectives and business that would arise should the risk materialise;
- ***Probability*** – the likelihood of the risk arising; and
- ***Proximity*** – when the risk is likely to occur. This assists with prioritisation and urgency associated with managing the risk.

The scores and associated descriptions are shown in the figures below.

Figure 1. Scoring Protocol – IMPACT

Impact Rating	Impact Description	Impact on Cost
1 – negligible	It will have little effect on project milestones, timescales or achievement of objectives or benefits	No additional cost
2 – minor	It may delay delivery or quality of one or more deliverables but not delay the overall project or affect achievement of objectives or benefits	No additional cost
3 – moderate	A project milestone is delayed which could extend timescales but is unlikely to materially affect successful delivery of the project objectives and benefits	Additional cost by up to [x]%
4 – major	It is likely to delay the achievement of a number of project milestones or a major milestone which could significantly extend timescales. Successful delivery of the project objectives and benefits could also be materially impacted.	Additional cost by up to [x]% to [x]%
5 - catastrophic	Project objectives no longer achievable or major reduction of benefits due to significant time, cost or quality issues.	Additional cost over [x]%

Figure 2. Scoring Protocol – PROBABILITY

Value	Impact Description
1	*Rare* – it is highly unlikely that this risk would materialise – less than [x]% chance
2	*Unlikely* - it is unlikely that the risk will materialise – less than [x]% chance
3	*Possible* – Could happen – [x]% - [x]% chance
4	*Likely* - Often a risk that is outside your direct control or influence – [x]% - [x]% chance
5	*Almost certain* – 80%+ chance. Often a risk that is outside your direct control or influence.

Figure 3. Scoring Protocol – PROXIMITY

Score	Proximity
1	9 months +
2	6 – 9 months
3	3- 6 months
4	1 – 3 months
5	< 1 month

The impact score multiplied by the probability score give the overall risk score.

Figure 4. RAG rating

		IMPACT				
		Negligible	Minor	Moderate	Major	Catastrophic
PROBABILITY		1	2	3	4	5
Almost certain	5	5	10	15	20	25
Likely	4	4	8	12	16	20
Possible	3	3	6	9	12	15
Unlikely	2	2	4	6	8	10
Rare	1	1	2	3	4	5

The risk scores determine the amount and urgency of mitigation action and monitoring required in effectively managing the risk.

The proximity score provides another dimension for prioritising mitigation and focusing resources for effective risk management.

The gross risk score is calculated by:

Impact x Probability x Proximity

The figures below provide guidance on the actions required.

Figure 5. Risk Management – actions

Risk score 15-25 With Proximity 50-125	Close monitoring by Project Board High or very high exposure Urgent need to consider additional mitigation action Contingency plan required
Risk score 8-12 With Proximity 20-50	Close monitoring by Project Director and Work Stream Leads Urgent need to consider additional mitigation action Contingency plan required Exception reporting on increasing severity to red
Risk score 4-6 With Proximity 8-18	Medium exposure Need to consider additional mitigation measures Close monitoring/management by risk owner Review by Project Director and Work Stream Lead
Risk score 1-3 With Proximity 1-6	Low exposure Monthly monitoring by risk owner Could consider relaxation of control to divert resources

4.2.1 Risk Status

The Project Manager updates the risk status depending upon progress with management and resolution.

- ***New*** – a newly reported risk within the month
- ***Open*** – the risk has been assessed, a risk owner identified and is being actively managed

- ***Escalated*** – the risk has been escalated to the Programme Board or other governance body for review and advice
- ***Transferred*** – either the risk has materialised and has been transferred to the issue log, or has been transferred out of the project to another body to manage
- ***Closed*** – the risk has been resolved or its consequences accepted.

4.3 Mitigation Strategy

A risk mitigation strategy seeks to mitigate the risks and safeguard the delivery of the project/programme and its objectives and indeed the investment being made in the scheme. This is achieved through proactive actions that reduce either:

a) The probability of a risk occurring; or

b) The impact of the risk.

The mitigation strategy comprises of 3 approaches to deal with the risk

- ***Acceptance*** - accept the risk but take no pre-emptive action to resolve it (unable to address the risk or not cost effective to do so), but consider contingency plans should the risk materialise.
- ***Manage*** - develop a mitigation plan to reduce probability and or impact
- ***Transfer*** - the risk is moved to another individual, department or function, to manage

The proposed mitigation is summarised on the risk register. Where the risk is deemed to be significant i.e. red, a detailed mitigation action plan and contingency plan (proposed pro-forma at appendix A) will be prepared and presented to the Programme Board. This provides team members, and managers with clarity of the action that is expected from them while the Programme Board, senior management and other governing bodies have the knowledge of the steps being taken on their behalf to reduce the risk.

5 Roles and Responsibilities

5.1 Programme Director

The Programme Director is responsible for ensuring that all risks have been assigned a Risk Owner and are actively being managed. The Programme Director is specifically responsible for:

- Ensuring all Programme/Project risks are identified and captured on the risk register
- Check the assessment (RAG) and mitigation strategy and category for all risks

- Ensure all Risks are assigned with the most appropriate Risk Owner with the authority and responsibility to manage them
- Review any with risks increasing severity (Amber to Red based on pre-mitigation score)
- Escalate risks to the Programme Board for consideration when mitigation is outside the Programme/Project manager's jurisdiction, or additional support outside of the Programme/Project is needed
- Consider if there are new unidentified risks
- Ensure the top 3 risks are reported on the monthly work stream progress reports and the Programme highlight reports

5.2 Programme Board

The Programme Board is accountable for the overall management of the programme/project risks and is required to review the Board level risks as a standing agenda item. They should:

- Review and monitor all Red risks on the register and as a minimum examine in detail all risks with a score of 16 to 25.
- Identify strategic risks and mitigation
- Allocate as necessary resource to support the risk management process
- Agree the overall risk tolerance level (risk appetite)
- Provide direction to the Programme Director as required for management of risks

5.3 All staff

To be alert to possible risks and to raise these with the Programme Director.

Risk ID:		Date Raised	
Risk Owner:		Risk Actionee:	
RAG Status		Proximity:	
Risk Description:			
Impact Description:			
Proposed Mitigation:			
Action		Actionee	Deadline
Contingency Plan:			
Action		Actionee	Deadline

APPENDIX D

Reporting Templates

WILSON CAMPUS DEVELOPMENT

PROGRAMME HIGHLIGHT REPORT

Programme	Wilson Re-development Project
Senior Responsible Officer	
Programme Lead	Sue Howson
Programme Initiation Date	
Programme Purpose	
Programme Stage	

Report Date:	Reporting Period:

Workstream Status	
[Workstream 1]	GREEN
[Workstream 2]	GREEN
	GREEN

Red: to achieve success immediate remedial action is required
Amber: delay possible, or task/milestone not mission critical
Green: on target to succeed

Overall Status of the Wilson Campus Programme	**GREEN**

Current Project Status
(Insert narrative and provide explanation for any deviation from 'GREEN' status i.e. behind on programme and reason, overspend on budget and reason etc.)

Progress Update

(Insert narrative)

Change Control

Description of change requested	Impact			Status
	Cost	Programme	Quality	

Milestones/Tasks

Milestones/Tasks	Target Date	Estimated date of delivery	% Completed	RAG Status
				GREEN
				GREEN
				GREEN
				GREEN
				GREEN

Tasks for next period

(Insert narrative)

-

Key Project Risks and Issues

Description of Risk	Score/ RAG	Mitigation	Owner
xxxx	95	xxxx	

Description of Issue	Impact H/M/L	Management Plan	Owner
xxxxx	H	xxxxxx	

Committee: Health and Wellbeing Board

Date: 20 June 2017

Agenda item:

Wards: All

Subject: Health in All Policies Draft Action Plan

Lead officer: Dagmar Zeuner, Director of Public Health, LBM

Lead member: Cllr Tobin Byers, Cabinet member for Adult Social Care and Health

Forward Plan reference number:

Contact officer: Clarissa Larsen

Recommendations: The Health and Wellbeing Board is asked to:

A Endorse the final Health in All Policies principles and priority actions (point 12.1 – 12.7 and appendix 2).

B Agree to the proposed governance and the HWBB as the lead thematic partner to champion the approach, provide oversight for delivery of the action plan and propose further actions where required (point 14).

PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1. As discussed by the HWBB at its seminar in January it was agreed to develop a HIAP (Health in All Policies) action plan as follow-up from the Local Government Association peer review and workshop at the end 2016. The action plan set out in this report has been developed and agreed by Council officers and is brought to the HWBB for its endorsement, consideration and action. It is proposed that the HWBB has overview of the HIAP action plan and that, as part of the HWB Strategy refresh, HIAP actions be included for future monitoring.

DETAILS

Why HIAP and why now?

2. As previously considered by the HWBB, HIAP offers a means for the council to optimise delivery of its statutory duty for population health and wellbeing including its HWB strategy. In particular, the approach helps to reduce health inequalities because it focuses attention on the underlying social, economic and environmental causes that the whole council can influence.

3. The persistent inequalities between the East and the West of the borough are an on-going challenge and ‘Bridging the gap’ has been a long-standing priority for the whole council as well as for the Health and Wellbeing Board and Merton Partnership.

4. HIAP presents potential for strong co-benefits, across the council and partners. Health and health equity not only being important goals in their own right but also prerequisites for achieving other corporate and partnership goals such as educational attainment, community/family cohesion, employment, safety, sustainability and prosperity.

5 In current times of serious financial constraints, HIAP with its strong emphasis on inter-sectoral collaboration offers a promising way of increasing efficiency of public sector spending.

6. In Merton there is currently a window of opportunity to make significant progress on HIAP because of congruence between the Council's 2020 vision of Best London Council, political will and active commitment from the CCG and voluntary sector. This is complemented by the refresh of the seven statutory mayoral strategies in 2017, including London's Inequality Strategy that has HIAP as a theme and offers opportunity for policy synergies and leveraging regional support. There is an opportunity to reflect this approach in Merton policy and strategies including the 2018 refresh of the Health and Wellbeing Strategy 2018 and partners can also consider how HIAP can be taken forward through their own organisations' policies and plans.

Context/work so far

7. The HWBB considered LGA's peer assessment findings at its January seminar. The LGA peer reviewers found Merton was well positioned to take forward HIAP. On request to recommend specific initiatives from elsewhere that could be replicated in Merton for speedy progress, LGA instead encouraged Merton to develop HIAP as a way of working across the council and partners to identify its own, context specific, actions to ensure real ownership.

Terminology and proposed principles

8. Clear terminology and common understanding are essential for making HIAP successful across the council and partners. Below is a preliminary list of proposed principles, for discussion.

8.1. HIAP is an approach, a way of working and common commitment to maximising the positive health impacts across all council functions to improve outcomes for residents, not an end in itself.

8.2. HIAP is not health imperialism but a means for fostering inter-sectoral working and collaboration for mutual benefits.

8.3. Health in this context is seen as an integral part of overall wellbeing (social/ecological model) rather than just non-illness (medical model); serving as universal marker for good government.

8.4. Healthy ‘settings’ (such as schools, workplaces etc.) are places where good health is created rather than just venues for health education.

8.5. Health and wellbeing is recognised as an explicit political goal with HIAP being a tool to increase informed decision making by demonstrating potential win: wins as well as trade-offs between wellbeing and other political goals.

8.6. HIAP is a long-term ambition. In working towards HIAP we plan to be pragmatic and iterative, explicitly avoiding additional bureaucracy by building on current work and using existing structures and processes; but also encouraging ‘spotting health & wellbeing opportunities’, balanced by robust checks of evidence of impact and learning as we go along.

8.7. We look out for synergies in HIAP across London, including the refresh of the Mayor’s strategies; together with opportunities to work with other interested councils.

Suggested initial priority actions

9. HIAP is the umbrella framework for a variety of suggested priorities. We have included actions where we anticipate that the HIAP approach adds most value to delivery and impact. The criteria are set out in Appendix 1. We purposefully propose a mix of different types to allow some experimentation and learning. They are all building on existing work and future plans and take into consideration the LGA self-assessment and workshop and HWBB January session and will link to future strategic planning.

10. In recognition of the financial situation, none are expected to require additional financial resources (but some might attract external support/funding). In the longer-term a HIAP approach is expected to lead to increased efficiency.

11. As learning increases, it is expected that more opportunities will be picked up but equally some actions will be dropped as not suitable so that the plan evolves over time.

12. The main priorities are listed below. Appendix 2 summarises more details including anticipated timeframes, governance arrangements, potential external resources and corporate support required as well as a named public health lead for each action. The Chief Executive or a Director of the Council has also been nominated as champion for each action. The Director of Communities and Housing and the Director of Public Health will lead the programme of work on HIAP whilst the champions will speak up for these actions and keep them in the mind-set as future policies and strategies are planned. The Health and Wellbeing Board will provide an overview of the

Action Plan. Some proposed actions below are highlighted as tentative (*explore*). They have been raised as ideas but require more work to check out evidence of likely impact and feasibility of implementation.

12.1 Leadership and advocacy for HIAP approach across council and partners

- Refine and finalise HIAP action plan and seek ownership and commitment across council (departmental management teams) and partnerships (HWBB and Merton Partnership). Council Directors to champion priorities (see suggested names against priority areas).
- Organise workshop for councillors (co-facilitated with LGA) on prevention matters/HIAP, with invitation to cabinet leads, CCG and HWBB chairs across London.
- Organise and grow informal lunch and learn sessions on cross-cutting health and wellbeing topics to bring together teams from different directorates.
- Work with Head of Policy, Strategy and Partnerships on relevant new policies and strategies to promote health and wellbeing wherever possible.
- Develop and agree prevention framework with NHS partners (as part of STP) to clarify roles, responsibilities and best use of scarce resources between council and CCG, based on evidence of impact and cost-effectiveness.
- Bring councillors and GPs together as place shapers for awareness raising and relationship building opportunity – Dr Karen Worthing to invite East Merton Cllrs to locality meeting.
- Use opportunity of senior leadership programme that is underpinning working towards 2020 Best London Council to strengthen cross-directorate working for health and wellbeing.
- *Explore* option for Merton to become member of the Healthy Cities UK network, as visible symbol for HIAP commitment and to enhance shared learning and capacity building (more details in Appendix 3).

12.2 Embedding the social value act in commissioning and procurement

Explore developing a toolkit and charter for commissioners (possibly shared with CCG)

- Organise training for commissioning staff
- Use the PH re-procurement of adult drugs and alcohol treatment services as demonstration project

12.3 Healthy Workplaces

- Refine and implement the Council Healthy Workplace action plan, including training for staff in promoting health and wellbeing (Making Every Contact Count) and *explore* development of simple Pulse Staff Survey.
- Take forward the Healthy Workplace Charter with Merton businesses through the Merton Partnership.

- Work with the CCG on making health and care provider organisations healthy work places (implementation of STP priority).

12.4 Joint work plan between environment directorate and Public Health

- Use health impact assessment focussed on estate regeneration and Morden town centre development to create health promoting environments (PH working alongside colleagues from environment).
- Working jointly on health in the new Local Plan towards 2019.
- Implement the One Public Estate (OPE) project.
- Implement the Local Alcohol Action Area.
- Merton participation in national TCPA (Town & Country Planning Association) project - Building Healthy Places.
- *Explore* joint working opportunities to reduce air pollution, especially around schools.

12.5 Embedding 'Think Family' into everyday council working

- Use development and launch of the refreshed children, young people and families' well-being model to reach across the Council to embed 'Think Family' approach into everyday business including strategy, commissioning and service development.
- Deliver awareness sessions for staff; roll out of training on signs of safety/wellbeing with a focus on Neglect Strategy and underpinning risk factors: parental mental health; domestic abuse, parental substance misuse, family poverty, housing/homelessness.

12.6 Tackling childhood obesity

- Implement and refine the child healthy weight action plan.
- *Explore* developing the 'Merton Mile' (as supported by collective DMT), building on the daily mile from the child healthy weight action plan to increase levels of physical activity and use of green spaces in Merton.
- Collaborate with pan London childhood obesity initiatives.

12.7 Dementia friendly Merton

- Re-invigorate the local Dementia Action Alliance (DAA) as the vehicle to become a dementia friendly borough and get as many organisations, groups and teams as possible signed up and pledging three actions (including council teams).
- Develop and implement dementia friendly initiatives, working towards 2020 accreditation as dementia friendly borough.

12.8 The action plan is an evolving document and further suggestions of potential actions have already been made on housing and homelessness with a discussion planned for July as well as developing literacy themed activities in libraries to improve health and wellbeing.

Proposed Governance

13. The principle is to use existing management arrangements within the Council, to provide practical channels for promoting agreed actions, generating further ideas, evolving the action plan and challenging progress. For partnership issues with the CCG, One Merton Meeting (OMM) is the respective forum.

14. The HWBB is the lead thematic partner to champion the HIAP approach, provide oversight for delivery of the action plan and propose further actions where required; working jointly with other relevant thematic partnerships. It is proposed the HWBB overview of HIAP action plan be linked to future monitoring of the HWB strategy which is due to be refreshed for 2018 and will include HIAP.

15. To monitor progress we will use existing measures / indicators and systems to gather information.

16. The proposed council intelligence hub and analyst network will be enormously helpful in bringing together different data and information sets covering health and wellbeing as well as the social, economic and environmental determinants and allowing joined up monitoring and interpretation.

17. Ultimately one of the aims for progressing HIAP is to reduce the persistent inequalities between the East and West of the borough. The next annual public health report is planned to look at time trends of these inequalities for a better understanding of our baseline and projected future changes.

NEXT STEPS

18. The importance of ownership of a HIAP approach across the Council and partners will be central to success. This does not require using the 'HIAP jargon' but working in its spirit. Implementation of the action plan is the essential next step.

TIMETABLE

Once the approach is agreed the action plan will be finalised and implemented to timelines outlined in Appendix 2

FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report.

LEGAL AND STATUTORY IMPLICATIONS

None for the purpose of this report.

HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

Health in All Policies is directly concerned with improving health equity.

CRIME AND DISORDER IMPLICATIONS

None

RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

APPENDICES

Appendix 1 – Criteria for choice of HIAP priority actions
Appendix 2 – HIAP draft action plan
Appendix 3 – Healthy Cities Network

Background Papers

None

Officer Contact

clarissa.larsen@merton.gov.uk

Appendix 1

Criteria for choice of HIAP priority actions:

Relevant	Impactful	Deliverable
• Synergy with priorities of HWB Strategy and LBM wider strategies e.g. Bridging the Gap • Focuses on issues that can best be addressed in a collaborative approach across the Council and/or with partners.	• Targets the specific issues which are having the greatest impact on inequalities in health outcomes relating to the HWB and wider LBM strategies. • Focuses on the social determinants of health. • Draws on the evidence base and data to ensure effective and cost-effective interventions.	• Identifies and addresses short, medium and long term goals. • Outlines specific actions to be taken. • Identifies resources available for delivery. • Has an effective governance model in place.

Appendix 2 - HIAP Action Plan

Priority / key activity Expected impact	Completion date	How resourced?/ Corporate support/ Ext partners	Governance	PH Lead	Suggested Thematic Partnership Lead
1. Leadership for HIAP across council and partners Impact: HIAP to become established way of working		**Existing resource; various ext. support**	**Overall champion: Ged Curran HWBB**		
Refine and finalise HIAP action plan and seek ownership and commitment across council (DMTs) and partnerships (HWBB) Champion HIAP approach for specific priority area *Explore* role of Merton Partnership (MP) and its subgroups (incl health & wellbeing session at May away-day)	May 17	PH and partners PH / Policy, Strategy and Partnerships	PH CMT members John Dimmer & DZ	Dagmar Zeuner/ Clarissa Larsen	HWBB MP
Organise workshop for Cllrs (co-facilitated with LGA) on prevention matters/HIAP, with invitation to cabinet leads and HWBB chairs across London	June 14 (tbc)	LGA support	HWBB / PH	Amy Potter / Clarissa Larsen	HWBB
Organise and grow informal lunch & learn sessions on cross-cutting topics to bring together teams from different directorates - Building on success of the first one organised by PH trainees and delivered by Steve Langley about homelessness which attracted a mix of different staff from all directorates - incl audit, community safety and triggered discussion about cross-working opportunities.	On-going	Volunteer presenters from across the council	HWBB / PH	Anjan Ghosh / PH trainees	

Priority / key activity Expected impact	Completion date	How resourced?/ Corporate support/ Ext partners	Governance	PH Lead	Suggested Thematic Partnership Lead
Refine and agree prevention framework with NHS partners (as part of STP) to clarify roles, responsibilities and best use of scarce resources, based on evidence of impact and cost-effectiveness. For example prevention framework informed procurement by PH of re-designed healthy lifestyle service with less resource to absorb PH grant reduction.	Summer 17	STP support; SLP support	PH & CCG / CRG; OMM, RCBS (STP)	Amy Potter	HWBB with others
Bring Cllrs and GPs together as place shapers for awareness and relationship building opportunity – details tbc; Dr Karen Worthing to invite East Merton Cllrs to locality meeting	Spring 17	CCG support; Democratic Services; Cllr Tobin Byers; Potential ongoing support from vision leadership for HWBB development	KW and PH / HWBB	Dagmar Zeuner / Clarissa Larsen	
Use opportunity of senior leadership programme underpinning working towards 2020 Best London Council to strengthen cross-directorate working for health and wellbeing For example: use one SL session to engage council teams in sign up to dementia action alliance including three pledges (linked to priority of dementia friendly Merton below)	On-going Late spring	HR support	HR and PH / best London council 2020 governance	Dagmar Zeuner (with Kim Brown) Anjan Ghosh	

Priority / key activity Expected impact	Completion date	How resourced?/ Corporate support/ Ext partners	Governance	PH Lead	Suggested Thematic Partnership Lead
Explore option for LBM to become member of the healthy cities UK network as visible symbol for HIAP commitment and to enhance learning and capacity building (more details in appendix 4)	April 18	PH CPD (£1500 per annum subscription fee)	PH / HWBB Requires cabinet sign-off	Amy Potter	HWBB / MP
2. Embed Social Value Act into commissioning and procurement Impact: as many commissioning opportunities as possible secure additional social value.		**Existing resources: joint work with corporate policy, procurement and HR**	**Overall champion: Caroline Holland Procurement board; cross council steering group?**		
Explore developing a toolkit and charter for commissioners (possibly shared with CCG)	From Sept 17	Vol sector and CCG	PH working with DJ	Dagmar Zeuner (with Dawn Jolley)	
Organise training for commissioning staff		Joint work with corporate policy, procurement and HR	HR L&D	Amy Potter	
Use the PH re-procurement of adult drugs and alcohol treatment services as demonstration project	April 18 (goes live)		PH working with DJ/procurement board	Amy Potter	S&SSG
3. Healthy Workplaces Impact: improve work productivity and health of residents who are also employees.		**Existing resources; potentially external funding including HEE**	**Overall champion: Caroline PH & HR / workforce board**		

Priority / key activity Expected impact	Completion date	How resourced?/ Corporate support/ Ext partners	Governance	PH Lead	Suggested Thematic Partnership Lead
Refine and implement the Council Healthy Workplace action plan. *Explore* working towards Mayor's Healthy Workplace charter excellence (London scheme under review; decision depends on robustness of standards and bureaucracy) Develop and implement training linked to One You Merton for council staff in promoting health and wellbeing (making every contact count MECC) - initially front-line providers, later possibly also commissioners, policy. *Explore* development of a Pulse Staff Survey (as proposed in collective DMT).	On-going programme Sept 17 Oct 17	Potentially HEE / PH academy funding for MECC Commissioned One You Merton service PH/HR	PH & HR / workforce board PH	Amy Potter / Barry Causer (with Kim Brown) Barry Causer Barry Causer (with Kim Brown)	HWBB
Take forward the Healthy Workplace Charter with Merton businesses through the Merton Partnership.		Chamber of Commerce partner	PH / MP	Barry Causer	HWBB
Work with the CCG on making health and care provider organisations healthy work places (implementation of STP priority).		CCG	PH working with CCG; RCBS (STP)	Barry Causer	HWBB
4. Joint work plan between environment directorate and Public Health Impact: creation of health promoting environments; healthier lifestyles		**Existing resources; variable external funding.**	**Overall champion: Chris PH/environment DMT**		
Use health impact assessment focussed on estate regeneration and Morden Town centre development to create health promoting environments	From Sept 17		PH & Future Merton	Amy Potter	SCP

Priority / key activity Expected impact	Completion date	How resourced?/ Corporate support/ Ext partners	Governance	PH Lead	Suggested Thematic Partnership Lead
Implement the One Public Estate (OPE) project		Cabinet office (50K+350K)	CL & JMG / MP; Wilson programme board	Dagmar Zeuner (overall lead E&R)	SCP
Implement the Alcohol Action Area	LAA approved Jan 17; now action plan	Ext support (non-financial)	PH & Safer Merton	Amy Potter	SCP
Explore joint working opportunities to reduce air pollution, especially around schools	From Sept 17	Mayor's initiatives	PH & regulatory services & CSF	Amy Potter	SCP
5. Embedding 'Think Family' approach across the council everyday business Impact: improve child health and wellbeing and harm reduction – reduction of child maltreatment and children requiring care.		**Existing resources; variable external resources.**	**Overall champion: Yvette MSCB, Children's Trust Board**		
Use development and launch of the refreshed CYP and families well-being model to reach across the Council to embed 'Think Family' approach across everyday business including strategy, commissioning and service development..	March 19		MSCB, Children's Trust Board	Julia Groom (lead CSF)	CTB
Deliver awareness sessions for staff; roll out of training on signs of safety/wellbeing with a focus on Neglect Strategy and underpinning risk factors: parental mental health; domestic abuse, parental substance misuse, family poverty, housing/homelessness.	March 19	CSF	MSCB, CTB	Julia Groom (supporting CSF)	CTB
6. Tackling childhood obesity Impact: improved life chances and reduced health inequalities.		**Existing resources; variable external**	**Overall champion: Yvette Children's Trust; HWBB**		

Priority / key activity Expected impact	Completion date	How resourced?/ Corporate support/ Ext partners	Governance	PH Lead	Suggested Thematic Partnership Lead
Implement and refine the child healthy weight action plan	March 18	Volunteer support from AELTC; Potentially Sport England and other PA grants;		Julia Groom	CTB
Explore developing the 'Merton mile' (as supported by collective DMT), building on the daily mile from the child healthy weight action plan to increase levels of physical activity and use of green spaces in Merton	Daily mile active in some schools	Child Healthy Weight Steering Group	CSF, PH & environment colleagues	Julia Groom / Hilina Asrress	CTB / HWBB
Collaborate with pan London childhood obesity initiatives (i.e. 'Big weight debate' follow-on)	March 2018	Support from HLP, PHE, LADPH; potential London prevention fund; potential London social investment opportunities	PH / HLP (prevention board), LADPH; GLA	Hilina Asrress	CTB
7. Dementia friendly Merton Impact: building community engagement and civic life, improving the quality of life and wellbeing of people with dementia and their carers	**April 2020**	**Existing resources; Various external**	**Overall champion: Simon Older people steering group; One Merton Meeting (OMM)**		
Re-invigorate local Dementia Action Alliance (vehicle for becoming dementia friendly Merton by providing network of organisations, groups, teams that each pledge three actions)	From April 17	Local organisations & groups; Alzheimer's society	PH / DAA	Daniel Butler	HWBB

Priority / key activity Expected impact	Completion date	How resourced?/ Corporate support/ Ext partners	Governance	PH Lead	Suggested Thematic Partnership Lead
Develop and implement dementia friendly initiatives, working towards accreditation as dementia friendly borough (Accreditation handled by Alzheimer's society, based on robust standards)	2020	As above	PH / DAA	Daniel Butler	HWBB

Appendix 3

Healthy Cities Network - WHO Healthy Cities Network

Healthy Cities is a ground-breaking and values-based World Health Organization (WHO) initiative that focuses on city-level political leadership, partnership working and participatory processes to tackle the social determinants of health and health inequity. It grew out of a concern for urban health and the particular challenges and benefits the urban environment provides for human health.

The network provides political, strategic and technical support to members. Health is the business of all sectors, and local governments are in a unique leadership position, with power to protect and promote health and well-being. This is not about the health sector only; it includes health considerations in economic, regeneration and urban development efforts.

The Network operates in five year phases refreshing its goals and themes each phase. Goals and themes for Phase VII, which will run from 2018, and which Merton could consider joining, are currently under development. To join the UK Healthy Cities Network local authorities need to demonstrate that they have:

- Political commitment to Healthy Cities, including a named lead politician
- A commitment to participate actively in the Network
- A commitment to pay the annual subscription for the national network of £1,500 per annum, which, given the benefits and potential learning opportunities of the Network could be funded from the public health CPD budget.

Committee: Health and Wellbeing Board

Date: 20th June 2017

Subject: Update on Better Care Fund (BCF)

Lead member: Councillor Tobin Byers

Contact officer: Annette Bunka, Senior Commissioning Manager, NHS Merton CCG

Recommendations:

That the Health and Wellbeing Board

A. Notes this report

B. Agrees to delegate the review of the BCF Plan submission to the Chair and Vice-Chair, and to delegate the final sign-off of the BCF submission to the Chair of the Health and Wellbeing Board.

---

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report provides an update to the Health and Wellbeing Board regarding the 2016/17 year end position in relation to performance of the Better Care Fund (BCF) and outlines the plans for 2017-19 and progress against those plans. A paper detailing the achievements within the BCF was presented to the Health and Wellbeing Board on 28th March 2017.

The national planning guidance for BCF has not yet been finalised and published, with no publication date set. In May, the LGA made a decision to share the draft planning guidance which is currently being worked through across health and social care.

A request is therefore made to the Health and Wellbeing Board for approval of delegated authority to enable the BCF Plan, once finalised, to be signed off via chair's action.

2 BACKGROUND

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which was announced by the government in 2013 with the aim of improving the lives of some of the most vulnerable people in our society, by placing them at the centre of their care and support, providing them with integrated health and social care. In order to support this aim, a Better Care Fund Plan has been developed and agreed across health and social care.

The key priority for integration in 2016/17 BCF was to strengthen the relationships and collaboration between providers in Merton with the aim of:

- Reducing the growth of emergency admissions
- Reducing length of hospital stay
- Reducing permanent admissions to care homes

- Improving service user and carer experience.

3 DETAILS

3.1 Performance 2016/17

Metric	Q4 Performance	Commentary
Non-elective admissions	The annual target of 18,819 for this performance measure has not been achieved for the 2016/17 reporting period with a year-end outturn of 19,900 for London Borough of Merton.	Factors for this variation include challenges early in the year regarding vacancies within community services which have now been addressed. Part of the additional growth was also found to be inappropriate short stay admissions (0-1 day LOS) at St George's following a clinical audit. Commissioners have applied challenges to the Trust contract in order to mitigate this behaviour. The CCG continue to work and manage the situation with our acute providers.
Permanent admissions to residential care	This target has been achieved, with an end of year out-turn of 104 against a target of 105.	Data will be validated by NHS Digital during July/August 17
Re-ablement activity	149 reablement services were offered to customers aged 65+ during October to December, which was an increase from 2015/16 but did not achieve the proposed target	Data will be validated by NHS Digital during July/August 17. It was not possible to include the data from Intermediate care services, which has reduced the expected position. Work to rectify this is taking place.
Delayed Transfers of care	The 2016/17 annual target of 2,799.1 per 100,000 population has now been met with a 2016/17 year end outturn of 2,622.6 per 100,000 population reported for London Borough of Merton.	The CCG and Local Authority have jointly monitored and managed this performance measure throughout 2016/17 which has helped deliver performance levels consistently below the London average.
Social care-related quality of life	This target has not been achieved with an end of	London Borough of Merton outturn shows a marginal

This measure is an average quality of life score based on responses to the Adult Social Care Survey.	year out-turn is 18.5, against a plan of 18.8.	decrease in reported levels of quality of life from the 2015/16 score of 18.6. Data will be validated by NHS Digital during July 17, following which benchmarking will be possible. A review will take place to understand this further.

3.2 Proposed Targets and Trajectories for 2017/18

The BCF policy framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2016-17, with only minor amendments to reflect changes to the definition of individual metrics, with quarterly metrics for non –elective admissions and delayed transfers of care and annual metrics for admissions to residential and care homes and effectiveness of reablement.

Work is taking place to agree the targets and trajectories for 2017/18.

For delayed transfers of care, London has been set target reductions for achievement by September 2017 which should be sustained through the winter until March 2018.

For Merton this represents a 9% target reduction in days delayed. This has been apportioned using the 16/17 activity data to work out the average NHS to social care ratio split.

Work is in progress that we think will help us achieve that performance improvement which includes local implementation of the 'High Impact Changes for Managing Transfers of Care'.

3.3 Development of BCF for 2017/19

As outlined at the Health and Well Being Board in March, following the publication of the South West London Sustainability and Transformation Plan (STP), multi-agency task and finish groups have been established to deliver this work, which is expected to have a significant and positive impact on the delivery of the BCF objectives. These plans will form a significant part of the BCF plan going forward, with the priorities for 2017/19 focussing on:

- Integrated locality teams including support for complex patients, roll out of frailty work and case management support, end of life care, dementia and falls.
- Intermediate care and re-ablement, rapid response and discharge to assess.
- Enhanced support to care homes.

The task and finish groups report into Merton Integrated Delivery Group who will report into the Merton Joint Commissioning Group once established.

A summary of the schemes and progress to date is outlined below:

3.3.1 Integrated Locality Teams

A multi-agency group has been established to further develop current multi-disciplinary working across health and social care to proactively support keeping people well at home and avoid unnecessary emergency admissions to hospital. This group has reviewed current arrangements and developed a proposed model going forward. An implementation plan has been developed which the group has agreed and actions are being undertaken to achieve the agreed aims and objectives of the teams. These will be presented to the next Merton Integrated Delivery Group, before wider engagement takes place. This group will also oversee a range of other schemes, including the roll out of the frailty pilot undertaken and a project manager has been recruited to support the delivery of this scheme. Engagement with patients and the voluntary sector has started, with a view to maximising the impact of this work.

3.3.2 Intermediate Care, Re-ablement, Rapid Response and Discharge to Assess.

A multi-agency group has been established to improve capacity and access to enable more people to go home sooner from hospital where possible and avoid unnecessary admission to hospital so that more people are able to remain independent in their own home.

Significant improvements have been put in train over the last year, with the focus of this work stream maximising the impact of services that have already been commissioned and identifying and addressing outstanding gaps. As part of this, a gap analysis has been undertaken and an action plan drawn up. This includes building on the co-location of services already undertaken and supporting joint assessment, care planning and service delivery as well as supporting joint training and team building.

Improved relationships are facilitating the bridging of gaps in care provision to prevent unnecessary hospital admission and facilitating a reduction of hospital length of stay.

Work is taking place to make the process of discharge for hospital teams as simple as possible and enable the most effective use of available capacity.

3.3.3 Enhanced Support to Care Homes

To aim of this work stream is to provide enhanced support to care homes in order to provide improved quality, help people access the right care and support and provide more care out of hospital. This will take learning from the National Vanguard programme and in particular the successes from the work undertaken by the Sutton Vanguard and includes, review and development of the support available to residential and nursing homes (including enhanced primary care support and MDT working), development of care home workforce, development of the CQC liaison meeting to form the Joint Intelligence Group, improvements in the hospital transfer pathway and use of ‘Red Bag’ and supporting more joined-up commissioning and collaboration between health and social care. Some of these elements have already started, including establishment of the Joint Intelligence Group. Recruitment is underway for a commissioning manager post, and this will form one part of their work area.

4 ALTERNATIVE OPTIONS

Not applicable.

5 CONSULTATION UNDERTAKEN OR PROPOSED

Not required.

6 TIMETABLE

Not applicable.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

The BCF is a pooled budget of which £5.5m is transferred from Merton CCG to London Borough of Merton. In addition to this, iBCF funding of £2.745m has been allocated to London Borough of Merton, the spending of which forms part of the BCF agreement, along with Disabled Facilities Grant. Discussions are taking place regarding the allocation of the iBCF, with NHS expectations of an impact on hospital admissions/ discharges, alongside challenges from social care in relation to provider expectations to make good previous year's fee restrictions.

A risk sharing agreement for 2017/18 is under discussion between London Borough of Merton and Merton CCG.

8 LEGAL AND STATUTORY IMPLICATIONS

There is a signed section 75 in place between the CCG and the LA setting out the terms of the BCF pooled fund.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Integration programme is sensitive to human rights, equalities and community cohesion and is governed under current service management arrangements.

10 CRIME AND DISORDER IMPLICATIONS

Not applicable.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

Risk management and health and safety are managed by current service management arrangements.

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

Not applicable.

13 BACKGROUND PAPERS

BCF Plan 2016/17, draft guidance –Integration and Better Care Fund Planning Requirements for 2017/19, High Impact Changes for Managing Transfers of Care.

This page is intentionally left blank

Committee: Health and Wellbeing Board

Date: 20 June 2017

Agenda item:

Wards:

Subject: Adult Social Care Funding 2017/18

Lead officer: Simon Williams, Director of Community & Housing

Lead member: Tobin Byers, Cabinet member for Adult Social Care and Health

Forward Plan reference number:

Contact officer: Richard Ellis, Head of Adult Commissioning

Recommendations:

A. For the Health and Wellbeing Board to note the report.

DETAILS

1. Introduction

1.1. The Adult Social Care budget has been under pressure for a number of years, in line with the national trend. The pressure is a combination of the need to make savings to address the significant reductions in Government funding for local government and growing demand from disabled and older adults.

1.2. The national pattern of demand and costs has not played out exactly as predicted in the past nor as reported in the media today. Whilst the ageing population has increased demand for local authority funded social care, this has partly been mitigated by demand management strategies. Therefore the number of older people receiving care has not risen as predicted. However, the amount of care that people receive and the cost of that care has increased as the complexity of needs and prevalence of dementia amongst service users has increased. Alongside this there has been a significant growth in demand from people transitioning into adulthood with complex physical and learning disabilities.

1.3. In the early days of austerity, there was a strong focus on market management and procurement 'efficiencies' , which translated as freezing or reducing care fees. In recent times, there has been considerable pressure to increase fees again to restore some stability to an uncertain market. The problems in the care market have been exacerbated by constraints in the supply of care labour. There is very little spare capacity in the system, and with 11% of the total adult social care workforce in Merton coming from other EU countries, there must be a further risk of contraction. (source: Skills for Care)

2. 2016/17 budget outturn

2.1. Adult Social Care ended the year with a net overspend of £9m, although that includes some one-off pressures. The majority of the pressure was in the placements budget, predominantly relating to the number of home care hours commissioned, transitions costs and increased care fees. There was also a reduction in client income and increased costs from deprivation of liberty assessments.

3. 2017/18 budget

3.1. Whilst the budget was formally approved by full council in March 2017, the work to develop the budget took place from July onwards, with final revision in February. The pressures on Adult Social Care were therefore assessed on a mid-year position, which varies a little from the year-end position. In particular, there was an increase in placements spend and a growth in residential placements for older people.

3.2. Cabinet, and subsequently full council, accepted the case that Adult Social Care needed significant growth to be able to maintain statutory services. This was despite the continued reduction in Government support to local government, albeit partially offset by the Social Care Precept.

3.3. Cabinet proposed, and Council approved, a 3% Social Care Precept for 2017/18, which raises c£2.4m pa. In total, £9.3m of growth was added to the Adult Social Care budget, which after a number of other unrelated adjustments, results in a gross budget of £80.5m and a net budget of £59m.

3.4. The growth is funded by three sources:

- Social Care Precept - £2.4m (approx.)
- iBCF - £2.745m
- Reserves - £4.2m

3.5. Growth has been allocated based on the patterns of activity and income in 2016/17, which are expected to continue into 2017/18 and on unavoidable care fee pressures in 2017.

Growth ASC growth 2017/18		**Funded by**		
	£000	**Precept***	**iBCF**	**Reserves**
Client income shortfall	1,300			1,300
Other	100			100
Provider uplift – NLW	1,100	1,100		
Provider uplifts - residential	820	820		
Transition to adulthood	470	470		
Residential placements	3,800		990	2,810
Home Care activity	1,755		1,755	
	9,345	**2,390**	**2,745**	**4,210**

** estimate*

3.6. The fall in client income reflects national trends, but also some local systems issues that are being resolved. The National Living Wage was increased by 4%. Although many care employers pay above this, the NLW puts upward pressure all wages in the service sectors. In addition, the cost of residential and nursing care is increasing significantly as local authorities are forced to compete with private fee payers for a limited supply in order to meet the ongoing demand for beds. An allocation has been made for additional residential and nursing placement costs based on a hundred care beds at average cost spread evenly over the year, based on the pattern of demand seen in 2016/17.

3.7. Home Care hours have continued to rise, with an increase of 21% between March 2016 and March 2017. The funding allocation is based on an assumption of a continuation of this trend at average hourly costs. Home Care contracts are currently out to tender. The new model will have three prime providers covering three geographic patches, who will be expected to take the majority of new cases. In addition there will be a back-up provider list and a specialist care list. These contracts are expected to be awarded for a November 2017 start.

3.8. The core Better Care Fund transfer remains at £5.5m. With the mandated increase in the mandatory part, this means that the discretionary part of the transfer has decreased by c£60k. The allocation of the funding has agreed, subject to receipt of the final guidance. Plans focus resources on fewer lines of activity. This includes coordinating local authority and CCG investment in voluntary sector wellbeing programmes, and support for reablement and integrated teams.

4. The year ahead

4.1. 2017/18 is likely to be a financially challenging year despite the additional funding. The Social Care Precept and iBCF funding has created expectations that there are funds available, when in reality the additional funding provides some stability only. Providers have already set out expectations for most or all of the iBCF funding to be used to make good previous years' fee restrictions. Meanwhile NHS England has been setting out its own expectations. The iBCF grant is a grant from DCLG and is therefore only subject to the conditions they set, which in brief are: that is forms part of the BCF pool and is spent on meeting adult social care needs, and/or reducing pressures on the NHS and/or ensuring that the local social care market is supported.

4.2. Care labour shortages are expected to continue, particularly in home care. A competitive labour market and losses of some EU workers have added to a long term issue with the attractiveness of care work. The new prime Home Care providers will be expected to undertake extensive recruitment programmes, but that will only have a partial impact his year. Whilst there are some new nursing homes being built in the south-west London area, few are within the price range of local authorities. There is also a risk that current homes may shift their focus more towards self-funders.

4.3. Our focus for the year ahead will be on:

- Delivery of the further savings that form part of the council's medium term financial strategy;
- Meeting our core statutory duties;
- Stabilising the local care markets;
- Helping pressure on the NHS, particularly in relation to improving hospital discharges.

ALTERNATIVE OPTIONS

N/A

CONSULTATION UNDERTAKEN OR PROPOSED

N/A

TIMETABLE

As outlined in the report.

FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

N/A

LEGAL AND STATUTORY IMPLICATIONS

N/A

HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

N/A

CRIME AND DISORDER IMPLICATIONS

N/A

RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

N/A

APPENDICES

None