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Merton Council

Health and Wellbeing Board

Date: **8 October 2019**

Time: **6.15 pm**

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

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

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: communications@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.

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Health and Wellbeing Board Membership

Merton Councillors

- Tobin Byers (Chair)
- Kelly Braund
- Oonagh Moulton

Council Officers (non-voting)

- Director of Community and Housing
- Director of Children, Schools and Families
- Director of Environment and Regeneration
- 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

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HEALTH AND WELLBEING BOARD
25 JUNE 2019

(6.14 pm - 8.10 pm)

PRESENT Councillor Tobin Byers – Chair
Councillor Oonagh Moulton,
Dr Andrew Murray - Vice Chair and Chair of Merton CCG
Hannah Doody - Director of Community and Housing
Rachael Wardell - Director of Children, Schools and Families
Chris Lee - Director of Environment and Regeneration
Dr Dagmar Zeuner - Director of Public Health
Dr Doug Hing - Merton CCG
Dr Andrew Otley -Merton CCG
Barbara Price - Merton Voluntary Services
Brian Dillon - Chair Merton HealthWatch
Rob Clarke - Health and Social Care Forum.

ALSO PRESENT Dave Curtis – Merton HealthWatch
Sarah Keen - CAMHS Merton Commissioning Manager
Julia Groom –Public Health Consultant
Teresa Bell - Independent Chair Safeguarding Adults Board
Suzanne Marsello -St George's University Hospital
Dr Sy Ganesaratnam - The Federation

1 APOLOGIES FOR ABSENCE (Agenda Item 1)

Apologies for absence were received from Councillor Kelly Braund and James Blythe

The Chair welcomed new members to the Board:
Cllr Oonagh Moulton
Barbara Price – MVSC
Rob Clarke – Health and Social Care Forum

And thanked the departing Members: Cllr Janice Howard, Khadiru Mahdi and Lyla Adwan-Kamara

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

There were no declarations of Pecuniary Interest

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

The minutes of the meeting on 26 March 2019 were agreed as an accurate record

4 SAFEGUARDING ADULTS ANNUAL REPORT (Agenda Item 4)

Teresa Bell, the Independent Chair of the Merton Safeguarding Adults Board, presented the Merton Safeguarding Adults Board Annual Report 2017-2018.

The Independent Chair highlighted that this report is for 2017/18, and progress has been made since then including a new web site for the SAB. She continued by explaining that although the data for 2018/19 is not yet validated, she is confident that this will show a change in the level of referrals. There is now a very useful dashboard available and she hopes to see a change in practice based on a sounder understanding.

The Independent Chair explained that it has not been possible to benchmark because the data is imperfect, and some time is needed to become more confident. This year she expects the data to be more in line with comparator boroughs. The Director of Community and Housing explained that for benchmarking purposes, the more concerns raised the better as it shows that people know what to do, it is important that these are then converted to Section 42 enquiries.

The voluntary sector representatives were pleased to note the engagement with the voluntary sector, and offered to help with continued engagement. The Independent Chair said that that her Board Manager would set up a session with the voluntary sector to establish the best way of engaging with them

The Board thanked Teresa Bell for her report

RESOLVED

The Board considered and approved the Merton Safeguarding Adults Board Report for the period 2017-2018

5 SEXUAL HEALTH STRATEGY (Agenda Item 5)

Julia Groom, Public Health Consultant, presented the report on the Merton Joint Sexual Health Strategy.

The Board discussed the report. In answer to a question Julia Groom replied that there was a need to better understand why STI are rising in the over 50 age group, and the wide age band needs to be built into the strategy.

When asked about HIV infection Julia replied that there were differences in the approach to two groups MSM (men who have sex with men) and BAME communities. The Gay community is very aware of HIV issues and there is less stigma attached to HIV in this group. However there are challenges amongst some BAME communities. It is recognised that this is an area for continued focus and there needs to be support and prevention programmes with African and Faith groups.

Dr Doug Hing raised the issue that there are opportunities to link sexual health with social prescribing and mental health services, particularly with relationship issues. He

asked how much work had been done to understand the needs and services provided in neighbouring boroughs. Julia Groom explained that the current service model is for joint commissioning with Wandsworth and Richmond.

Councillor Moulton welcomed the report and noted that there had been success in reducing the number of teenage conceptions. She asked what we are doing for teenagers to further reduce these figures, especially targeting those in the east of the borough. Julia Groom replied that Merton continues to see a decline in these figures but there is still work to do around awareness, education, ambition and access to good services. Relationships and Sex Education will become statutory and support for teachers will continue. We are keen to look for other opportunities, and understand that young people want to focus on relationships and wellbeing

The Director of Children Schools and Families thanked Public Health officers for their high level of consultation with children and young people regarding these issues. She then asked if the vision should include a reduction in sexual violence, Julia Groom said she will take on board

Dr Andrew Otley said the reduction of teenage pregnancy in the East of the Borough had been dramatic.

Julia Groom said they will be developing the Sexual Health Strategy over the summer and will bring back to the Board before going to Cabinet.

RESOLVED

That the Health and Wellbeing Board:

A. reviewed and endorsed the proposed vision and priorities for the borough wide sexual health strategy;
B. considered their roles and opportunities for promoting sexual health in the borough;
C. supported the Fast Track Cities London programme.

6 HEALTH AND WELLBEING STRATEGY (Agenda Item 6)

The Director of Public Health presented the report on the Merton Health and Wellbeing Strategy 2019-2024 Final Draft – A Healthy Place for Healthy Lives

She explained that whilst the Health and Wellbeing board was not abdicating its oversight of health and care that the Health and Wellbeing Strategy is focussing on creating a healthy place – the physical, social and economic conditions all around us which make us healthy.

The Vice Chair said that he thought that this Strategy is brilliant, commended the engagement in developing the plan and particularly welcomed the way it complements the Local Health and Care Plan. He asked how we can ensure that the Health and Wellbeing Board really focusses on the Strategy and that just an annual

report might not be enough. The challenge is how we can make this a live working document.

The Director of Public Health explained the rolling programme priorities that will be reported to the Board in October. This will include a suggested priority of healthy workplace focussing on mental health and active travel. It will also include a continued focus on the whole system approach to diabetes.

The Chair thanked Dagmar and her team for all their work on this, and put a caveat on recommendation B that it in addition to the annual reporting of the Health and Wellbeing Strategy that it is a live document.

RESOLVED

That the Health and Wellbeing Board:

A. Considered and agreed the final draft Health and Wellbeing Strategy 2019 – 2024.
B. Noted and agreed the proposed annual reporting of the Health and Wellbeing Strategy to the Board

7 CAMHS LTP REFRESH (Agenda Item 7)

Sarah Keen, the CAMHS Merton Commissioning Manager, presented her report on the CAMHS LTP refresh. She explained that this was the report for 2018 - 19 and that the report for 2019 – 20 will be reported later this year.

The Chair thanked the CAMHS Merton Commissioning Manager for her report and observed that some of the work is already familiar to the Board which has previously received reports on the Trailblazer and iThrive.

Suzanne Marsello, said that she welcomed this report and particularly the Crisis Care Planning for 2019 which is an important area.

Hannah Doody commented that she would be interested in the data that sits behind the CAMH report and how it compares to other boroughs especially across south west London.

Board members agreed that it was a very good report and thanked Sarah for it.

RESOLVED

The Health and Wellbeing Board signed-off the Child and Adolescent Mental Health Service (CAMHS), Local Transformation Plan

8 THE NHS LONG TERM PLAN, CCG MERGER DISCUSSIONS AND THINKING ABOUT PLACE-BASED COMMITTEES (Agenda Item 8)

The Board received a presentation from DR Andrew Murray on the NHS Long Term Plan, CCG merger discussions and thinking about Place-based Committees.

The Co-Chair of MVSC asked how will the dialogue work across PCNs (Primary Care Networks) for example, on social prescribing would there be a need to have a conversation with each PCN. Dr Murray answered that PCNs have a right to funding for social prescribing and it would make sense to work with MVSC, a lot of work has already been done.

Councillor Moulton asked how much consultation there will be with Local People? Dr Murray answered that PCNs are part of the national agreement, and so there will not be consultation with local people. Moving forward there will be more allied healthcare professionals in the network, and CCGs will merge. This will not change the GP service. Consultation is currently taking place on the PCN through engagement with GPs

The Director for Children, Schools and Families thanked Dr Murray for his presentation and asked where safeguarding would sit in this future structure as there is a need for very local information and discussion. Dr Murray replied that this was a very valid point, and that the CCG is also concerned. He suggested that there may be some safeguarding activity across the borough with a local contact borough by borough.

The Chair of Merton HealthWatch voiced concern about integrated care and its resourcing, and the absence of the Green Paper. Dr Murray replied that the Green Paper would be welcomed, but the annual NHS funding settlement may not meet demand. The integration outlined in the presentation, will free up resources and increase efficiency by reducing management and duplication. The Director of Community and Housing added that essentially it needs to be about how we do things better together.

The Chair concluded the discussion by explaining that the Governance arrangements are to be finalised, work is going on with CCG and through the LGA with HWBB chairs. The Leadership Centre is also helping us to look at what have achieved and how to use this learning. He thanked Dr Murray Andrew for the thorough presentation.

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Committee: Health and Wellbeing Board

Date: 8 October 2019

Wards: All

Subject: Merton Health and Care Plan

Lead officer: James Blythe, Managing Director, Merton & Wandsworth CCGs and Hannah Doody, Director of Communities and Housing

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

Contact officer: Jennifer Nolan, Head of Communications, Merton & Wandsworth CCGs, and Sunita Patel, Head of Communications, Merton Council

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Recommendations:

A. The Board is asked to approve plans for public communications of the final Merton Health and Care Plan document.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The Merton Health and Care Plan has now been finalised. Communications and engagement teams for health and care organisations in Merton have come together to propose a joint plan for publicly launching it – with the primary audiences being local residents and staff within our organisations.

The objectives are:

- To outline the ambitions of the local health and care plan and demonstrate the actions we're taking, so:
    - Local people are aware of the improvements being made to health and care.
    - Frontline staff understand the plans for integrating health and care, accelerating delivery and ensuring the improvement of care for local people as swiftly as possible.
- You Said: We Did – we have engaged widely on the plans and need to demonstrate how we've listened.

2 BACKGROUND

The Merton Health and Care Plan describes our vision, priorities and actions to meet the health and care needs of local people and deliver improvements in their health and wellbeing through the life stages of: start well, live well and age well. It is a two-year (2019–2021) plan which focuses on the actions, which no single organisation could achieve alone. By working together, we believe health, social care and the voluntary sector can deliver quality health and care services that support local people.

It has been essential to develop this plan with local people – a commitment of all our partners. Between August 2018 and July 2019, we spoke to hundreds of local people to hear what they want from health and care services and to test our ideas at different stages in the development of the plan.

In November 2018, we held an engagement event for local people, health and care staff, and representatives from community organisations. We talked about the kinds of things that no single organisation can achieve alone and how organisations could work better together. We also shared what people had already told us about what they want from local services.

We have used the ideas generated during the event, as well as existing insight, to develop our Health and Care Plan, considering priorities around prevention and early intervention

The plan was published as a discussion document in May 2019 to test it with our partners and those who helped shape it. We used this to continue the conversation - and start talking to people about how to put ideas into action. We did this through a mix of face-to-face discussions, online survey and written feedback – targeting those who attended our deliberative event in November, our Patient Engagement Group, local voluntary and community groups (including Healthwatch and Merton Voluntary Services Council), NHS staff and GPs.

Publishing this plan won't be the end of the conversation and we want to continue to engage with local people and community organisations as we put these plans into action.

3 DETAILS

Communications and engagement representatives from health and care organisations across Merton and Wandsworth meet together on a monthly basis to discuss joint initiatives and where we can work smarter together.

We are all communicating with the same people in the borough so it make sense for us to work together to do that, where it makes sense.

Merton representatives have discussed and propose the following plan for launching the health and care plan. The activities below would be used on a specific launch date to enable us to harness our collective ‘communications impact’.

- An infographic style public facing summary document – focusing on the work we are delivering and how priorities have been shaped by discussions with local people
- One ‘publically promoted’ key action/deliverable from three areas: Start Well, Live Well, Age Well to form a core narrative about the plan’s ambitions – to help explain to local people the types of initiatives that are in the plan
- A joint press release targeting local media
- A film using appropriate existing footage of local leaders from the November engagement event and South West London Clinical Conference, with an introduction from the Health and Wellbeing Chair

- Bespoke internal communications content produced by partners to communicate effectively with their staff e.g. videos of leaders talking about plans and explaining what it means for them in particular
- Syndicated external copy to be used across partner channels e.g. newsletters and websites
- Use scheduled events to discuss the plan with local people

4 ALTERNATIVE OPTIONS

4.1. A more 'low-key' publication approach could be taken – by simply publishing the document across organisations' websites. However, this could make promotion of delivery milestones going forward more challenging.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. Engagement work on the health and care plan is set out above. Communications plans have been developed in partnership by all organisations.

6 TIMETABLE

We propose the launch date takes place at the beginning of November in order to allow the necessary materials to be produced and agreed.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. The financial implications of the activities outlined above will be covered by existing communications budgets.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. N/A

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. N/A

10 CRIME AND DISORDER IMPLICATIONS

10.1. N/A

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. N/A

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

12.1. Attached Slides that will be presented to HWBB

13 BACKGROUND PAPERS

The Merton Health and Care Plan

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Merton Health and Care Together

Merton Health and Care Together: Start Well, Live Well, Age Well

A Local Health and Care Plan for Merton

Discussion Document: March 2019

Merton Health and Care Together:

Start Well, Live Well, Age Well

Contents

Merton Health and Care Together:

Start Well, Live Well, Age Well

Introduction

All the partners of Merton Health and Care Together want to ensure that people enjoy even better health and outcomes than their parents and live, longer healthier lives.

Within Merton, there is still an unacceptable difference between the life expectancy of people who are relatively wealthy compared to those who are not. We also know that some of our communities have particular needs that we are not always meeting. There is some excellent work being carried out across the Borough, but we are aware that:

- Whilst Services do a good job in reacting to people's needs, we need to do better proactive work to avoid ill health
- Some services are not joined up, with a resulting lack of continuity for service users
- Information sharing between services in the whole system is difficult
- There is huge value to be gained through better partnership working between statutory services, carers, communities and the voluntary sector
- We have problems recruiting and retaining the right workforce and getting the best out of them
- Both commissioners and providers of care have financial challenges

The Health and Care system is facing very significant challenges. People are living longer but many of us are, or can expect to, live with a series of long term conditions such as dementia, cardiovascular disease and diabetes. We recognise that services need to enable people to live healthy and rewarding lives and as such should take their individual circumstances into account.

We all share a responsibility to continue to ensure that our services are as joined up as they possibly can be in a whole system approach to wellbeing. We have formed a 'Merton Health and Care Together' Board to help us all work together in the best interests of Merton residents. Representatives from the NHS, Local Authorities, , and other key health and wellbeing providers will regularly review progress and make sure we are on track to meet the current and future needs of people in Merton.

The Vision for Merton Health and Care Together:

"Working together, to provide truly joined up, high quality, sustainable, modern and accessible health and care services, for all people in Merton, enabling them to start well, live well and age well"

We will deliver this through:

Supporting independence, good health, and wellbeing: people are enabled to stay healthy and actively involved in their communities for longer, maintaining their independence. People will be at the heart of the system, and care will wrap around them. The effective use of technology and data will help us understand people and their needs to provide the right advice, support or treatment.

Integrated and accessible person centered care: Joint teams in the community will provide a range of joined up services, seven days a week, that help people to understand how to take care of themselves and prevent the development or rapid progression of long-term physical and mental health illnesses. People will be helped by their health and care professionals and wider wellbeing teams, to make use of a much more accessible and wider range of services.

A partnership approach: Local communities will become more resilient, with voluntary sector organisations playing an increasingly important role in helping to signpost vulnerable people to the right service and in some cases providing that service. Peer support will have a vital role to play in counteracting loneliness and contributing to people's overall mental health and wellbeing.

Merton Health and Care Together

Our Context and Challenges

Merton Health and Care Plan, in context

The Merton Health and Care Plan is one element of work in Merton, and across South West London, to improve health and wellbeing

The Merton Health and Care Plan seeks to improve services through strong partnership working between providers and commissioners of health and care services in Merton. Reporting to the Health and Wellbeing Board, we will do this in the context of, and in conjunction with, the Merton Health and Wellbeing Strategy, and the South West London Health and Care Partnership:

Merton Health and Wellbeing Strategy:
Led and owned by Merton Health and Wellbeing Board, this seeks to create a healthy place that enables people to start well, live well and age well. Whilst health and care services are a partner in this strategy, it focuses on making significant improvements to those things that create good health and wellbeing such as the built environment, green spaces, and supporting healthy lifestyles.

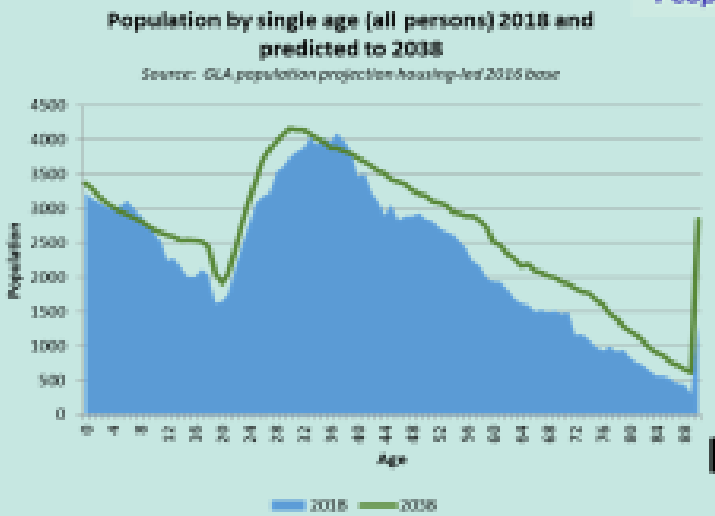
South West London Health and Care Partnership:
A partnership of the organisations providing health and care in the six South West London boroughs, divided into four local partnerships in Croydon, Kingston and Richmond, Sutton and Merton and Wandsworth. The partnership enables commissioning and transformation of services where this is best done across more than one borough, for example in cancer commissioning, transforming hospital services, and specialist mental health

Joint Strategic Needs Assessment: The Merton Story 2018

Key challenges:

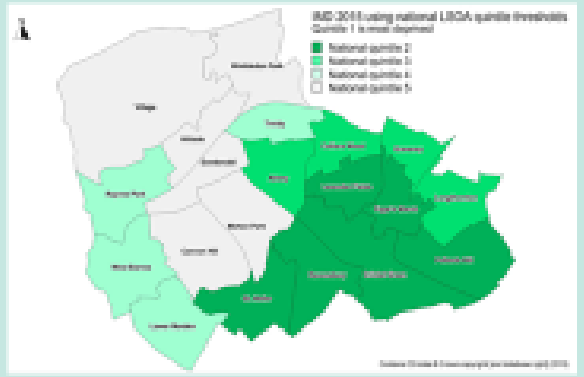
- Emotional Wellbeing and Mental Health
- Supporting wellbeing and independence
- Long term conditions
- People with complex needs
- The need to take a holistic approach

Demographics of Merton



Inequalities and health divide

"People in East Merton have worse health and shorter lives"



Healthy lifestyles and emotional wellbeing

Males

65.4

Longer than London (63.2) and England (63.5)

Females

66.3

Longer than London (64.0) and England (64.8)

However, the gap between the 30% most and least deprived wards is 9.4 years for men and 9.3 years for women

Exercise

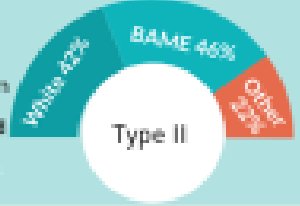
In 2016/17, just over 17% (28,000) of adults aged 19 and over were doing less than 30 minutes of moderate exercise a week. This is lower than London (23% and England 22%)

Increasing complex needs and multi-morbidity

Diabetes (Types I and II)

6.1% have diabetes which is slightly lower than London (6.5%) and England (6.7%).

Type II diabetes is more common in people of South Asian and African/Afro-Caribbean origin and affects people from BAME backgrounds at a younger age.



Dementia

An estimated 1,700 people aged 65 and over have dementia in Merton; 74.4% have received a formal diagnosis.

This is higher than London (71.1%) and England (66.4%).

Child and family vulnerability and resilience

Children in care

England 62 per 10,000

London 50 per 10,000

Merton 36 per 10,000

Merton has a lower rate than London and England

16-17 year-olds not in Employment, Education or Training

3.5%, lower than London (5.3%) and England (6%).

Emergency admissions due to injuries from falls

England 2,114 per 100,000

London 2,201 per 100,000

Merton 3,262 per 100,000

Falls are the leading cause of older people being admitted to hospital as an emergency.

Hidden harms and emerging issues

Air pollution

Tuberculosis

London 22.2 per 100,000

SW London 12.8 per 100,000

Merton 18.0 per 100,000 (about 40 people)

Seasonal mortality

More people die in the winter than the summer

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Merton's changing population and rising demand for services

Our growing population means that by 2030 there will be:

- 45% more people with diabetes
- 50% more people with heart disease
- 80% more people with dementia

The number of births in Merton in 2016 was 3,246. There is a general downward trend. By 2025 it is projected that there will be an estimated 2856 births.

By 2025 there will be a 17% increase those aged 11-15 years. East Merton currently has a higher proportion of younger people compared to west Merton however, it is forecast that the number of younger people will decline in east Merton by 2030

There are 141,000 people of working age in Merton, increasing by 3.1% by 2025

The over 65 population in Merton is projected to grow by 10.3% by 2025. The Over 75 population will double

37% of Merton's population are from a Black, Asian, or Minority Ethnic (BAME) group; remaining unchanged by 2025. English, Polish and Tamil are the most commonly spoken languages in Merton. Children and young people from BAME backgrounds make up 67.9% of those attending a Merton school

These trends have important, well-reported, impacts on health and care demand as well as public space and housing. Working-age disability, with more disabled people surviving longer and the costs of their support increasing, means social care for people of working age now costs local authorities as much as that of older people.

Quality, Performance and Financial Context

We have a number of challenges to the quality and performance of our current services, in the context of significant financial challenges across the public sector

Quality and Performance Context: the NHS quality agenda sets out the three key elements for commissioning high-quality care: safety, effectiveness and experience. Through this process there is ongoing work to improve issues of staffing and workforce, and spread of best practice

There has been an ongoing challenge, in common with the wider NHS, in achieving standards for hospital waiting times for outpatient care and emergency care. Merton has also worked hard to achieve the standards for access to psychological therapies, and will introduce a new service model in order to make this sustainable. Performance against indicators of integrated health and social care perform well in Merton, for example levels of delayed transfers of care are some of the lowest in London.

Financial Context: Growth in population, and demand for new treatments and therapies will outstrip the budget. The NHS in Merton needs to achieve an annual efficiency of £11.5m to live within its means. The London Borough of Merton needs £10.4m in savings over the next 4 years.

Providers of services need to deliver significant service redesign on top of the already challenging financial position they face, most notably at St Georges Hospital. Local Authorities continue to face significant financial and sustainability challenges, as do many of their suppliers in the care market.

What residents tell us

Continuity of care remains a priority for people in Merton, with a particular reference to ongoing support for managing long term conditions such as diabetes.

Accessibility of services is very important to people in Merton, particularly for services they have to use regularly

There is significant support for better **integration of health and social care services**. Services do not always feel **person centred** and did not always take into account the background and preferences of the individual.

People in Merton place a lot of value in **therapy support, and other specialist input**. However people did report concerns about the capacity of these teams and their ability to recruit and retain good staff

People are very positive about the move towards services **encouraging wellbeing and independence**. The social prescribing pilot in East Merton has held up as being a particularly good example of this.

Mental Health is a clear priority for people in Merton. Access to mental health services was raised as a concern, particularly for services for common mental health issues.

We held a partnership health and care event on 21st November to get feedback on the areas of focus and come up with ideas to improve our work for people in Merton:

Merton Health and Care Together

Our Work

Our Work: Underpinned by The Merton **Prevention Framework**

Prevention means helping people stay healthy and independent. It focuses on healthy lifestyles, underpinned by social, emotional and mental wellbeing, and creating a healthy place, where people can flourish and making health choices is easy.

We will focus on the evidence, which shows that support at a personal level is most effective as a core part of services provided by health and care teams, in both the statutory and voluntary sector

Merton Health and Care Together: 5 prevention priorities

1) Wellbeing Digital Hub
Single directory for health and wellbeing, for use by residents and front-line staff

2) Network of 'connectors' to link patients to wellbeing services and activities
Supporting the wide community of people providing health and wellbeing advice and support to do so consistently, accurately, and with an up to date knowledge of the community assets within Merton

3) Structured conversations training for front line staff
Skills for health and care staff to encourage users of services to engage in healthy lifestyles and support people to change their behaviour where required

4) Delivering healthy workplaces
Support our workforce to have good health and wellbeing, knowing that this is good for them, and those they support. We will focus on key issues such as mental health, joint health, healthy lifestyles through a common workplace framework

5) Embedding healthy lifestyles in clinical pathways
For example; healthy maternity pathway incl smoking, alcohol and maternal obesity

Merton Health and Care Plan on a Page

Our Vision:

Working together, to provide truly joined up, high quality, sustainable, modern and accessible health and care services, for all people and partners of Merton, enabling them to start well, live well and age well:

- Supporting Independence, good health and wellbeing
- Integrated, person centred care
- A partnership approach

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Responding to the needs of Merton Residents…			…Merton Health and Care Together will Focus on…	…to improve the lives of Merton residents
Prevention Framework across the life course	Start Well	**Integrated support for children and families** - More children in need due to abuse, neglect or family dysfunction, than London and England - Greater increase in children with special education needs than London and England . - Higher rate of A&E attendances in children under 18 years of age, than England. **Emotional Wellbeing and Mental Health** - Increase in children's use of substance misuse service, in contrast to a reduction across England - Rate of child admissions for mental health conditions higher than local authority nearest neighbours and England. - The fifth highest rate in London of emergency hospital admission for self-harm	**Emotional Wellbeing and Mental Health**: Children and young people to enjoy good mental health and emotional wellbeing, and to be able to achieve their ambitions and goals **Children and Young People's Community Services:** Create an integrated commissioning strategy identifying opportunities for integration **Developing Pathways into Adulthood**. Children and young people should continue to receive high quality services as they become young adults	Improved experience of and access to mental health provision Service tailored to individual and family needs Reduced need for emergency intervention
	Live Well	**Wellbeing and Log Term Conditions** - The main causes of ill health and premature deaths in Merton are cancer and circulatory disease - Steady increase in diabetes prevalence; an additional 1,500 people in Merton - Fewer than 1 in 5 adults are doing 30 minutes of moderate intensity physical activity a week - 1 in 4 adults are estimated to be drinking at harmful levels - Over half of adults in Merton are overweight or obese - Only 16.5% use outdoor space for exercise/health reasons, lower than London and England - 10% of the working age population have a physical disability **Mental Health and Wellbeing** - Higher reported levels of unhappiness and anxiety than in London and England - 16% of adults estimated to live with common mental health disorders like depression and anxietyHigher rate of emergency hospital admission for self-harm than London and England	**East Merton Model of Health and Wellbeing:** Developing a wellbeing model that underpins a holistic approach to self-management of long term conditions **Diabetes:** life course, whole system approach. Focus on prevention and health inequalities. **Primary Mental Health Care:** Single assessment, primary care recovery, wellbeing and Psychological Therapies **Primary Care at Scale:** improve quality, reduce variation and achieve resilience and sustainability	Improved wellbeing and independence Greater LTC control and outcomes Improved access to primary and community services Improved access to mental health support
	Age Well	**Complex health and care needs** - More people are living into older age with multiple long-term conditions - An estimated 1,686 older people have dementia in Merton - Merton currently supports around 4,000 adults with social care needs - Fewer people remain at home 3 months after reablement than both London and England - 11% of people have a long term illness, disability or medical condition - 5,900 people aged over 75 live alone. - Emergency admissions due to falls are significantly higher than London and England	**Integrated Health and Social Care:** Proactive and preventative services, rapid response, improving discharges, enhanced support to care homes, falls prevention, dementia care and high quality end of life care	Improved experience, and control of care Reduction in falls and ambulance callouts Fewer emergency admissions and A&E

Merton Health and Care Together:

Start Well

Together we will focus on:

Emotional health and Wellbeing for Children and Young People: Mental health issues amongst young people in Merton are on the rise and outcomes can be poor. We will deliver integrated, easily accessible mental health services for children and young people

Community Health Services for Children and Young People

We have an opportunity over the next two years to review our portfolio of children's community services, and recommission a truly integrated model of care

Developing Pathways into Adulthood

Services should respond to needs without using age as a barrier and it is up to us to facilitate this with flexible commissioning arrangements, so that different rules can apply

Why have we chosen **emotional wellbeing and mental health for young people** as an area of focus?

Page 25

Mental health issues amongst young people in Merton are on the rise and outcomes can be poor

Let's take some facts...

- We have more children admitted for mental health conditions than the average for London and England
- We have the fifth highest rate in London for emergency stays in hospital for self-harm by young people
- We have very high numbers of children in need of support due to abuse, neglect or family dysfunction, compared with London and England
- The number of children with an Education Health and Care Plan or Statement of Special Education Need is growing faster than London, and England
- The number of young people accessing substance misuse services is rising, against the national trend

What are we doing to improve services?

We will deliver integrated, easily accessible mental health services for children and young people

Increasing children and young people's access to high quality mental health services, with a focus on the most vulnerable

Develop the local workforce to ensure the capacity and expertise to deliver high quality, and evidence based services

Work in partnership with schools and colleges to deliver a 'whole school' approach to emotional health, well-being and mental health

A **robust healthcare pathway is in place for children and young people in the criminal justice system**, on the edge of offending and antisocial behaviour.

To deliver a high quality Early Intervention in Psychosis service for children and young people from age 14

WHAT
will the impact be?

Children and young people will receive high quality support leading to:

- Access to mental health services improving by over 30%
- Access to support in schools via Mental Health Support teams
- Improved waiting times for children and adolescent mental health services
- Improved experience of services through better advice and support
- Reduction in the rate of hospital admission

WHO
are we trying to help?

Around 64,000 young people aged 0-24

Around 2400 children with mental health problems

Why have we chosen **community health services for children and young people** as an area of focus?

The number of young people in Merton is set to rise significantly and we want to give them the best start in life:

Let's take some facts...

- 'School readiness' is a key measure of a child's development. In 2016/17, 73.94% of children living in Merton achieved this standard, similar to London, but we want to do better
- Parental mental health problems, parental misuse of alcohol and drugs and domestic violence are the most significant risk factors that impact on a child's health and wellbeing. Merton has a higher rate of these issues than London and England
- There has been a greater increase in children with an Education Health and Care Plan (EHCP) or Statement of special education needs (SEN) than London and England, driven by increases in diagnosis of autism, but also through an increase in social, emotional and mental health needs.
- Childhood immunisations are below the national target of 95%.
- 4,500 primary school children are estimated to be overweight or obese. One in 5 children entering reception are overweight or obese and this increases to 1 in 3 children leaving primary school in Year 6 who are overweight or obese.
- There is a higher rate of A&E attendances for children than the England average

What are we doing to improve services?

We have an opportunity over the next two years to review our portfolio of children's community services, and recommission a truly integrated model of care

The creation of an integrated commissioning strategy: this will include a focus on joint outcomes for children, young people and their families CYP and families; review of current commissioning arrangements and identifying opportunities for integration in borough aligned with the refresh of the Health and Wellbeing Strategy.

Review of community health services: we will review our community services for children and families, with a view to developing and commissioning an integrated model of care by April 2021

Integrated Model of Care: we will ensure that the commissioning strategy and community services review delivers integration of community paediatrics, child and adolescent mental health services, public health services and community services. These services will address children and young peoples individual needs. We will also seek to embed the Pathways into Adulthood principle that services will be available up to the age of 25 where this is preferable for individual young people

WHAT
will the impact be?

Development of truly integrated and person centred community services for Children and Young people, resulting in:

- A reduction in children attending A&E and being admitted as an emergency
- Improvements in school readiness
- Improved health and wellbeing
- Improved experience of services
- Shorter waiting times
- More responsive services for those with the greatest needs

WHO
are we trying to help?

Around 64,000 young people in Merton

Around 1600 Children with an Education, Health and Care Plan

Why have we chosen **developing pathways into adulthood** as an area of focus?

Young people experience significant difficulties in the “transition” from children’s to adult services. We need services that provide support into adulthood, that focus on the needs of individual young people, and do not discriminate based on age.

There is currently a Pathways to Adulthood Board, that exists in the context with children with complex special needs that are likely to be eligible for adult health services once they turn 18yrs, looking at what that transition looks like.

Statutory duties for children’s services go up to the age of 25yrs with a requirement in the Care Act that the planning starts in year 9, or 14 years old. Adult services will need to think about their growth and development and we must collectively seek to smooth this transition.

Care leavers also have a level of care up to the age of 25. They will often have complex mental health needs and may be traumatised but may not meet the statutory criteria of adult social care. Although their legal status changes at the age of 18, they may become adults at different stages/ages. These young adults need an adolescent service to chaperone them through this time rather than being excluded due to artificial boundaries.

Services should respond to needs without using age as a barrier and it is up to us to facilitate this with flexible commissioning arrangements, so that different rules can apply. There is not yet a full and clear understanding yet from children’s and adults services of the legal complications that may arise from this work, but it is our commitment to work in partnership to identify and resolve any challenges that arise

Merton Health and Care Together:

Live Well

Together we will focus on:

Primary Mental Healthcare
We will deliver high quality and easily accessible services that take account of peoples wider health and wellbeing

Primary Care at Scale
Increased demand for care, and changes to national policy and workforce means we must transform how primary care is delivered

East Merton Model of Health and Care
Deprivation and need in East Merton demands a new approach to health and wellbeing. We will spread this learning across Merton to help all residents

Diabetes
The number of people with diabetes, or at risk of diabetes is growing significantly in Merton. We will develop primary and community care services to ensure people are supported to manage their condition effectively

Why have we chosen **primary mental health and wellbeing** as an area of focus?

Many people with common mental health problems do not get the care and support they need, and this has a significant impact on their health and wellbeing

Let's take some facts...

- Around 8% of people in Merton reported low levels of happiness, broadly in line with London and England.
- A greater number of people in Merton reported high levels of anxiety compared to London and England.
- There are an estimated 24,000 adults in Merton with common mental health disorders such as depression and anxiety, around 16% of the adult population, which is lower than London but higher than England
- Only 7% of these adults are known about by Merton GPs. This suggests that many adults in Merton experiencing common mental health conditions remain undetected, and potentially unsupported
- Common mental health problems are proven to make managing diabetes, and other long-term conditions, much more challenging, with poorer overall health outcomes as a result

What are we doing to improve services?

We will deliver high quality and easily accessible services that take account of peoples wider health and wellbeing

We will deliver a single point of access to adult mental health services to help manage the demand for secondary mental health care

We will commission a wellbeing service to provide social support, including psycho-social interventions, to people with a range of mental health problems. This may include vocational support, benefits advice, housing advice, information workshops, and social peer group development.

We will commission an expanded Psychological Therapies service to provide clinically effective psychological therapies for common mental health problems. It will be integrated with physical health care pathways to provide targeted psychological therapy to clients with specified long term conditions

We will commission a Primary Care Recovery service to facilitate discharge from secondary mental health services, provide psychological therapies, and ongoing mental health care support

WHAT
will the impact be?

Increase access rate from 19% to 25% over the next two years, an additional c1600 people who will receive psychological therapies support

Around 1,800 people a year recovering from common mental health problems

Around 1000 more people living with long term conditions better supported, leading to a 25% reduction in use of emergency services

WHO
are we trying to help?

Around 140,000 adults living in Merton

Around 24,000 people living with common mental health conditions

Around 16,000 people living with a long term condition

Why have we chosen **primary care at scale** as an area of focus?

Challenges such as increased demand and complexity of care, workforce shortages as well as changing national policy means we must transform how primary care is delivered

Let's take some facts...

- The primary care workforce has changed with a shift towards more GPs working part time and in a salaried or locum capacity. This can cause gaps in frontline clinical time for consultations but also in a reduction in leadership capacity within practices
- National policy demands the provision of primary care 8am-8pm care 365 days a year.
- There is an increasing number of elderly and more complex patients needing care in the community.
- There are differences in the quality of services between different GP practices in Merton
- There are significant health inequalities between the east and west of the borough.
- The existing infrastructure (IT & estates) are not always fit for purpose to deliver high quality care

What are we doing to improve services?

A new GP contract sees practices increasingly working together to improve resilience and quality, increase capacity and provide local care alongside other local services in the community.

We will realise the benefits of the new GP contract by:

- Supporting all practices to come together in networks to deliver a range of new services;
- This will include significant new investment for the creation of new front line posts, embedded at network level
- Identifying opportunities to align community contracts and staff with these network arrangements

We will work to support our workforce by:

- Enhancing skill mix and using community services staff appropriately;
- Training existing practice staff to work in different ways e.g. receptionists sign posting people to community resources
- Delivering economies of scale
- Ensuring staff want to work in Merton and are retained

We will continue to improve access by:

- Development of the locality access hubs
- Embracing opportunities from technology and innovation where it makes sense to
- Explore the possibility of a single point of triage
- Joining up urgent care systems with primary care so that patients are seen in the most appropriate place to meet their needs.
- Improving public education in relation to self-care

We will improve organisational efficiency by:

- Maintaining and scaling up back office functions in practices
- Investigating efficiencies of scale could be achieved and also utilisation of collective purchasing power

WHAT
will the impact be?

High quality, sustainable Primary Care which is accessible, pro-active and co-ordinated, delivered across the Borough.

Over 20,000 more appointments available, including ability for patients to be seen on the day where clinically necessary

All Merton registered patients able to access primary care services online

All patients have access to social prescribing services.

Patient care is holistic and joined up across multiple agencies

WHO
are we trying to help?

Merton has a GP registered population of 220,000
Around 140,000 adults
Around 16,000 people living with a long term condition

Why have we chosen the **East Merton Model of Health and Care** as an area of focus?

Deprivation and need in East Merton demands a new approach to health and wellbeing. We will spread this learning across Merton to help all residents

Let's take some facts...

- Significant social inequalities exist within Merton. Largely as a result, people in East Merton have worse health and shorter lives: There is a gap of 6.2 years in life expectancy for men between the most deprived and least deprived areas in Merton. The gap is 3.9 years for women
- Premature mortality (deaths under 75 years) is strongly associated with deprivation, with all wards in East Merton being more deprived and having higher rates of premature mortality than their West Merton counterparts.
- Marked social inequalities are important drivers of the health divide. However Merton's plans for economic growth and regeneration have the potential for improving life chances and securing better health outcomes over time.
- Unemployment claimant rates in Merton are lower than London; however rates are more than double in the East of the borough, compared to West Merton. Unemployment in East Merton is higher than London and England
- 16% of households are overcrowded in Merton, but there are nearly doubled the proportion of overcrowded households in East Merton than West Merton

What are we doing to improve services?

We will seek to embed wellbeing into health and care services, and make the most of our community assets

We will deliver a whole health and wellbeing system working together: We recognise that health is about whole people (physical, mental and social) who are part of whole communities

We are working together on the vision for East Merton, driven by a requirement to address health inequality and rationalise and improve estates through the **development of the Wilson Hospital** site in Mitcham

At the core of the Wilson Health & Wellbeing Campus will be an **enhanced East Merton Primary Care Hub** offering significant scope for GP's working at scale for the whole population of East Merton.

Social Prescribing supports people to take control and explore behaviour change, as well as building social networks and enhancing community cohesion.

Local people will have **access to a wide range of services** on the site, to include community services, acute specialist consultants, social prescribing, diagnostics and community based voluntary services

WHAT
will the impact be?

Social prescribing available in every GP practice in Merton leading to:

- Improvements in wellbeing of around 25% as measured by the wellbeing star, for those referred to the service
- Around 30% reduction in use of GP services for those referred to the service
- Around 25% reduction in emergency hospital visits, for those referred to the service
- Greater utilisation of community assets and voluntary sector groups

WHO
are we trying to help?

Adults and
Children across the
whole of Merton

Why have we chosen **Diabetes** as an area of focus?

The number of people with diabetes, or at risk of diabetes is growing significantly in Merton. We will develop primary and community care services to ensure people are supported to manage their condition effectively

Let's take some facts...

- Unhealthy diet, smoking, lack of physical activity, and alcohol account for around 40% of total ill health. The main causes of ill health and early death in Merton are cancer and circulatory disease
- Six percent of our residents are already diagnosed with diabetes
- Over half of adults living in Merton are overweight or obese. One in three children leaving primary school in Merton are overweight or obese
- We know type 2 diabetes can be prevented or reversed through better diet and more exercise. Fewer people in Merton exercise regularly than the London and England average
- Around £10bn - ten percent of the national NHS budget - is spent on treating diabetes every year in England.

What are we doing to improve services?

We will develop primary and community care services to ensure people are supported to manage their condition effectively

Supported patient self-care and self-management

- Healthy lifestyle, diet and exercise.
- Social prescribing.
- Mental health/IAPT.
- Online resources and local support services information.

Consistent and high quality primary care

- Register for patients who are pre-diabetic.
- All people with pre-diabetes or diabetes receive annual HbA1C testing, diet, lifestyle advice, social prescribing interventions or referral to structured education
- Population analysis to target high risk patients
- Provide primary care diabetes clinical teams with appropriate education and training
- Offer injectable therapy
- Annual support from consultant diabetologist and pharmacists

A new Diabetes Community Service

Establishment of a Diabetes Clinical Advice Service:

- Single point of contact for diabetes-related advice and guidance
- Supportive GP visits from Community Services providing additional clinical capacity, as well as both face-to-face and virtual GP Practice support in the delivery of care.

WHAT
will the impact be?

Better care and support for people living with diabetes, or who are at risk of diabetes:

- Increased uptake of diabetes prevention programme
- Increase proportion of people receiving the 9 care processes as outlined by NICE
- 5% reduction in emergency hospital visits due to diabetes complications
- Reduction in medicines costs

WHO
are we trying to help?

Around 13,500 people with diabetes

Estimated 2,000 living with undiagnosed diabetes.

Merton Health and Care Together:

Age Well

We will deliver this through:

Integrated Health and Social Care

The population is ageing and increasing numbers are living into older age with multiple long-term conditions such as heart disease, diabetes, and dementia. Complex needs require services that put the person in the centre. We will deliver:

- Proactive care for those at highest risk
- Improved response to crises and more effective reablement
- Integrated Locality Teams
- Support for the most frail and those with the highest need for services, such as those with dementia, and the end of life, and residents of care homes

Why have we chosen **Integrated Health and Social Care** as an area of focus?

The population is ageing and increasing numbers are living into older age with multiple long-term conditions such as heart disease, diabetes, and dementia. Complex needs require services that put the person in the centre.

Let's take some facts...

- The population is ageing and increasing numbers are living into older age with multiple long-term conditions such as heart disease, diabetes, and dementia
- Merton currently supports around 4,000 adults aged 18 and over with social care needs. Merton performs well for providing social care support to people in the community, higher than comparable local authorities and England
- Merton has comparably low rates of delayed transfers of care from hospital to home but the proportion of older people who were still at home 91 days after discharge from hospital following reablement is lower than London and England
- 10.8% of people in Merton were diagnosed with a long term illness, disability or medical condition
- Merton has around 17,000 carers. We know that caring can have a negative impact on the carer's physical and mental health, and that caring can adversely affect education and employment.
- Feeling isolated and lonely has a profound negative effect on physical and mental health and wellbeing. This is particularly important given we have an estimated 5,900 people aged over 75 living alone
- Falls are the leading cause of older people being admitted to hospital as an emergency, and rates are very high compared to London and England

What are we doing to improve services?

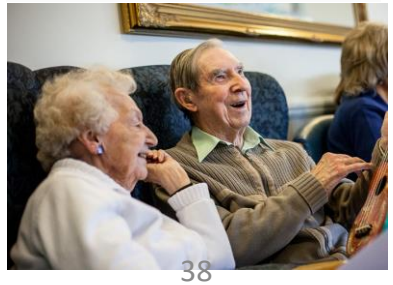
We will provide proactive, integrated and responsive care, including particular enhancements for those most frail and in need of services

Proactive care for those at highest risk. This will include the identification of high risk individuals, allocation of a key worker, person-centred planning and a common care plan across organisations

Improved responses to crises and exacerbation of conditions, including rapidly available alternatives to hospital admission, supported hospital discharge, rehabilitation, intermediate care and reablement

Integrated Locality Teams comprising of General Practice, social workers, community health services and mental health professionals. These teams will provide oversight and coordinated care to older people in Merton

Enhanced support for those most frail and those at the end of life. This will include supporting Care Homes with dedicated primary care support, enhanced community services, additional therapy input and dietetics and improved IT infrastructure



WHAT
will the impact be?

Provision of preventive, proactive, holistic and patient centred care, resulting in:

- Improvements in quality of life and experience
- Care Homes residents will require c500 fewer visits to hospital as an emergency, and will be admitted less often

WHO
are we trying to help?

Around 25,000 older people in Merton

Estimated 1700 people in Merton with dementia

Around 850 care home residents

Merton Health and Care Together

Creating the right environment for change

What needs to be in place to create the right environment for change?

The population is ageing and increasing numbers are living into older age with multiple long-term conditions such as heart disease, diabetes, and dementia. Complex needs require services that put the person in the centre.

Let's take some facts...

- Our current systems do not always talk to each other, and information sharing is inconsistent
- Whilst we aspire to person centred care, this can mean different things to different people, and different professionals approach it in different ways.
- Whilst we aspire to be able to support people to maintain independence and take care of their health and wellbeing, this requires a shift in mind-set and an appreciation of individuals circumstances and resources
- Providers of services do not always work together proactively
- The contracts we have in place with providers do not always encourage integrated care, and in some cases make it more difficult
- We have a workforce that is ageing, and we have challenges recruiting to certain professions
- Certain parts of the health and social care system have critical challenges in remaining sustainable.
- Some of the health and care estate is not fit for purpose
- There is limited use of technology to improve the delivery of services

What do we need to do to create the right environment for change?

We recognise that we need to make significant changes to the way health and care services work

Common Outcomes: We will ensure that services work together towards a common goal, and have a demonstrable impact on health and wellbeing

Developing a person centred approach: We will define a common approach to person centred care across and within providers of care in Merton

Provider development: We will develop greater collaboration between providers of services, and break down any barriers that get in the way of great care

Market development: We will address current risks in the market of health and care provision

Workforce: We will work with partners across South West London to address workforce gaps and training and development needs

Reforming our contracting and incentives: Contracts for services will encourage integration, and reward person centred care

Estates: We will develop a single estates strategy that supports integration and ensures community based integrated care

Digital: We will take the opportunities afforded by the NHS Long Term Plan to incorporate digital approaches to the delivery of services for people in Merton

Delivering the plan: the Merton Health and Care Together Board

Senior leaders from across the local authority, NHS and voluntary sector meet on a monthly basis to ensure improvements are delivered for people in Merton

The Merton Health and Care Together Board oversees the development and delivery of the Merton Health and Care Plan. Every major provider and commissioner of health or care services in Merton is represented (see right)

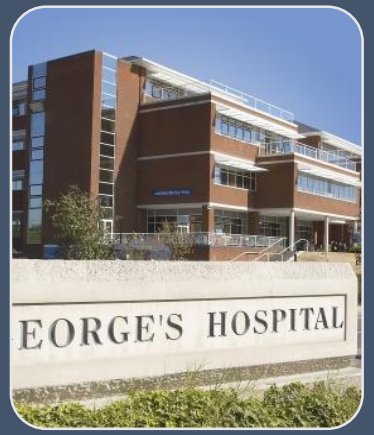
The Merton Health and Care Together Board is co-chaired by Merton Clinical Commissioning Group's Managing Director, and the Director of Communities and Housing of the London Borough of Merton. Held on a monthly basis, it oversees the development of the health and care plan, drives delivery, and ensures that the benefits of the plan are tracked and quantified. By having all of the leaders in the system in one place, the Merton Health and Care Together Board can effectively unblock any issues and manage any risks to successful delivery for people in Merton

The Merton Health and Care Together Board reports into the Health and Wellbeing Board on a regular basis. Each partner organisation also takes regular updates back to their organisations. Merton Health and Care Together is supported by a small programme team, who oversee and support delivery of the work programme.

Other work

Acute Transformation: Planned Care and Urgent & Emergency Care

Outside of the Merton Health and Care Together Programme, the NHS is working to ensure the quality and sustainability of acute hospital services meets our aspirations



Planned Care

- Developing primary care to support people outside of hospital where possible
- Cancer: new diagnostic tests to reduce the need for invasive procedures. Psychological support for people living with and beyond cancer
- Effective Commissioning Initiative, ensuring that procedures are evidence based
- New community services to manage hospital demand e.g. community ophthalmology services
- Clinical Assessment Services
- Outpatient redesign. Development of virtual clinics online and over the phone
- Diagnostic pathway improvement

Urgent and Emergency Care

- Ambulatory care. Same day medical support for adults and children to avoid admissions to hospital
- Integration of primary care expertise and capacity to avoid A&E attendances where possible
- Alternative Care Pathways: working with London Ambulance Services to identify where patients can receive support quickly rather than attend A&E
- Older Peoples' Advice and Liaison Service: providing tailored support to older people when in A&E
- Integrated Urgent Care (NHS 111)

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Committee: Health and Wellbeing Board

Date: 8th October 2019

Subject: Priority Actions for Merton Health and Wellbeing Strategy

Lead officer: Dr Dagmar Zeuner, Director of Public Health

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

Contact officers: Mike Robinson, Consultant in Public Health; Barry Causer, Head of Strategic Commissioning, Public Health; Clarissa Larsen, Health and Wellbeing Board Partnership Manager

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Recommendations:

That the Health and Wellbeing Board consider, agree and champion the first of the rolling programme of priority actions for Merton Health and Wellbeing Strategy 2019 – 2024 as:

A. The new priority of Healthy Workplace, adopting the London Healthy Workplace Award as a framework for developing work places as healthy settings, with an initial focus on mental health and active travel.

B. Keeping the momentum on tackling diabetes, with a continued focus on tackling diabetes, through a whole systems approach.

C. To continue to self-develop and improve as a Board to be fit for the future and to consider how to involve children and young people as part of this development.

PURPOSE OF REPORT AND EXECUTIVE SUMMARY

The purpose of this report is to set out for consideration by the Board the first priority of the Health and Wellbeing Strategy of healthy workplace. The paper also recommends keeping a focus on the on-going work to tackle diabetes (and child healthy weight) to keep the momentum going and to outline current work with the Leadership Centre and prospective involvement of children and young people in the work of the Board.

BACKGROUND

1 The new Health and Wellbeing Strategy was agreed at our June meeting. The Strategy sets out a new vision together with a set of principles and ways of working which will influence everything we do as a Board; focused on creating a healthy place for healthy lives, across the life course of Start Well, Live Well, Age Well and through the three key attributes of:

- Promoting mental health and wellbeing
- Making the healthy choice easy
- Protection from harm

Published copies of the full Health and Wellbeing Strategy are now available and are being shared widely. An accessible, one page summary document is also being developed with the support of Young Inspectors.

In response to the discussion at the June Board, a summary of the baseline position on the key outcomes has been produced. (see Appendix 1)

2 In delivering the Strategy, we agreed to focus on a rolling programme of a few priority actions, determined by an explicit rationale that:

- Considers evidence of need (using the Merton Story and community voice) with an opportunism to tackle emerging/topical issues.
- Investigates how the proposed priority will address the principles of the Board (specifically, promoting fairness, engaging and empowering communities and having a Health in All Policies/Think Family approach).
- Has clarity on how the Board will add value in a way that won't be delivered otherwise; how will our partner contributions create something more impactful together than individually, and how this will contribute to wider local and regional work.

Synergy with the Local Health and Care Plan

3. Throughout its development the Health and Wellbeing Strategy has linked to the Local Health and Care Plan. As the HWB and Merton Health and Care Together Board begin to work more closely, we will continue to coordinate with colleagues on both of these plans to ensure they complement each other.

DETAILS – PRIORITY ACTIONS

As reflected in the Strategy, Board members have recognised that the partnership works best when it focusses on one or two key priorities. Initial consideration of potential priorities took place at both the March and June Boards.

HEALTHY WORKPLACE

4. We propose that the first priority for action of the new Health and Wellbeing Strategy should be Healthy Workplace. Specifically, to encourage the development of healthy workplaces across Merton by scaling up commitment to the London Healthy Workplace Award.

Through the commitment of Health and Wellbeing Board partners and, more widely, organisations across the borough, we can aim to work towards a longer-term ambition of widespread achievement of the LHWA standards of Foundation, Commitment and Excellence.

5. We have discussed the criteria for identifying priorities and the rationale for choosing Healthy Workplace as the first priority for action is:

- Unequivocal evidence of need - the rate of working days lost in Merton due to sickness absence is greater than in London or England as a whole.

- Opportunity to apply the principles of the Board including promoting fairness and community engagement.
- Adding value to what can be achieved by individual organisations alone, through learning and contributing to wider local and regional work.

In addition as part of the engagement workshops on the Strategy there was widespread stakeholder support for a focus on healthy settings and identification of key outcomes that can be delivered through healthy workplaces (e.g. better mental health, more active travel and more people eating healthy food).

Further information on the rationale for choosing Healthy Workplace as a priority, the baseline position in Merton, and action already being taken is included in Appendix 2.

London Healthy Workplace Award

6. The London Healthy Workplace Award (LHWA) is an accreditation scheme led by the Mayor of London's Office and supported by Public Health England. It acts as a template for good practice and recognises London employers who invest in their employee's health and wellbeing. The scheme supports organisations of all sizes across public, private and voluntary sectors.

The current award is an updated version of the London Healthy Workplace Charter, which ran between 2012 – 2018. The LHWA has been updated to incorporate the latest evidence on how best to promote health and wellbeing in the workplace. The award framework consisted of three pillars under which sits nine standards, each of which has criteria which must be met in order to achieve the Award. These are illustrated in the diagram below:

More information about the standards, the criteria for their achievement at each level of the Award, and the application process is available on the GLA website at https://www.london.gov.uk/sites/default/files/lhwa_overview_2019.pdf

Role of the Health and Wellbeing Board

7. There are a variety of actions that Board members can take to help promote healthy workplaces, both as individuals and as a group as a whole. The examples below are offered for discussion and not suggested as firm pledges at this stage:

- Individual Board members can encourage their own organisations to be exemplars of the roll out of the LHWA across Merton. Many organisations already have an occupational development or workforce development infrastructure which can be harnessed for this purpose, rather than new capacity being required.
- Board members can promote the concept of the settings approach that is at the heart of the new Strategy, rather than the traditional framing of health improvement as a matter of personal responsibility leading to new conversations with colleagues. The Board as a whole can act as a mutual support network and be a space for practicing such conversations.
- Individuals can apply to join the London Healthy Workplace Award Network Group which has been set up on Knowledge Hub (www.khub.net) and share their learning with the Board as a whole.
- Several other Merton-focussed groups are already supporting or planning healthy workforce initiatives, for example Merton Chamber of Commerce are working with Healthy Dialogues to work with small employers in the three Business Improvement Districts.
- One of the agreed prevention priorities of Merton Health and Care Together, is to deliver healthy workplace programmes.
- Work is also taking place across the SWL Health and Care Partnership, with the draft SWL Diabetes plan including reference to key settings including healthy workplaces.
- The Board can offer to share learning with others and may be able to gain access to additional London wide resources through such an approach. This may be helpful given that work will need to be done within existing resources.

Focus on mental wellbeing and active travel

8. To make real impact, the Board needs to adopt an approach that is realistic to competing demands on organisations' capacity. This can be done by promoting a staged approach to implementation, with initial focus in two priority areas, namely mental wellbeing (LHWA standards 4 to 6) and active travel (part of LHWA standard 7).

The reasons for recommending these areas are that they have both attracted attention from many directions and have stimulated a variety of sometimes

disparate initiatives. Both are issues which resonate with local or London-wide policy objectives, for example for mental wellbeing, the Mayor of London's #ZeroSuicideLDN campaign, and for active travel, the declaration of a climate change emergency by LBM and many other councils. Both were identified as important to stakeholders during the Strategy's engagement programme (and in the Diabetes Truth programme).

Some examples of actions in these areas, which the Board can take or promote, are

- Raising awareness and use of the "Good Thinking" website and the wide range of resources it points users towards (https://www.good-thinking.uk). The website has been quality assured by the NHS and many of its resources are free for Londoners.
- Undertaking training to become a mental health first aider. This 2-day training teaches people how to offer initial support to someone who is experiencing mental distress until appropriate professional help is received or until the crisis resolves. Employers who have included this within their staff development programme report benefits such as greater self-esteem and wider cultural changes.
- Seek stakeholder support for a Merton Active Travel Awards scheme. This scheme would celebrate excellence and innovation amongst Merton employers for initiatives that reduce car use and encourage walking and cycling for work-related travel.

9. The programme of action outlined above fits with the principles and ways of working we have adopted in the new Health and Wellbeing Strategy, and can inform development of more detailed plans in due course. Initial thinking about how each of the principles listed in the Strategy can be reflected in the role of the Board in action on healthy workplaces are shown in the Table below.

Reducing inequalities	Checking that there is a good spread of organisations across Merton geographically and by type that embrace the healthy workplace agenda, and highlighting gaps
Prevention and Early Intervention	Championing approaches such as education for staff with long term conditions e.g. diabetes (see diabetes section) and seasonal flu vaccination
Health in All Policies	Promoting policy implementation in line with LHWA standard 1.
Community engagement	Inviting business leaders, particularly where gaps have been highlighted, to engage with Board members, based on the positive experience of the Diabetes Truth programme
Experimenting and Learning	LHWA is evidence based. Developing links between Award criteria and Strategy key outcomes.

Think Family	Promoting family friendly policies such as understanding for carers, flexible working and support for parents

Healthy Workplace action planning

10. If Healthy Workplace is agreed as a priority, the Public Health team will develop a detailed action plan for the January HWB.

    As Board Members, we can support this by ensuring that Healthy Workplace is included in our organisations' forward plan and nominate a member of staff to be a first point of contact for the development of the Healthy Workplace action plan.

TACKLING DIABETES

11. In addition to the new proposed priority, we also recommend that we as a HWB keep the momentum on our work to tackle diabetes. Whilst good work is taking place and our whole systems approach and Diabetes Truth Programme have been cited as good practice, it is important that this momentum is maintained.

12. Good progress against each of the three themes in the Tackling Diabetes Action Plan has been seen over the last six months, with key highlights including:

    Clinical oversight and service improvement:

    - Systems and dashboards are in place, which will enable the partnership to identify any variations in care.
    - A number of new services, including those for key communities e.g. Tamil and African Caribbean communities, are starting soon.

    Holistic individual care:

    - Pathways have been established between diabetes services and other supportive services e.g. the Merton Uplift service, recently commissioned by Merton CCG.
    - An increase in uptake of the National Diabetes Prevention Programme, with Merton having the highest number of first appointments (285) from across South London between April 2019 and August 2019.

    Healthy place:

    - Monitoring and management of proposals for new fast-food take-aways (A5 use) has been included as part of Merton's Local Plan
    - The council has approved a revised advertising policy that will introduce restrictions on unhealthy food and drink (those high in salt, sugar and fat) in Merton, which mirror those introduced by Transport for London in February 2019.
    - Development of 'Schools Neighbourhood Approach Pilot (SNAP),

Child Healthy Weight

As part of a life-course approach, the Tackling Diabetes Action Plan is aligned with the Child Healthy Weight Action Plan. In addition to work on healthy place, progress has included:

- Increase in number of schools achieving health school status; training for school staff on raising awareness and talking about childhood obesity and weight; delivering healthy eating on a budget sessions for families, piloting an approach to holiday provision for young people.

Despite these successes, we think it is too early for the HWB to shift its attention away and propose instead to maintain a clear focus to keeping the momentum on tackling diabetes.

13. Keeping the momentum will also enable us to deliver further on our commitment to community engagement and empowerment- working with and for the people and communities we serve. This will keep a focus on inequalities; to essentially challenge and adapt our plans according to learning and new insights from residents and stakeholders, as appropriate for tackling a truly complex problem such as diabetes and child healthy weight.

    Keeping tackling diabetes as a priority will also mean we as a HWB are better prepared to apply the learning from the Diabetes Truth Programme and whole systems approach to other long term conditions in the future, such as respiratory disease.

Role of the Health and Wellbeing Board

14. There are a variety of actions that Board members can take to keep the momentum on tackling diabetes, which are offered for consideration:

- Although there has been some engagement with a number of vital groups e.g. the CCG Patient Engagement Group and LBM Joint Consultative Committee with Ethnic Minority Organisations, we can do more to understand what matters to local people, gather patients' feedback on services and release the potential that community groups can have in Merton.
- Keeping oversight of the fidelity of a whole system approach with an eye for the known risks e.g. a disconnect between work on healthy place and better holistic services, or reverting to an imbalance between preventative and treatment focus.
- The on-going advocacy and awareness raising around diabetes (and Child Healthy Weight), through a commitment to supporting World Diabetes Day (14th November 2019) and the Merton Year of Physical Activity, which will seek to enhance the awareness of the existing sport and physical activity offer in Merton.
- To 'think diabetes in the workplace' and explore putting the policies and processes in place to make reasonable adjustments for staff members who are at risk of, or living with, diabetes so that they can attend structured education and prevention programmes (see https://healthinnovationnetwork.com/projects/think-diabetes-in-the-workplace/)

- Encourage staff members to innovate, actively work with community groups and work in partnership across organisations boundaries including on development of a network of Diabetes Champions.
- Support MVSC in their three year programme, funded by the City Bridge Trust, to get a better understanding of how people from South Asian and BAME backgrounds are coping with diabetes, active co-production of service design and development and a subsequent review of services.

The HWB's view is welcomed on how to keep momentum at a time of significant change across the system, including the opportunity resulting from the development of the South West London approach to tackling diabetes and to judge the right time to hand-over priorities.

If the proposal that 'Keeping the momentum on tackling diabetes' is agreed, as well as co-ordinated work continuing, a more in-depth review of the 'impact' of the tackling diabetes action plan will be undertaken and reported back to the Board.

HEALTH AND WELLBEING BOARD WAYS OF WORKING

15. As well as the specific priorities of the Health and Wellbeing Strategy, there was a commitment to a set of principles, ways of working and continual development. This included an ambition to Think Family in all our work.

Children and Young People's Voice

16 The HWB has used creative approaches to engage adult residents in order to better understand lived experience and develop meaningful plans, such as the exemplar Diabetes Truth work with buddies. There is now an ambition to engage with children and young people, building on the creative approaches that have been developed to date to involve young people. These include, for example, Merton Youth Parliament implementing a manifesto based on the top concerns of local young people, including a gangs 'think tank' event, and feedback from LGBT and pupils informing the development of a Trans Inclusion toolkit for schools in Merton and Wandsworth.

The aim for the HWB would be to engage with young people on a priority that they identify, for example, a focus on climate change emergency, tapping into the energy young people are showing towards healthy planet, healthy place, healthy people, such as air pollution, single use plastics; safe open space. A Young inspector has expressed an interest in this work which also links to the wider climate change emergency activity.

If the Board agree to this priority, Young people will be asked to lead the way and identify how they would like to link up with the Board. Ideas could include, buddying members with young people; young people 'taking over' and setting the agenda for a Board meeting; Board members being scrutinised at youth parliament. It is proposed that activity could be developed in the spring and summer terms using existing learning, building on work with the Leadership Centre (outlined below) and working closely with Children Schools and Families.
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Leadership Centre and HWB Seminar 15th October

17. We as an HWB have committed to continued development and all members have participated in current work with the Leadership Centre. Interviews with Board members and Diabetes Truth volunteers took place over the summer to capture some of the outputs from our work as an HWB over the past few years.

Merton HWB was chosen by the Leadership Centre to work together to explore how we can use the learning of a more integrated approach to inform discussions on aligning health and care in the borough, whilst continuing to tackle the wider determinants of health. This will link to the work of Merton Health and Care Together, which reports to the HWB, and the Local Health and Care Plan with its focus on health and care services and integration.

We have a collective sense-making seminar planned for 15th October where we will consider the findings from the Leadership Centre and take the opportunity to look forward. This will include closer working with Merton Health and Care Together going forward as well as consideration of the priorities set out in this report, especially the involvement of young people in our work. The outcome of this, for us as a Board, should be a keener shared sense of what we are able to do, how we will do it and our fitness for the future.

Merton HWB features in LGA Publication

18. In recognition of some of our good work to date Merton HWB was featured in the recent LGA publication What a difference a place makes - The growing impact of health and wellbeing boards Merton was cited as one of the case studies of 'effective HWBs across the country'. Our work on the Diabetes Truth Programme and Social Prescribing specifically featured. The LGA is also convening work across South West London to consider the future of Health and Wellbeing Boards in the new place based governance.

NEXT STEPS

19. Subject to agreement, the priority action of Healthy Workplace and the continued focus on Tackling Diabetes (and child healthy weight) will be taken forward. We, as HWB members are committed to learning and want to understand whether we are delivering on our commitments. Our Strategy is intended to be a practical and live document giving direction to the Board and its partner organisations. To help members of the Board track progress we have prepared the baseline for the agreed indicators (see Appendix 1).

It is proposed that a full annual review of the Health and Wellbeing Strategy be reported to the Health and Wellbeing Board, including:

- progress on priority actions
- application of Principles and Ways of Working.
- a summary dashboard of key outcomes.
- ongoing development of the Health and Wellbeing Board as an effective system leadership team (including work with the Leadership Centre).

5. ALTERNATIVE OPTIONS

None at this stage; priority actions have been assessed against the agreed criteria for members of the Health and Wellbeing Board to consider.

6. CONSULATIONS UNDETAKEN OR PROPOSED

The recommended priority actions emerged from engagement on the Diabetes Truth work and the workshop and wider engagement programme on the Health and Wellbeing Strategy.

7. TIMETABLE

Timescales for the relevant priority are included in the report.

8. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

The Health and Wellbeing Strategy programme of priority actions will be delivered through decisions within existing governance and, where there is the opportunity, external funding.

9. LEGAL AND STATUTORY IMPLICATIONS

It is a statutory duty for the Health and Wellbeing Board to produce a joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment.

10. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Health and Wellbeing Strategy and priority actions are directly concerned with improving health equity.

11. CRIME AND DISORDER IMPLICATIONS

A key outcome of the Health and Wellbeing Strategy is to less self-harm and less violence.

12. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

N/A.

APPENDICES

Appendix 1 – Baseline Indictors

Appendix 1 – Health and Wellbeing Strategy baseline indicators

Key Healthy Place attributes:	Key outcome of the Health and Wellbeing Strategy:	Indicator*	Timescale† for impact	Merton	London	England
Promoting mental health & wellbeing	**Less self-harm Better relationships**	Hospital admissions for self-harm aged 15-19 yrs (per 100,000 pop) *(2017/18)*	Medium	364	341	649
	Less depression, anxiety and stress	Prevalence of depression (aged 18+) *(2017/18)*	Medium	7.3%	7.1%	9.9%
	Less loneliness Better social connectedness	% adult carers reporting as much social contact as they would like (aged 18+) *(2016/17)*	Short	29.8%	35.6%	35.5%
Making healthy choice easy	**More breastfeeding**	Breastfeeding prevalence at 6-8 week check *(2018/19)*[1]	Short	75.0%	50.5%	46.2%
	Less childhood obesity	Overweight (including Obesity) in Year 6 *(2017/18)*	Medium	35.9%	37.7%	34.3%
	Less diabetes	Diabetes prevalence (17+) *(2017/18)*	Long	6.2%	6.5%	6.8%
	More active travel	% adults cycling for travel at least three days per week *(2016/17)*	Short	6.4%	4.7%	3.3%
	More people eating healthy food	Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults) *(2017/18)*	Medium	56.9%	54.1%	54.8%

	More active older people	Percentage of adults aged 65-74 who are physically active for at least 150 minutes a week *(2017/18)*	Short	73.4%	55.1%	57.4%
Protecting from harm	**Less people breathing toxic air**	Deaths attributable to particulate matter (PM2.5) *(2017)*	Short	6.4%	6.5%	5.1%
	Less violence	Violence against the person (offences per 1,000 population) *(cumulative of 12 months ending Q1 2019)*	Medium	13.8	18.5	19.8

[1] *Breastfeeding data is unpublished due to coverage below the 95% standard.*

*Indicators have been chosen as 'markers' for Tackling Health Inequalities and Prevention - as we cannot measure everything and the Health and Wellbeing Board cannot deliver alone but as part of a wider system.

†Timescales for impact vary, as shown in final column. "Short" means an estimate of 1-2 years before we will see an effect; "Medium" 3-5 years, "Long" 6 or more years

APPENDIX 2: More information of the Healthy Workplace priority

Reasons for choice of this as a priority area

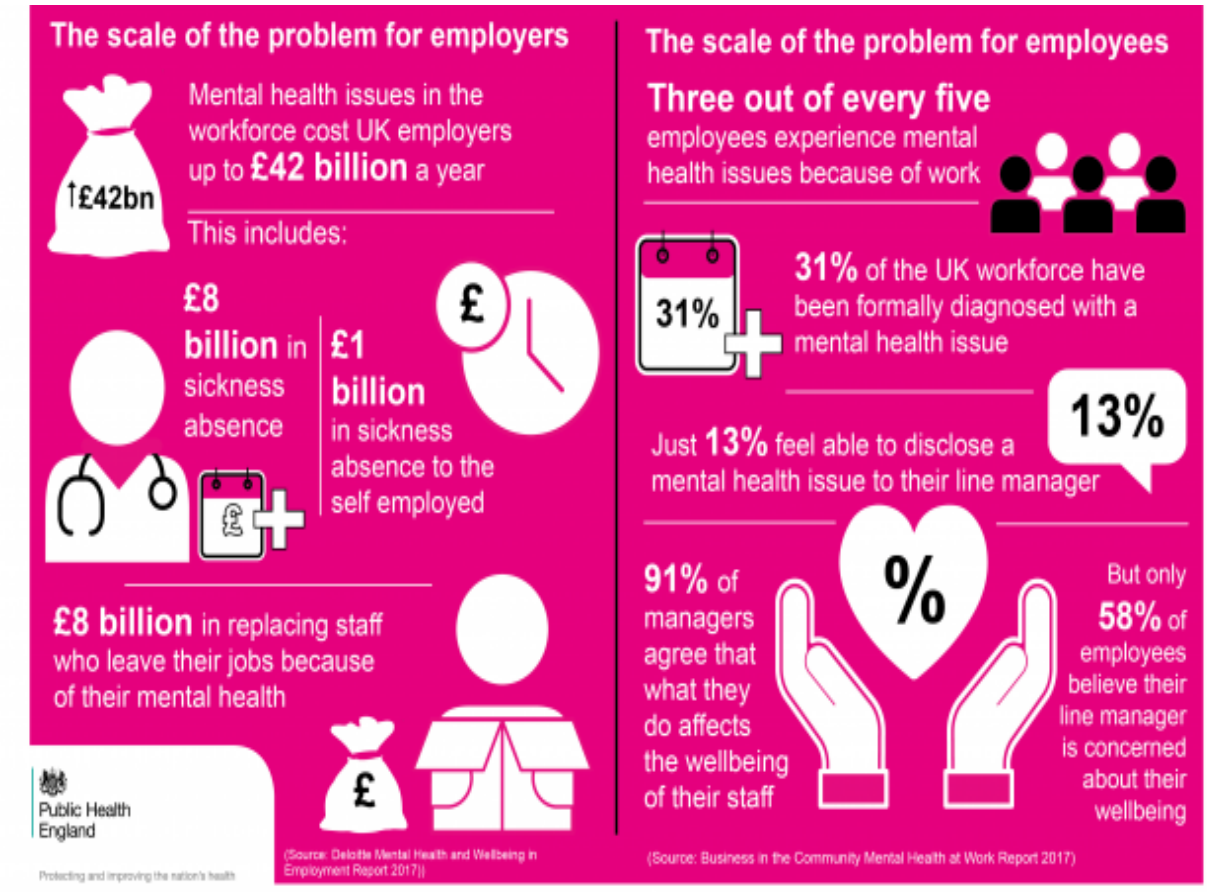
Healthy Workplace is proposed as a priority area for action by the HWB for the following reasons:

(1) The impact that can be made, given the large number of work places in Merton

(2) The potential to make a difference to a wide range of outcomes through HW

(3) The scope for people experiencing better outcomes from their workplace to cascade these changes to others

The scale of the issue nationally is summarised in the following infographic



The baseline position in Merton

Many workplaces in Merton are already healthy places. The link between a healthy work setting and productivity is well known, so the approach is adopted by many successful businesses. There are examples of good practice in both public and private sector organisations throughout Merton.

This has been demonstrated in the past by various external awards such as the London Healthly Workplace Charter . The GLA has now replaced this with the London Healthy Workplace Award (LHWA). This was launched earlier in 2019 and the application process for awards is now live.

What we are already doing on Healthy Workplace

There is already considerable activity taking place to promote healthy workplaces in Merton.

- LBM Public Health has commissioned an independent public health advisory and delivery consultancy to work with small and medium sized businesses in Merton's Business Improvement Districts to raise awareness of the benefits of healthy workplaces. Merton Chamber of Commerce facilitates access to individual businesses. This Healthy Workplace programme has proven to be successful at establishing grassroots exposure to making healthy choices easy. Overall feedback has been very positive with participants finding the workshops delivered helpful and informative and companies enquiring for a range of healthy workplaces support.
- LBM Workforce Strategy Board has included promotion of a healthy workplace as part of its overall development plan. HR and Public Health are working together on an action plan and business case to implement this further
- Merton Health and Care Together have identified Healthy Workplace as one of their prevention priorities. South West London and St George's Mental Health NHS Trust are the lead partner.
- SWL Health and Care Partnership are planning a healthy workforce component to their five year forward plan, which describes the system-level response to the NHS Long Term Plan
- The Merton Partnership Executive Board discussed HW at their last meeting (June 2019). Notes of that meeting are due to be approved at the next meeting in October.

Committee: Health and Wellbeing Board

Date: 8th October 2019

Agenda item: Merton Health and Care Together

Wards: ALL

Subject: Merton Health and Care Together

Lead officers: James Blythe, Managing Director, Merton and Wandsworth CCGs, Hannah Doody, Director of Communities and Housing

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

Contact officer: Louise Inman, Programme Director, Merton Health and Care Together

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Recommendations:

A. To consider and approve Merton Health and Care Together programme update on progress to date and ambitions for 2019-2021

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

To provide information and update the Health and Wellbeing Board on progress made by Merton Health and Care Together in delivering the ambitions as set out in the Local Health and Care Plan.

2 BACKGROUND

Merton Health and Care Together is a partnership consisting of the key health and care organisations responsible for commissioning and providing health and care services to the whole population of Merton. The partnership is responsible for delivering the ambitions set out in the Local Health and Care Plan. Delivery of the programme is overseen by the Merton Health and Care Together Board. The Board is co-chaired by the Merton CCG Managing Director and the Director of Communities and Housing and consists of the following organisations:

- London Borough of Merton- Adult Social Care
- London Borough of Merton- Children, Schools and Families
- London Borough of Merton- Public Health
- Merton Clinical Commissioning Group
- St George's NHS Trust (& representing Epsom St Helier NHS Trust)
- South West London and St George's Mental Health NHS Trust
- Central London Community Health Services NHS Trust
- Merton Health Ltd
- Local Medical Committee
- 6 x Primary Care Networks

- Healthwatch
- Merton Voluntary Sector Consortium

The Board meets on a monthly basis and is accountable to the Health and Wellbeing Board. The programme has two dedicated members of staff- a Programme Director and a Programme Manager. The work of the programme is delivered by the partnership. The programme team is jointly funded by London Borough of Merton and Merton Clinical Commissioning Group.

3 DETAILS

3.1. The Merton Health and Care Together Programme consists of the areas of work set out in the Local Health and Care Plan, namely:

- Start Well (SRO: Rachael Wardell, Director of Children, Schools and Families)
    - Emotional health and wellbeing for children and young people
    - An integrated service model to meet children's health and care needs
    - Developing a needs-led approach to 'Pathways to Adulthood' for children leaving children's services.
- Live Well (SROs: Dagmar Zeuner, Director of Public Health & Josh Potter, Director of Commissioning, Merton CCG)
    - 5 prevention priorities (a holistic model of prevention for individuals within a healthy place)
    - The Diabetes Action Plan
    - Improving mental health in primary and community settings
    - East Merton Model of Health and Wellbeing
- Age Well (SRO: Phil Howell, Assistant Director of Strategy, LBM)
    - Integrating the intermediate care pathway
    - Enhanced support to care homes
    - Integrated locality teams
- Enablers
    - Digital (SRO: Dr Sayanthan Ganesaratnam) – ensuring a digital first approach to delivering health and social care
    - Estates (SRO: Neil McDowell) – developing a shared understanding of local priorities, challenges and opportunities in the development of the local health and care estate
    - Workforce (SRO: Rachael Wardell) – developing a partnership approach to nurturing a health and care workforce that delivers strength-based, person-centred care.
    - Communications and Engagement (SRO: TBC) – developing a partnership approach to communicating with residents and the local workforce about the work of Merton Health and Care Together.

This report sets out the progress made by Merton Health and Care Together in delivering these ambitions.

4 ALTERNATIVE OPTIONS

4.1. N/A

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. N/A

6 TIMETABLE

N/A

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. N/A

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. N/A

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. N/A

10 CRIME AND DISORDER IMPLICATIONS

10.1. N/A

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. N/A

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

Merton Health and Care Together – attached document

13 BACKGROUND PAPERS

Developing the Merton Health and Care Together partnership and the Local Health and Care plan

The members of Merton Health and Care Together have been meeting since November 2017 with the aim of developing integrated ways of working between health and social care to improve outcomes for residents and service users. The group has agreed a Memorandum of Understanding outlining its shared vision and objectives[1].

The agreed vision:

Working together, to provide truly joined up, high quality, sustainable, modern and accessible health and care services, for all people of Merton, enabling them to start well, live well and age well."

The agreed and shared objectives:

1. To hold a shared vision to improve the integration and delivery of the health and care that the people of Merton receive
2. To support local people to take responsibility for leading healthy lives through making their own informed decisions – to Start well, Live Well and Age Well
3. To increase healthy life expectancy and reduce years lost due to poor physical or mental wellbeing, whilst reducing unnecessary admission to hospital, and accelerating an appropriate and safe agenda
4. To manage current and future demand for services in Merton, within constrained financial envelopes and ensuring that all partner organisations take collective responsibility
5. A commitment to a 'one service' integrated team approach, without organisational barriers hindering progress, in a person-centred and joined up system

Ideas on potential areas of focus for the partnership were presented at an engagement event in November 2018, where residents and representatives provided feedback on the proposals. This feedback was used to develop the Local Health and Care Plan 'discussion document' that has guided the work of the partnership since February 2019.

Implementing the plan: Key achievements to date

[1] NB: A task and finish group has been looking at developing metrics to measure the partnership's progress in achieving this vision and these objectives. In the process of this work, the group has identified some areas where the wording may need to be revised to better reflect the ambitions of the Board.

Start Well:

A) Emotional health and wellbeing for children and young people

- Refresh of Children and Young People's Mental Health and Wellbeing Local Transformation Plans
- I-Thrive system wide launch event (11th Sept 2019) with agreed next steps and individual/organisational pledges

B) An integrated service model to meet children's health and care needs

- Department of Children, Schools and Families and CCG Children's Commissioning team now meeting monthly as an integrated commissioning team. A half-day workshop resulted in an agreed vision and ways of working. The team is working jointly on developing proposals for a new integrated service model.

C) Developing a needs-led approach to 'Pathways to Adulthood' for children leaving children's services.

- A system-wide group has been established with an agreed scope of work encompassing all children in Merton who are currently using services – with an agreed ambition to ensure that their 'transition' to statutory adult services, or community organisations is needs-led, person-centred, strength-based and clearly communicated to and understood by the young person, their family/carers and the professionals involved in their care.

Live Well:

A) '5 Prevention Priorities'- These prevention priorities are five projects proposed by the Public Health team and agreed by the MHCT Board. They include:

1. Developing a digital wellbeing 'hub' to provide a digital point of first contact for all prevention services (health and social care).
2. Establishing a 'network of connectors' – equipping volunteers and community representatives across the borough with the skills and tools to support residents to live healthy lives.
3. Developing training to support 'structured conversations' equipping front-line staff from health and care services to have strength-based conversations with residents to promote healthy lifestyles.
4. Delivering healthy workplaces- all partners of MHCT to sign up to the London Healthy Workplace Award.
5. Embedding healthy lifestyles in clinical pathways- delivering the prevention ambitions of the NHS Long Term Plan.

- The projects of work are all now established. An outline specification for the digital wellbeing hub has been approved by the Board and is now being developed in more detail. One You Merton has mapped its network of 'connectors' and the network will be meeting in September for the first time. A training course for delivering structured conversations has been piloted with a cross-sector group of front-line workers. Work to identify existing efforts to promote healthy workplaces is underway, as is work to identify

opportunities to promote smoking cessation, healthy eating, and reduce problem-drinking, with a particular focus on people with severe and enduring mental illness and young people.

B) The Diabetes Action Plan

- System partners are working to implement the Plan as developed by the Health and Wellbeing Board. The CCG has commissioned Merton Health Ltd to deliver a Diabetes Local Incentive Scheme which has gone live with all GP practices. Practices are also participating in a SWL-wide National Diabetes Prevention Programme. Community health services are mobilising a new MDT approach to support primary care staff. The new mental health primary and community service (Merton Uplift) has begun aligning their mental health services to the diabetes pathway to promote access to mental health support for people with diabetes. A monthly diabetes steering group is monitoring mobilisation of these new services, with a quarterly 'summit' to monitor alignment with the Council's 'Healthy Place' strategy.

C) Improving mental health in primary and community settings

- Merton CCG have commissioned South West London and St George's Mental Health NHS Trust, and a consortium of voluntary and community sector organisations to deliver a primary and community care mental health service for people with anxiety or depression, and a primary care recovery service for people with severe or enduring mental illness who do not require secondary mental health services. The service went live in April and is working with system partners to promote access. Due to changes in national workforce guidance, there are some challenges with recruitment which SWLStG are working to address.

D) East Merton Model of Health and Wellbeing

Age Well:

A) Integrated Locality Teams

- Integrated Locality Teams (ILTs) were commissioned by Merton CCG in April 2018 to be run by Merton Health Ltd. Across four localities in Merton, coordinators work with primary care, mental health, social work, community health and other health and care colleagues to make sure that the health and care needs of those elderly Merton residents most at risk of hospital admission are met in a multi-disciplinary, person-centred and coordinated way. Initial data suggests that the teams have helped prevent numerous unnecessary hospital admissions. A number of residents receiving support from ILTs are in the last phases of life, and the work of the ILTs has encouraged conversations with residents to decide and record their preferred place of death.

B) Developing an integrated intermediate care pathway

- Intermediate care services provide support for a short time to help people recover from ill health and restore their independence. Intermediate care can help residents remain at home even if their health has deteriorated, recover after a fall, an acute illness or an operation, avoid going into hospital unnecessarily, or return home more quickly after a hospital stay. There are

four main types of intermediate care: reablement, crisis response, home-based and bed based care. In Merton these services are provided by Central London Community Healthcare NHS Trust (CLCH) and the London Borough of Merton (LBM) and include hospital discharge referral pathways for CLCH MERIT home, bed-based intermediate care and LBM reablement and social care services. In September 2018, Merton Health and Care Together asked these two organisations to pilot a more integrated hospital discharge referral pathway. This launched in St George's in December 2018 and was rolled out to Kingston and Epsom St Helier at the beginning of 2019. Conversations are now taking place between the two organisations to explore further opportunities for more joined up working across the intermediate care pathway, and between CLCH, LBM and primary care to develop proposals for a 'step-up' crisis response for those at risk of hospital admission.

C) Enhanced support to Care Homes

- Starting in April 2019, Merton CCG have commissioned Merton Health Ltd and CLCH to provide enhanced support to Care Homes. This includes ensuring that each Care Home has a designated primary care practice, and that GPs are supported by CLCH to deliver multi-disciplinary support to Care Home staff including nutrition and medicines advice. The project is intended to improve the holistic care of residents, resulting in a reduction of ambulance call-outs, ambulance conveyances and hospital admissions. Alongside this work, LBM are intending to roll-out a new set of commissioning standards to ensure that Merton bed-based care meets London ADASS quality standards. Merton Health and Care Together has established a system-wide Care Homes Steering Group to support implementation of this work and identify opportunities for the continuous improvement of quality and experience of care in Merton's Care Homes on an ongoing basis.

Enablers

Merton Health and Care Together recognises that there are various enablers that have traditionally been considered separately by individual organisations within the health and care system, where it may at times be beneficial to consider them collectively in partnership. Merton Health and Care Together has agreed the following 'enabler' workstreams: Digital, Estates, Workforce, and Engagement and Communications.

Digital

This programme of work began in April 2019. In line with the ambitions of the NHS Long Term plan, NHS partners in Merton are committed to a 'digital-first' approach. LBM is also cognisant of the opportunities presented by digital innovation and runs a successful telecare service, Mascot. Merton Health and Care Together is developing a digital strategy which will set out the local priorities for digital innovation that it makes sense to address as a partnership within Start Well, Live Well and Age Well, and work with regional and national bodies (e.g. the South West London Health and Care partnership, NHS Digital) to identify opportunities for funding and pilot schemes. This work is intended to complement regional development plans happening at scale across South West London. Merton Health and Care Together is also looking to develop an information governance framework to support the data sharing required for effective

joint working across the system and developing a dashboard to measure the impact of the programme in delivering the vision and objectives of the partnership.

Estates

Merton Health and Care Together is developing a local health and care estates strategy. This work brings together the ambitions and opportunities of One Public Estate and the NHS Estates development work to ensure that we are working effectively as a partnership to maximise the potential of the existing health and care estate in Merton. Partners from the main health and care organisations delivering services in Merton are working together to identify emerging needs and gaps in our estate's capability to support implementation of the Local Health and Care plan. This estates strategy will support delivery of Merton's zero-carbon ambitions.

Workforce

The Merton Health and Care Together programme team is exploring whether there is the potential to develop a systematic approach to shared workforce development, such as joint needs assessments and data quality initiatives, shared opportunities and jointly developed and delivered training. There are proposals to develop a shared statement of ambition describing, 'the way we do things round here' in terms of delivering person-centred, strength- based care, and proposals to align efforts to enhance recruitment and retention across the borough. These ideas are being discussed with partner organisations.

Communications and Engagement

Communications teams from each of the partner organisations meet together on a regular basis to identify shared opportunities for communication and engagement activities targeting Merton residents and the Merton health and care workforce. To date this has included successful campaigns around staying well in winter, flu vaccinations, and challenging mental health stigma. The group is developing a plan for communicating the ambitions of Merton Health and Care Together more effectively to residents and the workforce.

Next Steps: Merton Health and Care Together in 2020/21

This August, the MHCT Board agreed to develop a joint approach to planning how NHS funding for Merton is best allocated to deliver the priorities of the local health and care plan and to work collectively to address the funding challenges of each of the constituent organisations of the partnership to get the best value for the Merton £. All MHCT organisations have agreed to work together over the next few months to develop proposals for allocating NHS funds in 2020/21.

In September 2019 the Merton Health and Care Together Board held a facilitated development session to reflect on the achievements of the Board to date, and its resilience, to consider the ways in which the board could become more effective, and to review the membership and terms of reference of the board. As a result, the programme is putting in place a number of steps to refresh its governance which will be reported in full detail to a future HWB. The focus of the programme for 2020/21 will be to continue to implement the priorities of the Local Health and Care Plan, ensuring that we make the most of the opportunities presented by the developing primary care networks to ensure that we tailor our service models to reflect the differing needs of each network's populations.

Committee: Health and Wellbeing Board

Date: 08th October 2019

Wards: All

Subject: Better Care Fund – Plan for 2019/20

Lead officer: James Blythe Managing Director, Merton & Wandsworth CCGs, and Hannah Doody, Director of Communities and Housing

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

Contact officer: Annette Bunka, Head of Older People and Integrated Care - Merton, NHS Merton and Wandsworth LDU and Richard Ellis – Head of Strategy and Partnerships, London Borough of Merton.

Recommendations:

A. For the Board to note the report

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report provides a summary to the Health and Wellbeing Board regarding the 2019/20 Better Care Fund (BCF) plan. The BCF template was released in July for completion by 27th September 2019. As in previous years, it was agreed the co-chairs of the Health and Wellbeing Board sign off the template on behalf of the Board given the limitations regarding timescales. The purpose of the slides is to summarise the key elements of the template for the Health and Wellbeing Board to note.

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.

3 DETAILS

3.1 Finance Incorporated into the BCF Plan

Funding Sources	Income
DFG	£1,279,883
Minimum CCG Contribution	£12,871,787
iBCF	£4,114,486
Winter Pressures Grant	£747,910
Total	£19,014,066

Of the CCG minimum contribution of £12,871,787, the sum of £6,214,073 is allocated as a minimum sum to allocate to schemes where social care supports the system.

3.2 Summary of Schemes Types Funded through the BCF

Assistive Technologies and Equipment	£404,000
Carers Services	£348,000
Community Based Schemes	£843,380
DFG Related Schemes	£1,279,883
Enablers for Integration	£2,084,523
HICM for Managing Transfer of Care	£505,000
Home Care or Domiciliary Care	£1,755,573
Housing Related Schemes	£50,000
Integrated Care Planning and Navigation	£1,666,372
Intermediate Care Services	£6,469,402
Personalised Budgeting and Commissioning	£105,000
Personalised Care at Home	£2,100,000
Prevention / Early Intervention	£539,084
Residential Placements	£238,910
Other	£624,940
Total	£19,014,067

Further information is contained in the attached slides.

4 ALTERNATIVE OPTIONS – N/A

5 CONSULTATION UNDERTAKEN OR PROPOSED – N/A

6 TIMETABLE – N/A

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

The budgets incorporated into the BCF are included within the main section of this report.

8 LEGAL AND STATUTORY IMPLICATIONS

There is a 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, Merton Health and Care Together, which the BCF supports, 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

Merton Better Care Fund Update for 19/20

13 BACKGROUND PAPERS

Better Care Fund Planning Requirements for 2019/20, 2019-20 Better Care Fund Policy Framework, High Impact Change Model for Managing Transfers of Care.

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Merton Better Care Fund Update for 19/20

For Merton Health and Well Being Board 8th October 2019

Annette Bunka-Head of Older People and Integrated Care - Merton, NHS Merton and Wandsworth LDU

Richard Ellis-Head of Strategy and Partnerships, London Borough of Merton

Summary

- Better Care Fund Overview
- Funding Allocation
- Update on Initiatives Funded through the BCF
- High Impact Change Model
- Performance Targets

Better Care Fund Overview

- A programme spanning both the NHS and local government, the plan has been developed and agreed across health and social care.
- With the aim of improving the lives of some of the most vulnerable people, by placing them at the centre of their care and support, providing them with integrated health and social care.
- Key objectives for the plan include:
  - Reducing the growth of emergency admissions.
  - Reducing length of hospital stay and delayed transfers of care (DTOC).
  - Reducing permanent admissions to care homes.
  - Increasing the proportion of older people who were still at home 91 days after discharge from hospital into reablement.
  - Improving service user and carer experience.

Funding Allocation

Funding Sources	2018/19	2019/20
DFG	£1,186,109	£1,279,883
Minimum CCG Contribution	£12,011,626	£12,871,787
iBCF	£3,523,032	£4,114,486
Winter Pressures Grant*		£747,910
Total	£16,720,766	**£19,014,066**

*Not included in BCF in 2018/19

Of the CCG minimum contribution, £6,214,073 is allocated as a minimum sum to schemes where social care supports the system.

SUMMARY OF SCHEMES TYPES FUNDED THROUGH THE BCF	
Assistive Technologies and Equipment	£404,000
Carers Services	£348,000
Community Based Schemes	£843,380
DFG Related Schemes	£1,279,883
Enablers for Integration	£2,084,523
HICM for Managing Transfer of Care	£505,000
Home Care or Domiciliary Care	£1,755,573
Housing Related Schemes	£50,000
Integrated Care Planning and Navigation	£1,666,372
Intermediate Care Services	£6,469,402
Personalised Budgeting and Commissioning	£105,000
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Prevention / Early Intervention	£539,084
Residential Placements	£238,910
Other	£624,940
Total	£19,014,067

Context

- The key priorities for integration in 2019/20 BCF Plan mirror the Merton Health and Care Together Programme and support for the 3 key Age Well projects:
  - Integrated Locality Teams
  - Integrated Intermediate Care
  - Enhanced Support To Care Homes.
- We are also measured against key metrics and the high impact change model

Integrated Locality Teams

- Multi-disciplinary working across health and social care across Merton responsible providing integrated, person-centred, proactive care for complex patients at high risk of admission, those with severe frailty and those who are in the last year of life.

The BCF contributes to:

- The locality based community teams, made up of nurses (including case managers, care navigators, dementia specialist nurses, end of life care nursing)
- 4 health liaison social workers (1 additional post from previous years)
- Voluntary sector services, including Dementia Hub, Carers Support, falls and other prevention initiatives
- Telecare through MASCOT
- Holistic Assessment and Rapid Investigation (HARI) service (a specialist multi-disciplinary, geriatrician led service) and other falls preventions initiatives.

Integrated Intermediate Care & Rapid Response

- Single Point of Access (SPA) in place for referrals to CLCH Intermediate Care and LBM Intake team (which includes reablement) to avoid admissions and support people home from hospital sooner.

The BCF contributes to:

- Reablement services (with increases in provision in 2019/20 to support evenings, weekends and admission avoidance)
- Home and bed based rehabilitation
- Integrated domiciliary packages of care (increases in 2019/20 as part of iBCF)
- Rapid Response (MERIT) offering rapid two hour response to prevent admission to hospital
- In reach nurses at St George's to help with admission avoidance and complex discharges
- Community Equipment (ICES) (with increase in funding to support increasing demand)
- Dedicated social work input into Continuing Health Care processes
- 7 day working

Enhanced Support to Care Homes

- A range of initiatives and services providing enhanced support within care homes in order to improve quality, help people access the right care and where possible out of hospital.
- Initiatives include a successful Care Home Fora, the multi-agency Joint Intelligence Group and more tailored training and support.
- The Red Bag has been implemented and embedded which has supported getting residents back to their care home sooner following admission to hospital.
- A Care Homes Steering Group has just been established to co-ordinate the range of initiatives.

The BCF contributes to:

- Support given by Rapid Response (MERIT), End of Life Care Nurses and other specialists to care homes
- Equipment to pick up fallers in care homes (new funding from BCF and to be implemented in 2019/20)

Other initiatives through the BCF

- Through the winter planning funding as well as increasing capacity, we intend to build on our Winter Warm programme:
  - with the voluntary sector reducing factors that increase the likelihood of presentation to health or social care, including an enhanced lunch club offer, reducing isolation amongst older men through our music workshops, improving heating and insulation, supporting access to benefits and helping with small grants for energy, food and clothing.
- Disabled Facilities Grant (DFG). Support includes:
  - Hospital to home assistance and assistance with preventing admission or re-admission to hospital, e.g. blitz cleans, moving furniture and basic equipment e.g.bed/bedding.
  - Relocation Assistance
  - Emergency Adaptations
  - Dementia Friendly Aids and Adaptations Grant
  - Helping Hand Service for Low Level Hazards
  - Help with Energy Efficiency

High Impact Change Model

- A steering group comprising key system partners including St George's Hospital, Merton and Wandsworth CCGs, the Local Authorities and CLCH, agreed a work plan to support ongoing developments.
- A summary of the current assessed position and the aspiration for the year is detailed below:

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020
Chg 1	Early discharge planning	Established	Established
Chg 2	Systems to monitor patient flow	Established	Established
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Established	Established
Chg 4	Home first / discharge to assess	Established	Mature
Chg 5	Seven-day service	Plans in place	Established
Chg 6	Trusted assessors	Established	Established
Chg 7	Focus on choice	Established	Established
Chg 8	Enhancing health in care homes	Established	Mature

BCF Performance Targets

- Delayed Transfers of Care (total) On track
  - Below London average
  - Challenges in delays at St George's (attributed to health)
- Non Elective Admissions (HWBB) On track
- New Permanent Admission to Residential and Nursing Homes On track
- Number of People Offered Reablement and still at home after 91days On track

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Committee: Health and Wellbeing Board

Date: 8th October 2019

Wards: All

Subject: SWL CCGs merger proposals

Lead officer: James Blythe, Managing Director, Merton CCG

Contact officer: James Blythe, Managing Director, Merton CCG

Recommendations:

A. Note the update

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

To update the Board on the progress of the CCGs' merger proposals.

2 BACKGROUND

2.1. HWB received a paper earlier this year concerning the case for change for merger of the 6 South West London CCGs on 1st April 2020. The paper set out the numerous drivers including the substantial joint working that already takes place, the changing NHS policy landscape and the requirement for all CCGs to achieve a 20% management cost reduction.

3 DETAILS

3.1. The proposals for a merged CCG are now well progressed.

3.2. A draft single CCG structure has been shared with staff for comment. In line with the case for change, the structure makes efficiencies via the consolidation of corporate functions. This enables local, borough based teams focussed on service transformation and integration to retain similar resource levels to those seen currently. Comments on this draft structure will inform the formal consultation with staff necessary in the case that a merger proceeds.

3.3. A committee in common of the CCGs took place on 26th September and approved the submission of a merger application to NHS England. It has been agreed that this submission is subject to the support of the six CCGs' memberships. The Merton CCG membership will vote on the proposed merger on 16th and 17th October.

3.4. Draft governance documentation (a constitution, standing orders, terms of reference of key groups, etc) is under development. In this documentation, it is proposed that the full commissioning budget for each borough is delegated from the SWL CCG to a borough-based committee. In each of the six CCGs, local leadership teams have been developing proposals to manage this budget.

3.5. Our proposal in Merton remains that to the greatest extent practicable, the borough-based committee will make its substantial decisions about services in the borough via the Merton Health and Care Together Board, which will

for the purposes of CCG governance become a 'Committee in Common' between the CCG and the other MHCT partners.

3.6. There will also be a regular committee in common meeting between the Merton and Wandsworth borough committees, to discharge more routine duties (for example relating to the upward reporting from the borough committees to the SWL CCG) and commissioning spend where Merton and Wandsworth CCGs currently hold shared arrangements.

3.7. Finally there will be a partnership board established with St George's University Hospital NHS Foundation Trust. This will not be a formal committee but will provide shared executive leadership of the transformation of the acute pathway. St George's will continue to be a part of MHCT.

4 ALTERNATIVE OPTIONS

4.1. There is no formal alternative proposed at this stage. If the merger of the CCGs does not progress, Merton CCG will still be required to find 20% management cost reductions in 2020/21 whilst retaining all of the corporate functions required of a statutory body.

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. Extensive engagement has been undertaken with partners to support the merger application. Wherever possible, the CCG has sought to take account of the views of partner bodies in the development of its proposed future arrangements.

6 TIMETABLE

6.1. If approved by the membership in October, and subsequently by NHS England, the merger will take effect from 1st April 2020.

6.2. In order to move to a new operating model from this date, staff consultation would begin shortly after NHS England approval i.e. November 2019.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. There are no specific implications for the Board to consider.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. The Terms of Reference and membership of the Merton Health and Wellbeing Board will require updating to reflect the change in statutory body and the roles and job titles of CCG representatives. This is not addressed in detail in this paper.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. There are no specific implications for the Board to consider.

10 CRIME AND DISORDER IMPLICATIONS

10.1. There are no specific implications for the Board to consider.

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. There are no specific implications for the Board to consider.

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

None

13 BACKGROUND PAPERS - None