Merton Council
Health and Wellbeing Board

Date: **27 June 2023**

Time: **6.15 pm**

Venue: **Council chamber - Merton Civic Centre, London Road, Morden SM4 5DX**

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

1	Welcome and apologies for absence	
2	Declarations of pecuniary interest	
3	Minutes of the previous meeting	1 - 6
4	Beat the Street *A verbal update to be provided at the meeting.*	
5	Health and Wellbeing Board Rolling Priority 2023/24 – Outline Action Plan	7 - 20
6	Carers' Strategy Update *A verbal update to be provided at the meeting.*	
7	Right Care Right Person *To Follow*	
8	ICP Strategy and ICB Joint Forward Plan *A verbal update to be provided at the meeting*	
9	NHS Proposal for Paediatric Cancer Care in the South East	21 - 58
10	Better Care Fund (BCF) Plan 2023-25	59 - 98
11	HWBB Young Inspector Pilot	99 - 100

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Health and Wellbeing Board Membership

Merton Councillors

- Peter McCabe (Chair)
- Brenda Fraser
- Jenifer Gould

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

HEALTH AND WELLBEING BOARD
28 MARCH 2023
(6.15 pm - 8.05 pm)

PRESENT	Councillor Peter McCabe (Chair), Councillor Jenifer Gould, Dr Sy Ganesaratnam (Vice Chair), Mark Creelman, Dr Laura Jarvie, Jane McSherry, John Morgan, Anna Huk and Anthony Molloy
ALSO PRESENT:	Dave Curtis, Manager Healthwatch Merton, Julia Groom (Consultant in Public Health), Barry Causer (Public Health Lead for Adults, Health Improvement and Health Protection), Calvin McLean (Interim Assistant Director of Public Protection) Clarissa Larsen (Health and Wellbeing Board Partnership Manager), Jayde Watts (Democratic Services Officer)
IN ATTENDANCE REMOTELY:	Dr Karen Worthington, Sarah Goad (Chief Executive Officer, Age UK Merton), James Armitage (Head of Regulatory Services)

1 WELCOME AND APOLOGIES FOR ABSENCE (Agenda Item 1)

The Chair welcomed the new Chief Executive of Merton Connect, Anthony Molloy.

Thanks were passed on to Brian Dillon, Chair of Healthwatch, for his many years of participation to the HWBB, who has stood down from the Board.

Apologies were given by Cllr Brenda Fraser, Beau Fadahunsi, Adrian Ash who was substituted by Calvin McClean (Interim Assistant Director of Public Protection) and Dr Dagmar Zeuner who was substitued by Julia Groom (Consultant in Public Health) and Barry Causer (Public Health Lead for Adults, Health Improvement and Health Protection).

2 DECLARATIONS OF PECUNIARY INTEREST (Agenda Item 2)

There were no declarations of interest.

3 MINUTES OF THE PREVIOUS MEETING (Agenda Item 3)

RESOLVED: That the minutes of the meeting held on 24 January 2023 were agreed as an accurate record with amendments to include Anna Huk and Beau Fadahunsi full name in the list of attendees.

4 TOBACCO CONTROL AND STOPPING SMOKING AND VAPING (Agenda Item 4)

Barry Causer, Public Health Lead for Adults, Health Improvement and Health Protection introduced the paper which had been circulated to members.

Barry took this opportunity to provide an update on Beat the Street which was a game designed to encourage people to walk, cycle and travel more actively. Barry highlighted that in week 2 of the game just over 19,000 Merton residents had taked part; nearly 10% of all residents in Merton. Over 77% of those who took part had registered their contact details to allow for follow up and 38% of those registered had self-reported to be physically inactive and used Beat the Street as an opportunity to get more active. In total, 130,000 miles had been travelled by those that took park.

Barry then outlined the report which showed that smoking was the lead cause of preventable disease and illness across the UK, was strongly linked with health inequalities and required a strong multi-agency response. The Government had commissioned the independent Khan Review to assess the ambition to be smoke free by 2030, which showed it was likely to miss the target by approximately 7 years. A Government response was due shortly.

The number of people that smoked, both nationally and in Merton, had declined with 12.8% of Merton residents continuing to smoke. The report highlighted that a smoker who smoked 20 cigarettes per day would spend around £4,000 per year on tobacco.
Smoking remained one of the lead causes of death in England, causing lung cancer, respiratory illnesses and cardiovascular disease. It had a significant impact on communities and the NHS.

Smoking rates were higher in more deprived areas, among manual workers and for those that live in social housing. Smoking in pregnancy was also five times more common in the most deprived groups, so there was an opportunity for the HWBB to come together to tackle this inequality across the borough.

There were a number of local, regional and national stop smoking support groups for those that lived and worked in Merton and evidence clearly showed that a person was more likely to quit smoking with specialised support and advice.

In response to questions, the following was stated:

- Work was underway with housing associations which included Clarion who were funding a stop smoking pilot.

- The roll out of the Ottawa Model for smoking cessation, presented opportunities for people who leave hospital and to work jointly with the voluntary sector.
- There was no additional investment for stop smoking services during the pandemic. There was however more coverage of the risk of smoking and Covid, which was thought to have had an impact on the increased number of people that stopped smoking.
- Prehabilitation work through Better Health Merton took place and was a good example of seeking out opportunities to promote stop smoking and to embed stop smoking conversations and support via pathways including social workers, primary care, the voluntary sector or schools and colleges across the borough.
- In addition to the range of services on offer, GP's could be a powerful tool to support people stop smoking. Health and Wellbeing coaches have also been of great support and offered more personalised support over the course of six weeks.
- Midwives within the borough were working to support stop smoking.
- Vaping itself was not a licensable activity under The Licensing Act 2003 but if there were premises which sold alcohol and tobacco then the licensing objective of protecting children from harm and crime and disorder could be explored.
- Advertising was a huge factor in young people purchasing products and more collaborative work here could help, including the Under-18s Health and wellbeing Champions.
- Data showed that smoking rates were higher in the east of the borough. Statistics for quit rates by smaller geographical areas e.g. wards were requested to be shared with Board members. This was being investigated and would be reported to the next Health and Wellbeing Board.

RESOLVED: That the Board agreed the recommendations

5 HEALTH AND WELLBEING STRATEGY REPORT AND ROLLING PRIORITY OPTIONS (Agenda Item 5)

Julia Groom, Consultant in Public Health introduced the paper which had been circulated to members.

Julia brought attention to the 2019-2024 Health Place for Healthy Lives strategy which focused on the wider determinants of health, built on evidence produced by Michael Marmot in his review of Health Equity 10 Years On. This included a number of principles on tackling health inequalities, prevention, early intervention, health in all policies, community engagement and empowerment, experimenting and learning and think family. Prior to the pandemic, the Board had agreed to focus on its statutory responsibilities and duties alongside a chosen rolling annual priority.

The report proposed members select one of two rolling annual priority options for 2023/34:
Option A was to tackle air pollution, tobacco smoking and respiratory disease; Option B was addressing healthy workforce and workplace health linking to Covid recovery work.

Following agreement of an option, an outline partnership work programme for implementation would be produced and reported to the next Board meeting.

In evaluation of the options, the following was stated:

- Considering 'starting at home' working with the large number of health and Council staff in the workforce.
- Children and young people experiencing several issues relating to smoking, vaping and air pollution including asthma.
- South West London ICS providing some capacity to deliver health workplace.
- The crucial importance of climate and air pollution as a contributory issue.
- The opportunity to include part of Priority B in the chosen Priority A.

It was agreed that Priority A would be taken forward including elements of Priority B, for example, active travel and physical activity. An outline work plan would be presented to the next meeting of the HWBB.

RESOLVED: That the Board agreed the recommendations with an update provided to the board.

6 PRIMARY CARE STRATEGY AND INTEGRATED COMMUNITY SERVICES (Agenda Item 6)

Mark Creelman, Locality Executive Director introduced the paper which had been shared with members.

Mark explained that the Primary Care Strategy was created due to a change in people's needs and demands and presented opportunities around prevention and access across south west London. A Merton Plan to implement the strategy was also being developed. The aim was to have the best possible outcomes for people across south west London and for Merton residents so that they stay well, wrapping care around individuals who need it and streamlining access so that people get the right care from the right people.

A workshop took place in November which highlighted three main themes of prevention, proactive care and access. It was key to ensure the right

workforce was in place and well supported to deliver outcomes. There would also be work to do on resident expectations, so that they were aware of services available outside of seeing a GP. Good digital access was important for residents, although it was recognised that not everyone had digital access, so a multi-channel approach was needed. IT was also an area of focus to ensure primary care had the right IT support to do the job. The other key area was estates, to help ensure the right buildings in the right state to provide good care.

South west London had strong primary care and scored well in the GP Survey, being top four in the country, with the only outstanding practice across south west London. There was already a multi-disciplined team in Merton, so it was important to ensure that they had the right people for the right cohorts of patients, which would be enhanced over the next few months. A record number of appointments had been delivered in primary care, which continued to grow on a monthly basis. It remained important to check that there was the right balance of face-to-face appointments and digital consultations.

In response to questions, the following was stated:

- As part of the strategy, IT infrastructure had been identified as a priority for people to have the right tools to do the right job, and experts would be involved in improving this.
- Interest in the development of neighbourhood teams and how these integrated with other teams e.g. Family Hubs, health visitors.
- An aim to move away from multiple organisations around the person to better sharing of information, with potential for shared teams and models.
- Merton had a good foundation of multidisciplinary working through integrated locality teams with a particular focus on frailty.
- Dentistry and Opticians would be part of the Strategy, but it was important to understand what the challenges were in each of those areas. This will be addressed further once there was a better understanding of what those challenges were.
- Closer working with schools and children's centres would be beneficial going forward, alongside multi-professional training at PCN level.
- When working with young people, inclusivity remained vitally important to secure engagement.
- An aim to streamline and simplify data as much as possible whilst protecting patient confidentiality.

RESOLVED: That the Board agreed the recommendations

7 ICB DRAFT JOINT FORWARD PLAN (JFP) (Agenda Item 7)

Mark Creelman, Locality Executive Director introduced the paper which had been shared with members.

The Joint Forward Plan was a statutory requirement and had been shared with partners for comments to ensure that it reflected priorities and local Health and Wellbeing Strategies. The Plan was running concurrently with the ICP (Integrated Care Partnership) strategy that was brought to the last Board. The document will be finalised and published by the end of June. The HWBB consulted on the statutory requirement and that JFP pays regard to the Health and Wellbeing Strategy. Mark will take back the comments of the HWBB to feed into the final JFP which will be reported to the June HWBB for agreement.

In response to questions, the following was stated:

- Inclusion of green and environmental issues was welcomed as was wider support to carers and links to communities.
- The Council priority of Borough of Sport together with Actively Merton including Beat the Street were contributing to prevention.
- It was important to be inclusive on the individual needs of children and young people and this could be made more explicit.
- In relation to mental health services, self-referral and early help services could be better emphasised reflecting the work of CAMHS.

RESOLVED: That the Board agreed the recommendations

8 PLACE-BASED PARTNERSHIP PROGRESS AND VISION (Agenda Item 8)

Mark Creelman, Locality Executive provided a verbal update which included the following points:

- There were a number of strategic partnerships – the Health and Wellbeing Board, Integrated Care Board and Merton Health and Care Together – and dialogue on integration and day-to-day cooperation are underway to make partnership a reality.
- This would be a focus over the next year with an emphasis on making better outcomes for local people.
- This will be a key issue for the borough committee and an update on progress would be provided to the Health and Wellbeing Board.

Committee: Health and Wellbeing Board

Date: 27th June 2023

Wards: All

Subject: Merton Health and Wellbeing Board - rolling priorities 2023/34 outline action plan

Lead member: Cllr Peter McCabe, Cabinet Member for Health and Social Care

Lead officer: Dr Dagmar Zeuner, Director of Public Health

Contact officers: Julia Groom, Consultant in Public Health, Barry Causer, Public Health Lead for Adults, Health Improvement and Health Protection

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Recommendations:

Health and Wellbeing Board members are asked to:

A. Discuss the outline framework of an action plan for the agreed whole systems approach to tackling air pollution, tobacco and respiratory disease as a rolling priority for 2023/24.

B. Identify priorities and agree to champion different proposals within the outline programme plan.

C. Discuss a reporting schedule to the HWBB of the key elements of the rolling priority whole systems approach across 2023/24.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of this report is to set out an outline framework for the implementation of the priority agreed by the Health and Wellbeing Board members at the March 2023 Board: to take a whole systems approach to tackling air pollution, tobacco and respiratory disease. In addition, it includes the actions to support the healthy workforce and workplace in increasing active travel, which was important to the Board.

1.2 The report also sets out a proposed reporting schedule over the next year on specific areas of work that form part of the implementation of the HWBB priority.

2 BACKGROUND

2.1 At its meeting on 28 March 2023, the Health and Wellbeing Board (HWBB) considered and evaluated options for rolling priorities for 2023/4. Members considered the added value that the HWBB member organisations and its way of working, e,g. through a partnership approach, could add to key issues and the deliverability of work in a timely and effective way. To have the greatest impact, the Board members agreed to one rolling priority, working with a ‘whole system approach’ to provide system leadership, creating the right conditions for organisational and individual action, hand-in-glove with the delivery of holistic services.

2.2 Members agreed to the priority of 'tackling air pollution, tobacco, smoking and respiratory disease together'. This priority aligns closely to the Council Plan 2023 – 2026 commitment of Building a Sustainable Future. It also links to the recent Merton Annual Public Health Report 2022/23, the Chief Medical Officer's 2022 report on Air Quality, Merton's Climate Strategy and South West London NHS Green Plan.

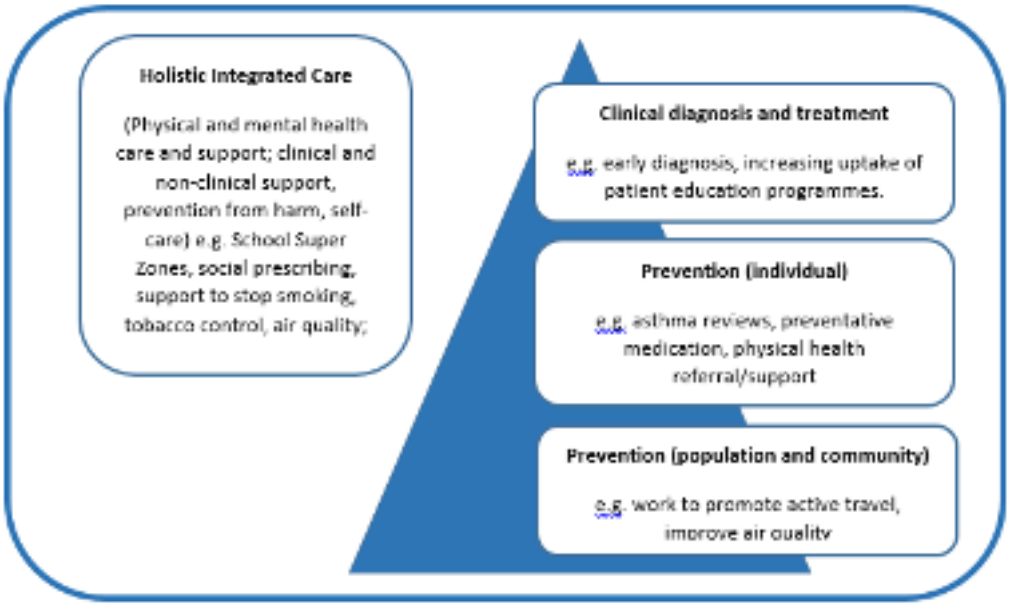
2.3 In agreeing this priority, HWBB members were keen not to lose aspects of the alternative priority of healthy workforce and workplace, and it was agreed that elements of this would be included in the proposed work programme. This report, therefore, also includes work to promote and increase workforce active travel.

3. DETAILS

Whole systems approach

3.1. The focus of the HWBB on tackling air pollution, smoking and vaping, and respiratory disease, as part of a whole system approach, will build on the assets, partnerships and work already underway in Merton. The framework will take a life course approach, include prevention and tackling health inequalities, and actively seek out opportunities to understand lived experience and residents' voice, including that of young people. It aims to deliver behaviour change at scale and early action and engagement. The diagram below (Figure 1) gives a suggested outline of the different facets of a whole system approach, using respiratory disease as an example. This will be iterative and will be refined over time as activity takes place, as we learn and understand more from engagement with residents.

Figure 1: Exemplar facets of a whole system approach



Evidence and Intelligence

3.2 The Chief Medical Officer's annual Report 2022 focuses on air pollution and provides robust evidence on the negative effects of air pollution on health and its associated impacts on lung development in children, heart disease, stroke,

cancer, exacerbation of asthma and increased mortality, among other health effects. The report highlights achievable solutions across different sectors and makes the case that we need to continue to be active in reducing outdoor air pollution as well as better outdoor air quality.

3.3 Merton Annual Public Health Report 2022/23 focuses on the health co-benefits of climate action, recognising how action on climate change can deliver real co-benefits to people's health and help reduce the health inequalities that exist across Merton.

3.4 Specifically, the report sets out how transport emissions have a direct impact on air pollution which is responsible for health conditions including heart disease, lung disease and cancer. The impact of air pollution on health is not equal, with those living in the 20% most deprived neighborhoods, and neighborhoods where more than 20% of the population are non-white, experiencing higher concentrations of air pollution (whist having lower levels of car ownership). Active travel refers to modes of travel that involve a level of activity including walking and cycling. This is important because data shows that just over 20% of adults are physically inactive in Merton, which amounts to over 30,000 adults. Promoting active travel as a way of reducing transport emissions can deliver health co-benefits and can be integrated into urban and transport planning to make it as easy and equitable as possible.

The Merton Story 2022/23 highlights:

3.5 **Tobacco:** 1 in 7 residents (around 22,900) in Merton still smoke, which is similar to London and England. Prevalence remains static and is highest in wards in the east of the borough (17.2% compared to 10.8% in west Merton - a 6.4% difference), in adults in routine and manual occupations, as well as those with long-term mental health conditions.

3.6 **Respiratory Disease**: Chronic obstructive pulmonary disease (COPD) is usually associated with long-term exposure to harmful substances, with smoking thought to be responsible for around 9 in every 10 cases. 1% of Merton residents or about 2,150 people are diagnosed with COPD, a disabling disease that often leading to exacerbations and hospital admissions. Prevalence in Merton is lower than the England rate (1.9%) but similar to both London and South West London. Prevalence is higher in wards in the east of the borough and is likely associated with a higher smoking prevalence. There were 51 COPD deaths in 2020 compared to 64 deaths in 2019 and 67 deaths in 2018.

3.7 In 2020/21, an estimated 4.7%, around 10,000 Merton residents aged 6 and over are recorded as having asthma, which often affects young people and has a direct impact on their quality of life. Recorded asthma prevalence is lower than England (6.5%), however, it is higher in wards in the east of the borough (5.1%) compared to wards in the west (4.2%).

3.8 **Transport and air quality**: The Mayor of London set a target for 80% of all journeys in London to be made on foot, by bicycle or public transport by 2041. In Merton transport links are good, although better in the west of the borough,

and currently 61% of journeys are made on sustainable forms of transport, approximately 30% by walking and only 2% by bicycle. Only a third of Merton's residents take part in 20 minutes of active travel a day, and there has been a decline over the last five years. Driver compliance with 20mph speed limits is less than 20%.

3.9 Merton's Air Quality Status Report, 2021, provides a full analysis of air quality in the borough in 2020, finding that Merton was still exceeding government targets. It is estimated that between 54 and 100 people a year die in Merton due to air pollution. The fraction of mortality attributable to particulate air pollution in 2020 is 7.2% in Merton and 5.6% in England. Across England those living in the 20% most deprived neighbourhoods and neighbourhoods where more than 20% of the population are non-white experience higher concentrations of air pollution.

Current Plans and Activity

The focus of the HWBB on air quality, smoking and respiratory disease will acknowledge and build upon existing work in Merton that includes:

3.10 **Air Quality Action Plan**: LB Merton has a legal duty to monitor air quality and to publish an air quality action plan. Air Quality has a direct impact on respiratory diseases including asthma and COPD. Evidence suggests that increases in pollution, less greenspace and poor living conditions, such as mould and damp significantly impact the quality of life of patients with respiratory illnesses. The current Air Quality Action Plan is due to be refreshed in 2023. Current activity includes:

- Auditing air quality in schools.
- Expanding electric vehicle charging points across Merton – vehicle charging strategy is out for consultation.
- Working with TFL on roll out of ULEZ; electric vehicle bus routes; working in Morden, a poor air quality hotspot, to reduce bus vehicle traffic pollution.

3.11 **Walking and Cycling Strategy development:** A Merton walking and cycling strategy will be developed from June 2023, this will inform a master plan for the borough, mapping walking and cycling routes, identifying opportunities and including an action plan. It will be adopted by March 2024.

It will also incorporate a 'curbside' strategy, proposing electric vehicle only bays, 'parklets' with outdoor seating and guidance for communities.

Human Forest electric bike hire has been introduced and Lime bikes will be coming shortly.

3.10 SWL NHS Green Plan 2023-25: sets out how SWL NHS will seek to deliver on ambitious national targets for all NHS organisations. The plan includes priorities for travel and transport to reduce carbon emissions from staff, patient, visitor and supplier transport; promoting greener, healthier forms of transport for staff and patients; educating staff and patients on the climate impact of their travel and promoting pollution awareness; making sustainable staff benefits and incentive schemes relating to travel, including cycle to work

and active travel incentives; and expanding electric vehicle charging infrastructure on NHS sites.

3.12 **Tobacco**: Smoking is the single largest driver of health inequalities in England and smoking status is associated with almost every indicator of deprivation or marginalisation. For example, those with mental illness, lower incomes, unemployed, homelessness, those in contact with the criminal justice system, living in social housing, those without qualifications, lone parents, and LGBTQ+ people. A paper to the HWBB in March 2023 (see background papers) set out the evidence and current activity.

3.13 A multi-agency stop smoking and Tobacco Control Steering Group has been set up that is delivering on actions that covers promotion of stop smoking services and communication on the benefits and how to stop smoking, considers the benefits (and concerns) around e-cigarettes (vapes) and also the work of tobacco control by trading standards which includes preventing underage sales, intelligence led test purchases and tackling illicit sales. Additional funding to expand the number of test purchase has been agreed by the Government, however the amount and conditions of the grant have not yet been announced.

3.14 **Respiratory Disease**: There is a SWL NHS steering group that is delivering on preventing and managing respiratory disease, led by SWL ICB. One example is the pilot programme taking place in two Primary Care Networks (PCNs), where spirometry testing is provided within the PCNs geographical area, so the patient does not need to travel to hospital for their diagnosis; which is more convenient and can facilitate provision of early treatment.

4. Priority Programme of Work

4.1 The purpose of the HWBB whole systems rolling priority is to take a ‘Health in All Policies’ (HiAP) approach, which contends that by considering health impacts when making policy, including action on sustainability, the overall benefits can be increased. A sustainable future can promote health, equity and sustainability together, building return on investment and maximizing overall impact. The Health and Wellbeing Board recognises that by working collaboratively, with partners and residents, we can build a sustainable future that has the health of all Merton’s communities at its core.

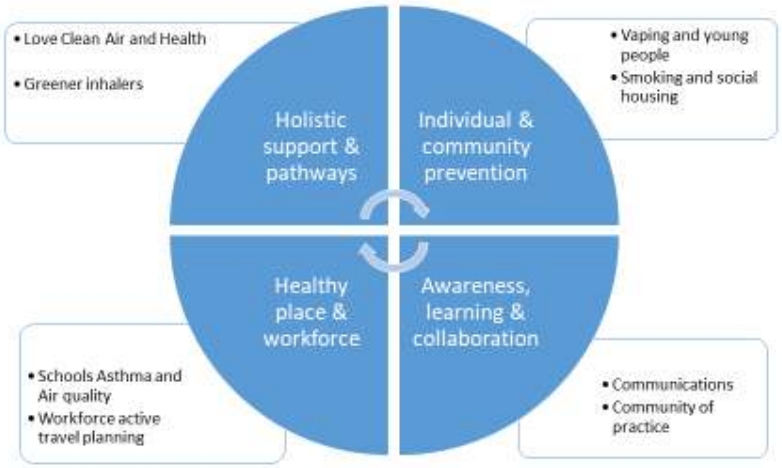
4.2 There is much activity underway relating to the priority and it is proposed that the HWBB agree a few core priorities and actions to champion. HWBB members can add value through collective focus, making explicit use of their different skills, experiences and roles as clinicians, community representatives, council officers and councillors and young people. This will inform the development of a whole systems framework, including the building blocks of:

- Holistic support and pathways
- Individual and community prevention
- Healthy place and workforce
- Awareness, learning and collaboration

Opportunities for the HWBB:

4.3 A group of officers met to review existing activities, discuss opportunities and identified the following options for the HWBB to champion. These build on current work, but also take a joined-up approach and would form the basis of a work programme for strategic oversight by the HWBB. These are grouped around the four themes above, but it is recognised that there are interdependencies across them. Some of these options already have identified resources and others would need resources to be identified or new resources secured, e.g. SWL inequalities/innovation funds.

Breathe Merton: outline framework for a whole systems approach to Air Quality, Tobacco and Respiratory health



4.4 **Options for the HWBB**

Theme	Option
Holistic Support and Pathways	**a) Love Clean Air and Health** The **Love Clean Air** Website provides information on air quality in south London. It is proposed that links with health partners are strengthened in order to ensure that information can be shared on the impact of air pollution and how to protect ourselves, building this into care pathways. For example, alerts to ensure residents with asthma and COPD are made aware and can manage their medication. This could be included and promoted by clinicians as part of patient annual Asthma and COPD management reviews. It could also include a focus on raising awareness of internal air quality, such as the increased pollutants from smoking, burning candles and household damp and mould.
	b) Greener Inhalers There has been a recent move to switch asthma inhalers to 'greener' ones –it has been proven that the newer inhalers significantly reduce carbon emissions compared to previous

	ones, are more cost effective and provide the same drug/dose to patients. Building on a pilot in Cricket Green Practice, this could seek to understand more about prescribing behaviour and patient expectations/wishes to make a swap to the greener inhaler the 'norm' in Merton.
Individual and community prevention	**c) Smoking and social housing** 22% of Merton residents living in social housing smoke, compared to 7.9% of those who own their own home. Higher rates of smoking mean people living in social housing are disproportionately affected by the substantial health and economic inequalities caused by smoking. A Stop Smoking in Social Housing pilot is being developed to ensure Merton residents living in social housing have an effective and easily accessible stop smoking service available to them via the public health commissioned stop smoking service 'One You Merton' and other services that are on offer including digital and self-care resources. This Stop Smoking in Social Housing pilot will bridge the gap and provide support to a large number of people who currently smoke and will target people living in areas of deprivation, as many of our housing estates are in the east of the borough such as Phipps Bridge, St Helier and Pollards Hill. These are also areas with higher rates of Core 20 population in Merton.
	d) Vaping and Young People While vaping can help smokers quit and the evidence is clear that vaping is around 95% less harmful that smoking, it is not harmless and is not for young people under 18. More information and awareness raising is needed to explain that vaping is a helpful way for people to stop smoking, but it should be discouraged in non-smokers, particularly young people. Increasing percentages of children and young people are trying vaping and/or vaping routinely, although it is illegal to sell vapes to the U18s. 7.0% of 11-17 year olds were current users, compared to 3.3% in 2021 and 4.1% in 2020 (ASH 2022 July). There is limited national research about vaping in Children and Young People and the Office for Health Improvement and Disparities (OHID) issued a call for evidence in April 2023. Complementing training and awareness to front-line staff on stop smoking and vaping, a 12-month programme is being developed to explore and understand vaping perceptions and use by children and young people in Merton. The aims are to understand the vaping landscape amongst children and young people in Merton; use this knowledge to develop a suite of tailored tools and resources for young people, schools, parents, wider services and develop an intervention based on insights from young people.

	The outputs from the programme will inform the local and wider national vaping landscape.
Healthy Place & workforce	**e) Active and Sustainable Travel Planning** Staff travel planning has been identified as a gap in some areas, for example there is no active travel plan for Merton Civic Centre, which hosts a health provider as well as Council staff. The NHS Green plan identifies ambitious targets for reducing car use and promoting sustainable and active travel. It is proposed to develop joined up place-based plans and policies for staff active travel planning, learning across public sector sites, and the voluntary sector. This could align with the development of the Merton Walking and Cycling action plan. These plans would seek to build upon, and learn from, the successes of Beat the Street programme (see Appendix 1); part of the Actively Merton programme delivered by Merton Health and Care Together. Beat the Street captured the imagination of all in Merton, with all schools taking part and c10% of all of the residents in Merton took part. Critically, c34% of participants self-reported to be physical inactive and the programme, linked to the Borough of Sport priority, has developed strong foundations for future action to promote active travel.
	f) The Mayor of London's Good Work Standard We will review and explore opportunities for Merton employers to adopt the the Good Work Standard, which sets the benchmark that the Mayor wants every London employer to work towards and achieve. Organisations able to meet the Good Work Standard criteria can apply for accreditation and recognition as leading employers from the Mayor. The initiative has been developed in collaboration with London's employers, trade unions, professional bodies and experts.
	g) Schools, Air quality and Asthma A pilot project is being developed to explore the impact of environmental factors such as air pollution on children and young people with asthma and to use the findings to improve asthma management pathways. Anticipated outcomes include reduced A & E attendances/admissions, improved school attendance, and the prevention of long-term health impacts. The project will work with pupils with asthma in four primary schools located in two of the borough's air pollution priority areas. It will focus on lived experience and innovative approaches to monitoring air quality including use of personal air quality sensors which track air quality in the home, school and journey to school. This project would engage young people, families, schools, GPs, and school nurses. The project relates directly to the national bundle for asthma deliverables on environment quality and will be a blueprint for further roll out.

Awareness, learning and collaboration	**h) Communication and Awareness** It is proposed to use the combined reach of HWBB members communication channels to raise awareness about the issues of air quality, tobacco and respiratory health. We will also work to respond quickly and promote same-day information on air quality, such as through the use of digital advertising screens and other channels. Develop awareness and training on the links between air quality, tobacco and respiratory diseases across front-line staff including housing, social care and in primary care, so that staff feel confident to have conversations with clients/patients (a Making Every Contact Count approach), for example through social prescribing routes. Promotion of the NHS led #AskAboutAsthma Campaign, which will run from 11th to 17th September 2023, which will include a week of events, including podcasts, videos, webinars, blogs and a one-day online conference on Thursday 14th September.
	i) Community of Practice - multi-agency learning In order to test out a joined-up approach to tackling air quality, tobacco and respiratory disease, it is proposed to develop a community of practice across organisations in Merton to test out different approaches, learn from each other, overcome barriers and share successes. It is suggested that the community of practice could be made up of 2 voluntary sector organisations, 2 GP practices, 2 LBM services, 2 schools. This would focus on supporting staff to take up active travel, enable sustainable travel, such as use of electric vehicles, give up smoking, and manage respiratory conditions. This would learn from recent work that has taken place in Merton, including a Green and Healthy GP practices pilot and school 'superzones' and wider evidence.

5. NEXT STEPS

5.1 The HWBB is asked to discuss the approach and consider the options for inclusion in a work programme, and any further opportunities, with a focus on evaluation, learning and scaling up.

5.2 Members of the Board are each asked to identify areas that they will champion both within their own organisations and more broadly across their networks.

5.3 An officer group, now formed as a Task and Finish Group, will meet to finalise the work programme and provide oversight, reporting back to each meeting of the Board to June 2024.

6. ALTERNATIVE OPTIONS

The preferred option for a rolling priority for the HWBB were considered at the March Board and the option outlined in this report chosen.

7. CONSULTATIONS UNDERTAKEN OR PROPOSED

The work programme will be undertaken in collaboration with partners and actions will involve engaging a range of stakeholders and residents.

8. TIMETABLE

As set out in the report and in line with options included in the work programme.

9 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

None for the purpose of this report.

10 LEGAL AND STATUTORY IMPLICATIONS

It is a statutory duty under the Health and Social Care Act 2012 for all Health and Wellbeing Boards to produce a joint Health and Wellbeing Strategy.

11 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Health and Wellbeing Strategy and priority chosen for 2023/4 focuses on action to help reduce health inequalities.

12 CRIME AND DISORDER IMPLICATIONS

None for the purpose of this report.

13 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None for the purpose of this report.

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

14.1. Overview of Beat the Street in Merton.

15 BACKGROUND PAPERS

15.1. Health and Wellbeing Board Paper on Stop Smoking and Tobacco Control (March 2023)
https://democracy.merton.gov.uk/documents/s49736/HWB%20Stop%20Smoking%20and%20Tobacco%20Control%20Working%20Version.pdf

APPENDIX 1. Beat the Street Merton: Executive Summary

Beat the Street is run by Intelligent Health. Founded by Dr William Bird MBE, our mission is to create resilience and improve health by connecting people to each other, their communities and their environment. We engage communities, share knowledge of the foundations of good health, and provide data analysis for actionable insight.

Intelligent Health aims to improve health at scale by focusing on people, the place they live and helping to provide purpose in their lives. This supports building the resilience essential to combat inactivity, loneliness and poor mental health, all of which have been exacerbated by the Covid-19 pandemic.

We have been running Beat the Street for over 10 years to tackle inactivity, health inequalities, and improve mental wellbeing, working in the community alongside local community assets and partners. We deliver sustainable health at scale, increasing long term physical activity, improving mental wellbeing and connecting people to nature in their neighbourhood.

"Helped give a reason to get my daughter out of the house for longer. She loves to walk but best the street helped us to keep her interested for longer and to walk further." Female, 30s

We follow the NHS England Core20PLUS approach to support the reduction of health inequalities. In our national programme, 100,000 adults and children (24%) were from the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) (2018-2021).

For residents it provides a fun gamified method to get out in their community and make small changes to daily behaviour that has a big impact.

Headline results

- 22,527 players (10% of population)
- 250,636 miles travelled
- Improved mental wellbeing for adults
- 48% of inactive adults became more active
- 46% of less active children became more active
- Improved mental resilience for adults
- 68 tonnes saving of CO2 *measured by carbon footprint calculator

Partner collaboration

Beat the Street Merton was commissioned by Merton Council and NHS South West London with support from the National Lottery via Sport England. Merton Council and NHS South West London have been integral to the successful delivery of Beat the Street in Merton by providing local knowledge, insight and connections. Throughout the six-week game phase, we worked with partners including Merton Connected, Wimbledon Guild, Walk & Talk, and Age UK, to name a few, to co-deliver and promote local activities, events, campaigns and services to help raise awareness of local provision and enable sustainability.

Caroline & Hannah's Story

“We've had lots of fun playing beat the street, one member of our family uses a wheelchair and has enjoyed tapping lamposts on our walks. We are fairly active walking daily, cycling 2-3 times a week and swimming 2 x per week. Because of our wheelchair, I have pre-scouted routes on my bike to check on accessibility. Beat the street has encouraged us to get our wheelchair bike out so that we can cover more ground. Parts of Merton are quite hilly and that's been a challenge. Beat the street encouraged us to get out in the rain! It has also encouraged us to explore parts of the borough we rarely go to and appreciate the lovely parks we have in Merton. We have had a lot of fun.”

Poplar Primary School

“After our visit from Chloe the whole school was buzzing with excitement to get going. The younger children love the fact that they had their own card, (like mum and dad's bank card) that they could use to swipe on the Beat Boxes. On the first few days of launch It was fantastic to see the child walking around with maps to navigate their way, which is a skill we are all forgetting to use as we become more reliant on mobile devices. I have had some children tell me that they have changed their route to school and now leave a bit earlier so they can scan more boxes on their way. Others are meeting with friends to go for bike rides at the weekends and family walks. It's been great and the whole Poplar community are really enjoying being part of it.”

Adult physical activity

During registration 38% of adults were inactive (n=5377). Following Beat the Street, 48% of adults who were inactive when they registered had become more active (n = 139 matched pairs). Overall, there was an 8% decline in the proportion reporting as being inactive (from 35% to 27%) (n=393 matched pairs). Furthermore, there was a 9% increase in the proportion achieving 150+ minutes of activity per week (n=393 matched pairs).

Physical activity behaviour change was even stronger for women and adults living in areas of high deprivation (IMD 1-4). For women, there was a 9% decline in the proportion reporting as being inactive (from 34% to 25%) (n=288 matched pairs). Furthermore, there was a 10% increase in the proportion achieving 150+ minutes of activity per week (n=288 matched pairs). For adults living in areas of high deprivation, the proportion of inactive fell by 14% (from 40% to 26%), while the proportion achieving 150+ minutes of activity per week increased by 14% (n=82 matched pairs).

Children's physical activity

At the time of registration, 54% of children were less active (n=5536), with 46% of these children reporting as being active after the game (undertaking an average of 60 minutes or more of daily activity across the week). Overall, the proportion of children reporting being less active declined by 7%, from 46% to 39% (n = 332 matched pairs). Furthermore, there was 4% increase in the proportion achieving an average of at least 60 minutes of activity per day (n = 332 matched pairs).

For girls, the proportion reporting being less active decreased by 4% and the proportion reporting 60 minutes of activity per day increased by 2% (n = 169 matched pairs). For children living in areas of high deprivation (IMD 1-4), the proportion of less active decreased by 5%, from 47% to 42% (n = 118 matched pairs).

Barriers to physical activity

Participants (n = 599) were asked about their major barriers to participating in physical activities in their local areas. Motivational and community safety issues were highlighted by 21% of the participants, respectively. 17% of players reported that the cost of accessing physical activity opportunities was a barrier.

Resilience

The Brief Resilience Scale was used to evaluate adult players' perceived ability to bounce back or recover from stress pre- and post-game. Overall, the proportion reporting high and normal levels of resilience levels increased by 1%, from 4% to 5% and 73% to 74%, respectively, while the proportion reporting low levels of resilience decreased by 3% (from 24% to 21%) after Beat the Street (n = 332 matched pairs).

For women, the change in their resilience was stronger. The proportion reporting high levels of resilience increased by 3% (from 3% to 5%), while the proportion reporting low levels of resilience decreased by 3% (from 24% to 21%). In addition, the proportion of women reporting normal levels of resilience increased by 1%, from 73% to 74% (n = 249 matched pairs).

For adults living in areas of high deprivation (IMD 1-4), the proportion reporting high levels of resilience increased by 5%, from 0% to 5% (n = 64 matched pairs).

Feedback - Adults

I walked more and it made me visit areas of the borough I wouldn't usually visit. Female, 40s

It makes me feel healthy and I lost weight while walking 7 days a week and is exciting. Female, Prefer not to say

Sense of community doing it all together on a day out. Female, 40s

I took a longer route and so I walked more steps and became more relaxed. Male, 40s

I feel much better mentally and physically after long physical activity, I feel happier. Female, 40s

I just moved from Ukraine so the game helped me to discover Merton and find many interesting places/parks. Male, 30s

Feedback - Children

I learned that you have to work hard and do it systematically, regularly! to win. Girl, 11 and under

It has helped me getting out of my house and enjoying family time during exercising. Boy, 11 and under

I liked the sounds on the beat boxes, and it made it more fun going to school. I had more energy and I did extra walks to collect points. Boy, 11 and under

It helped me because it made me do exercise and it got me moving more faster and made me tired. Boy, 11 and under

Helped by inspiring me to be sportive. Girls, 11 and under

It was fun! Boy, 11 and under

It helped me because I wanted to go out more often and we walked longer routes to be able to swipe the cards. Girl, 11 and under

Agenda

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Published on 30 May 2023

South West London and Surrey Joint Health Overview and Scrutiny Committee

Date: Wednesday 7 June 2023

Time: 7:00 pm

Place: The Guildhall, Kingston upon Thames

Members of the Committee

Councillor Agatha Akyigyina, Councillor Richard Chatterjee, Councillor Qasim Esak, Councillor Kate Forbes, Councillor Daniel Ghossain, Councillor Jenifer Gould, Councillor Lesley Heap, Councillor Trefor Hogg, Councillor Edward Joyce, Councillor Jim Millard, Councillor Bernie Muir, Councillor Eunice O'Dame, Councillor Stephen O'Shea and Councillor Anita Schaper.

Everyone is welcome to attend the meeting

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AGENDA

1. Appointment of a Chairman and Vice Chairman

To appoint a Chairman and Vice Chairman for the 2023/2024 municipal year.

2. Apologies

3. Declarations of Interest

Members are asked to declare any disclosable pecuniary interests or any other registrable or non-registrable interests relevant to items on this agenda.

Should Members require any advice on declarations of interest, please contact the relevant Democratic Services Officer in advance of the meeting.

4. Minutes

To approve as a correct record the minutes of the last meeting on 25 January 2023.

5. Principal Treatment Centre - Update on plans for consultation

A presentation on the Reconfiguration of Children's Cancer Principal Treatment Centre including an update on plans for the public consultation.

6. Urgent Items authorised by the Chair

7. Exclusion of the Press and Public

This item is included as a standard agenda item which will only be relevant if any exempt matter is to be considered at the meeting:

To exclude the public from the meeting under Section 100(A)(4) of the Local Government Act 1972 on the grounds that it is likely that exempt information, as defined in Part I of Schedule 12A to the Act *, would be disclosed.
(*relevant regulatory paragraph to be indicated eg paragraph 1 for information relating to any individual)

Welcome to this meeting

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By entering the meeting room and using the public seating area, you are consenting to being filmed and to the possible use of those images and sound recording for webcasting and/or training purposes.

Information about the Committee

The Committee is made up of two Councillors from each of the constituent areas.

Emergency evacuation arrangements

If the fire alarm sounds during the meeting, please leave the building by the nearest exit. If you require assistance, please remain seated and an Officer will assist you from the building.

Accessibility

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- Toilet facilities will be easily accessible from the meeting room.
- For people who are deaf or have hearing impairments, there is an induction loop (depending on the building, this may only be available in the first two or three rows).
- **A large print copy of the agenda can be requested in advance**

Filming

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Interests

Councillors must say if they have an interest in any of the items on the Agenda. Interests may be personal or pecuniary. Depending on the interest declared, it might be necessary for the Councillor to leave the meeting during the debate on any given item. Further information regarding declarations of interest can be found in Part 5A of the Constitution - Members' Code of Conduct.

Minutes

The Minutes briefly summarise the item and record the decision. They do not record who said what during the debate**.**

South West London and Surrey Joint Health Overview and Scrutiny Committee

7 June 2023

Principal Treatment Centre - Update on plans for consultation

Recommendation(s)

The Committee is asked to RESOLVE that:

1. a Sub-Committee should be established to formulate and submit a formal response to the consultation on the service reconfiguration on behalf of the Joint Health Overview and Scrutiny Committee; and
2. the membership of the Sub-Committee be approved as one Member from each authority; and
3. the Chair and Vice-Chair of the Sub-Committee be appointed for the lifetime of the Sub-Committee; and
4. the formal Terms of Reference of the Sub-Committee be finalised in consultation with the Chairs of the Joint Health Overview and Scrutiny Committee and the Sub-Committee.

Background:

The Committee will receive a presentation from the NHS England Specialised Commissioning Team on the Reconfiguration of Children's Cancer Principal Treatment Centre including an update on plans for the public consultation.

It is recommended that a Sub-Committee be established to formulate a formal response to the consultation on the service reconfiguration on behalf of the Joint Overview and Scrutiny Committee.

The Committee may wish to consider any particular areas of focus it wishes the Sub-Committee to consider. The lifetime of the Sub-Committee would be for the duration of the consultation period and would end after the submission of the formal response.

Reconfiguration of Children's Cancer Principal Treatment Centre serving south London, Kent and Medway, most of Surrey, East Sussex, Brighton and Hove

Presentation to the South West London and Surrey Joint Overview and Scrutiny Committee

7 June 2023

Structure of our presentation

Agenda
1. Background and case for change
2. Where are we now
3. Equality and Health Inequality Impact Assessment
4. Consultation plan and document, including stakeholder engagement
Annex

1. Background and case for change

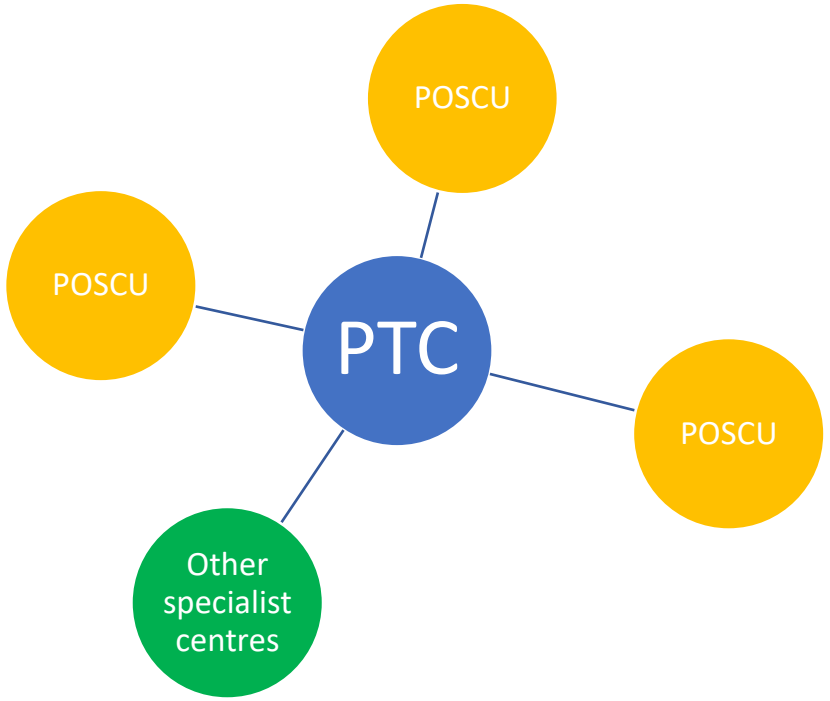
Caring for children with cancer

Principal Treatment Centres

Children with cancer in England receive some of the best care in the world, at the forefront of cutting-edge treatments and technology.

Their care is coordinated and led by Principal Treatment Centres, which provide diagnosis, treatment plans, and highly specialised care for children aged 15 and under with cancer.

Principal Treatment Centres are responsible for making sure each child gets the specific expert care they need for their particular cancer, and for coordinating treatment by different hospitals, if needed. Treatments for cancer in children can be complex and intensive and are often delivered as part of a clinical trial. Children can become acutely ill during treatment, requiring a high level of medical support.



Shared care

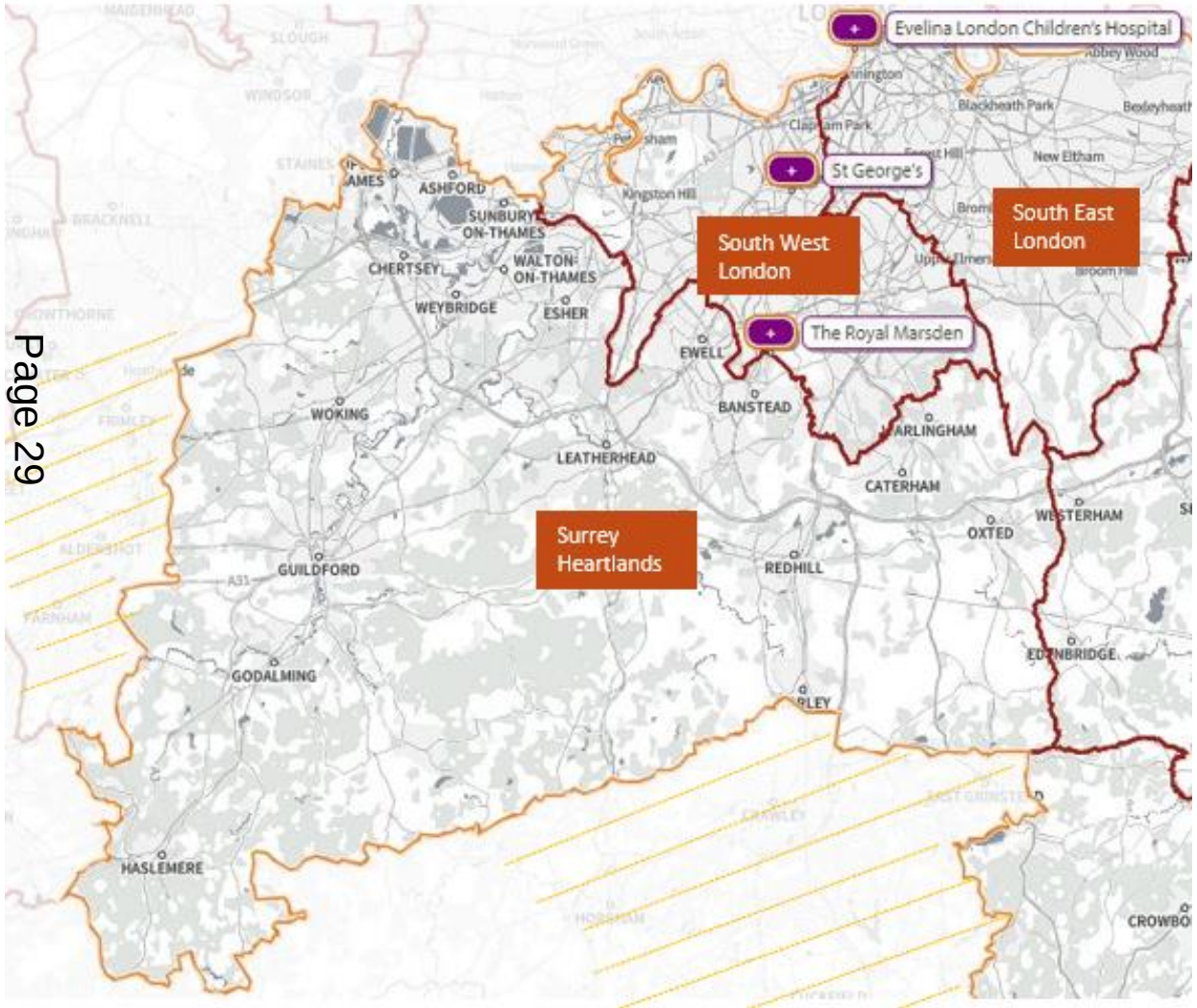
Principal Treatment Centres work in partnership with Paediatric Oncology Shared Care Units (POSCUs) at specified hospitals across their catchment areas, allowing care to be delivered closer to children's homes.

Many children with cancer also receive care in their homes. This can be from staff or 'outreach' services from the PTC, POSCU or staff from children's community nursing teams.

Principal Treatment Centres also coordinate children's care with cancer services that are provided at other specialist centres (if not provided by the Principal Treatment Centre), and with national services to ensure children receive the right care at the right time and in the right place.

The Principal Treatment Centre for south London, Kent, Medway, most of Surrey, East Sussex, Brighton and Hove

This Principal Treatment Centre is one of 13 across the country. It offers care to patients across a wide catchment area and some patients outside the catchment area who choose to access their care at this Principal Treatment Centre. The map below shows the locations of The Royal Marsden, St George's Hospital and Evelina London Children's Hospital.



There are also seven POSCUs within South West London and Surrey (with others across the wider region):

- St George's Hospital
- Kingston Hospital
- Croydon University Hospital
- St Peter's Hospital in Chertsey
- Epsom Hospital
- The Royal Surrey County Hospital in Guildford
- East Surrey Hospital in Redhill

The POSCU at Frimley Park Hospital has a formal referral pathway to the PTC at University Hospital Southampton

Childhood cancer in South West London and Surrey

Children newly diagnosed with cancer

While a diagnosis of cancer clearly has a huge impact on people's lives, it is relatively rare among children.

The rate of diagnosing new cancers among children in both South West London and Surrey is around **160 cases per million per year**. This means that around **1 child in every 6,200** are diagnosed with cancer each year.

On average, each year there are:
- 45 children diagnosed with cancer from South West London
- 35 children diagnosed with cancer from Surrey Heartlands

Children receiving cancer treatment

In total, the PTC treats around 1,400 children per year. Of these, in 2019/20:
- 259 children (18%) came from South West London
- 233 children (17%) came from Surrey Heartlands

Across both areas, nearly all children are seen as an outpatient (98%); 23% also had an inpatient stay.

Due to data quality for patient postcodes, we are not able to show the actual split of all these patients between boroughs. However, below we indicate the likely distribution of patients, based on population size.

South West London	Approximate number of new cancers **diagnosed** per year
Croydon	c.12
Wandsworth	c.8
Kingston upon Thames	c.5
Merton	c.6
Richmond upon Thames	c.6
Sutton	c.7

Surrey Heartlands	Approximate number of new cancer **diagnosed** per year
Elmbridge	c.5
Epsom and Ewell	c.2
Guildford	c.4
Mole Valley	c.2
Reigate and Banstead	c.5
Runnymede	c.2
Spelthorne	c.3
Tandridge	c.3
Waverley	c.4
Woking	c.3

South West London	Approximate number of patients **treated** per year
Croydon	c.70
Wandsworth	c.45
Kingston upon Thames	c.30
Merton	c.35
Richmond upon Thames	c.35
Sutton	c.40

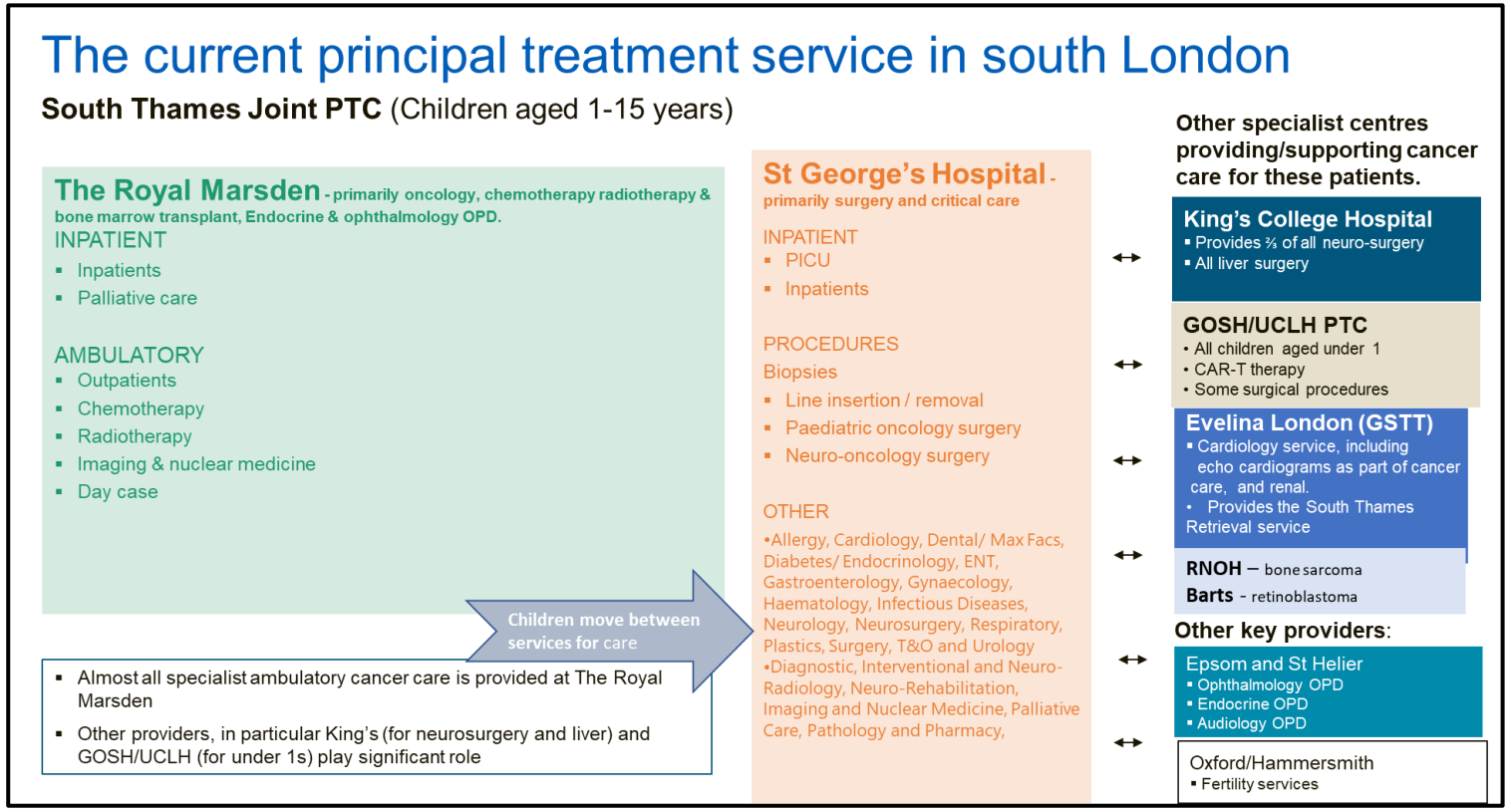
Surrey Heartlands	Approximate number of patients **treated** per year
Elmbridge	c.35
Epsom and Ewell	c.20
Guildford	c.25
Mole Valley	c.15
Reigate and Banstead	c.35
Runnymede	c.15
Spelthorne	c.20
Tandridge	c.20
Waverley	c.25
Woking	c.25

Please note that the tables contain modelled numbers and do not relate to real patient diagnoses or treatment.

Sources: NDRS new cancer registrations 2015-2019
ONS mid-year population estimates 2021
PTC programme "data lake" 2019/20 data

The current Principal Treatment Centre

- The Royal Marsden provides the majority of inpatient and outpatient care for children with cancer in the Principal Treatment Centre catchment area. Care is provided at its Sutton site.
- If children require surgery, critical care and some other specialist children's services they are treated at St George's Hospital in Tooting.
- The Royal Marsden works closely with the Institute of Cancer Research, which is based on its Sutton site, on world leading research into children's cancer care.



Some children also travel to other London hospitals for care, this is because of the expertise these hospitals have in specialist areas. This will continue in the future too.

Case for change

All Principal Treatment Centres must now be on the **same site as a children's intensive care unit and other specialist children's services.** This follows the publication of the new national specification for children's cancer Principal Treatment Centres in November 2021 which includes this requirement for all Principal Treatment Centres in England.

Locating the Principal Treatment Centre on the **same site as paediatric intensive care** will:

- ✓ mean very sick children do not need to be transferred between hospitals, as some currently do, to receive intensive care.
- ✓ means some admissions to intensive care can be avoided if intensive care doctors are able to visit the child on the ward and keep a close eye on progress.

Placing the Principal Treatment Centre on the **same site as other specialist children's services** will:

- ✓ minimise the number of children who need to move between sites for advice and treatment by teams with expertise in other specialities such as gastroenterology
- ✓ improve patient experience as patients can get more of their care in a familiar place rather than having to find their way around different sites.

Other **benefits** of relocating the Principal Treatment Centre include:

- ✓ the ability to provide a future-facing service ensuring that children get world-leading care as new treatments become available
- ✓ the potential to further develop research by locating cancer researchers alongside researchers into other childhood illness and relevant adult treatments.

Transferring critically unwell patients is associated with a risk of physiological deterioration and adverse events(1) and the emotional and psychological stress for parents should not be underestimated(2). Although specialist transport services have been shown to enhance safety and quality(3), the 2008 "Safe and Sustainable" framework, produced by clinicians and endorsed by the relevant Medical Royal Colleges, states that paediatric oncology and paediatric intensive care have "absolute dependency, requiring co-location". It is this clinical advice, backed up by subsequent expert reviews(4) that underpins the national service specification requirement.

See Appendix for references

There are two strong proposals for the relocated PTC

- Although the services which the **current Principal Treatment Centre** in south London provides are safe, by not having critical care services on site they can not provide the best quality care for children with cancer and they do not and cannot comply with the national service specification. The Royal Marsden is a specialist cancer hospital, not a children's hospital, and does not have a paediatric intensive care unit onsite or other specialist children's services required by the specification. Intensive care units are always on hospital sites that also provide many other specialist children's services. The Royal Marsden recognises that it cannot meet the national service specification and is supporting the reconfiguration process.

- We are fortunate to have two strong options for relocating the Principal Treatment Centre:
  - Evelina London Children's Hospital, which is run by Guy's and St Thomas' NHS Foundation Trust and is based on the St Thomas' site by Westminster Bridge
  - St George's Hospital, which is run by St George's University Hospitals NHS Foundation Trust and is based in Tooting.

NHS England London's consultation will seek views on the benefits and disadvantages of both options, along with enhancements and mitigations. Feedback will be part of the evidence considered when we take the decision.

- In combination with the new specification for Paediatric Oncology Shared Care Units (POSCUs) this will enable NHS England London to implement the national vision for children's cancer services, driving continued improvement across the network with enhanced levels of care closer to where children live.

We are ambitious for our PTC. In relocating the service, we believe there is the opportunity to go above and beyond the current specification by drawing upon the experience and expertise that exists within both providers who have submitted proposals, that preserves the strengths and expertise that is evident within the existing service at The Royal Marsden; and more widely, leverages opportunities that exist through collaboration between other parts of the NHS.

Things to note:

In setting its clinical model, the Programme Board overseeing this reconfiguration made a number of key decisions including:

- No matter which option is chosen, children will need travel to other London hospitals for the care listed below. This is because of the expertise these hospitals have in these specialist areas – these services are not going to move as part of the reconfiguration
  - Royal London Hospital (RLH), Whitechapel – eye cancer
  - Royal National Orthopaedic Hospital (RNOH), Stanmore - bone cancer
  - Great Ormond Street Hospital for Children (GOSH), Bloomsbury – care of babies aged 0 to 12 months with cancer of any type
  - King's College Hospital (KCH), Denmark Hill – liver cancer
  - St George's Hospital, Tooting and King's College Hospital, Denmark Hill – neurosurgery for cancer of the brain and central nervous system. See table below
  - University College London Hospitals' Grafton Way building (UCL), near Euston - proton beam radiotherapy at one of only two proton beam machines in England.

- **Access** - the Principal Treatment Centre must be accessible for all service users in terms of journey time and should therefore be based within Greater London.
- **Timeliness -** once a decision has been made, the new service must 'go live' within a 2.5 year implementation timeline
- **Affordability** - so long as both options remain affordable, the cost will not influence the decision. Instead, the decision will focus how to create the best possible service for children with cancer.

2. Where are we now

Where we are in the formal reconfiguration process

Programme timeline/expected milestones

Jan - April

- Evaluation of options concluded
- Planning for consultation (including preparing consultation materials and questions)
- Joint Clinical Senate panel
- **Meetings with OSCs/JOSCs**
- Engage with a number of stakeholder groups
- Drafting pre-consultation business case (PCBC) and supporting appendices
- Engage with Trusts involved

May - June

- Continue planning for consultation (including preparing consultation materials and questions)
- Commissioning of expert organisation(s) to support engagement
- Joint Clinical Senate report
- NHSE Stage 2 Assurance against the national 'Five Tests' in NHSE's 'Planning, Assuring and Delivering Service Change for Patients.'
- **Meetings with OSCs/JOSCs**
- Planning with Greater London Authority re Mayoral Tests
- Regular meetings with Trusts involved

End of June/July - September

- Conclude NHSE Stage 2 Assurance
- **Expect to launch consultation** (expected duration 12 weeks)
- Conduct mid-point review
- **As part of public consultation, consult with J/OSCs that deem the change substantial; engage with OSCs so that they can provide a response if they wish**

End September - December

- Conclude consultation, subject to mid-point review
- Consultation feedback analysed and outcome report produced and shared
- **Consultation with J/OSCs**
- Programme Board/NHS England - London consideration of feedback ahead of decision making
- Decision Making Business Case prepared
- Decision made and communicated
- Establish Implementation Board
- Begin planning to implement decision

To note:

Public Consultation currently spans the period July-end September which includes the summer holiday period. This has pros and cons in terms of the impact of engaging with key stakeholders. During July we will proactively target those groups we perceive may be challenging to reach to ensure initial contact is established and we can plan activities in before any significant periods of annual leave kick in. There will also be opportunities in September, once the summer holidays are over. A mid-point review will be conducted during which we will evaluate whether there an extension of the consultation may be required.

3. Equality and Health Inequality Impact Assessment

Equality and Health Inequality Impact Assessment: Process

Purpose of the EHIA

To support meeting legal duties including the Public Sector Equality Duty (Equality Act 2010) and the Health and Social Care Act (*to have regard to the need to reduce inequalities between persons in access to, and outcomes from healthcare services*)

What changes are we assessing the impact of?

A change in location of the current PTC and the implications of this change on patient travel arrangements including travel time, complexity of journey (including parking arrangements) and cost.

Additional considerations:

- the prospect of the service change process itself
- the prospect of a new environment and aspects of onsite accessibility
- other potential benefits

The EHIA takes a non-comparative, population-based approach.

Which population groups were considered in terms of experiencing differential impacts?

Those with a protected characteristic as specified in the Equality Act 2010, or who typically face health inequalities, including those living in deprived areas or families on low incomes (EHIA document contains full list).

For each group, using the information referenced below, plus professional and personal experience, the sub-group assessed any potential differential impacts of the proposed changes in relation to both the Public Sector Equality Duty and inequalities in access to, and outcomes from the service.

Sources of information used:

1. An equalities profile for the PTC catchment population
2. A travel time analysis report
3. Qualitative insight collected through patient engagement activities

Equality and Health Inequality Impact Assessment: overall findings

Impacts of travel time differences on health inequalities (access)
When comparing travel times to the current Principal Treatment Centre main site (The Royal Marsden) to either future PTC location, travel time analysis shows:

- there are differential positive impacts for children living in the most deprived areas and rural areas when travelling by public transport.

- there are differential negative impacts for children living outside London or in rural areas when driving.

Other impacts Several population groups (full list in EHIA) may experience a differential impact in terms of:
- complexity or cost of their journey
- uncertainty brought on by the prospect of the service change process itself
- on-site accessibility

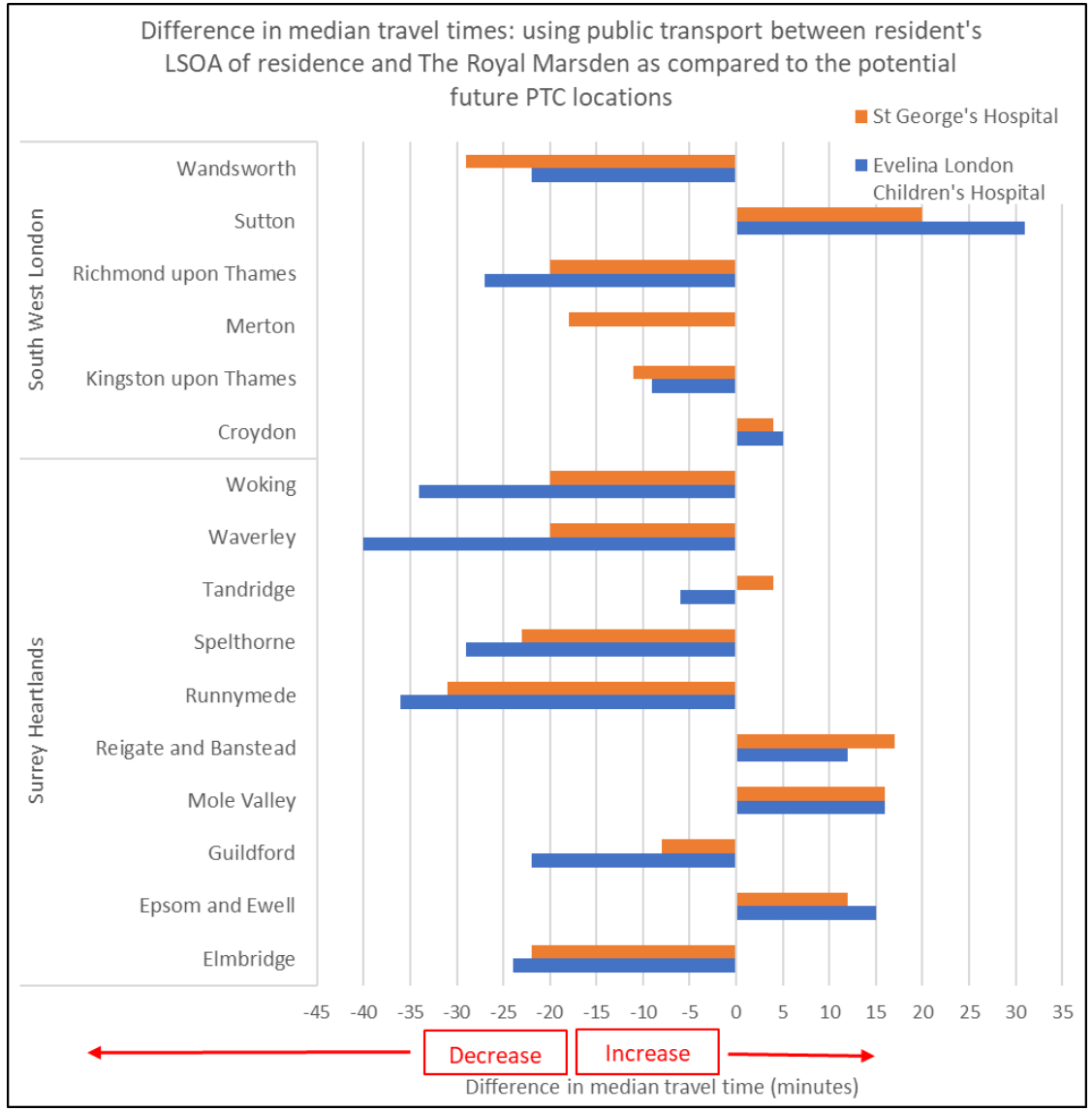
For example, patients and/or families:
- where a family member is disabled (or has a spectrum disorder)
- who are on a low income/living in more deprived areas
- with poor literacy and/or language barriers
- who experience digital exclusion

The Equalities profile document includes an estimated quantification of the size of each population group within the PTC catchment area.

Benefits for improving outcomes and reducing inequalities:
Compliance with the service specification will mean that healthcare related outcomes (in terms of patient experience and safety) are likely to be enhanced through receipt of co-ordinated, holistic care with a reduced requirement for treatment transfers at a time of crisis and the risk that certain types of transfers involve.

While this will benefit all children attending the PTC, the EHIA sub-group concluded that there may be a differential positive benefit for certain groups who may have a higher need for additional paediatric specialties (e.g. those with complex cancer care needs, co-morbidities, who are disabled or have or other conditions) or with communication difficulties (e.g. language barriers or poor literacy) where the reduced need for treatment transfers/multi-site appointments may be beneficial.

Equality and Health Inequality Impact Assessment: Public transport



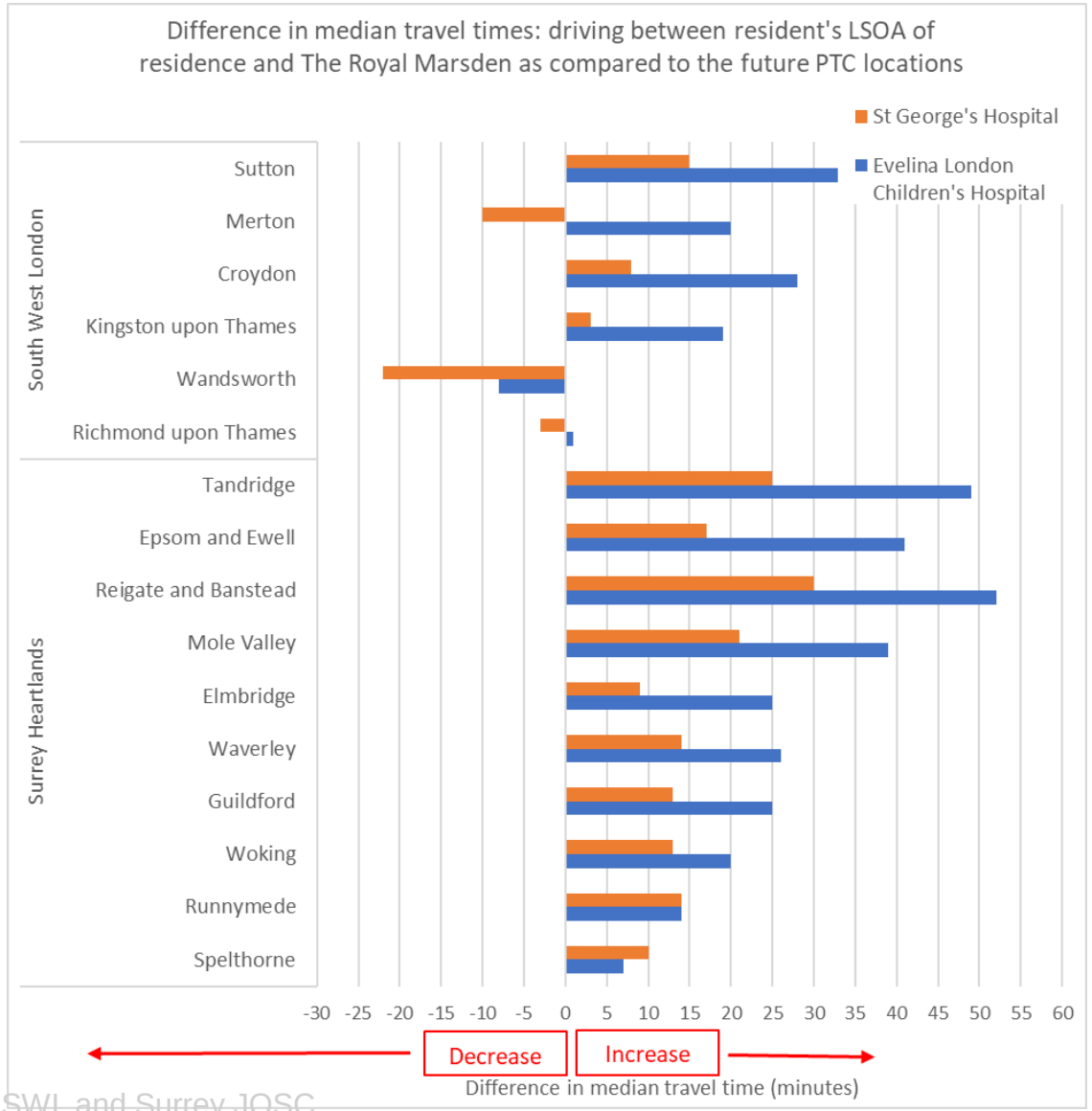
On average, the residents of most boroughs within South West London and Surrey would see a reduction in travel time to either Evelina London or St George's via public transport, compared to travelling to The Royal Marsden.

Due to their proximity to the current PTC, residents of Sutton, Reigate and Banstead, Mole Valley and Epsom and Ewell would see an increase in travel times in the region of an additional 15 to 30 minutes.

Residents of Croydon and Tandridge could also see small increases in journey time.

Please see Appendix for travel time analysis methodology

Equality and Health Inequality Impact Assessment: driving



On average, the residents of most boroughs within South West London and Surrey would see an increase in travel time for driving.

Residents of South West London would, on average, experience an increase in journey time of 18 minutes to Evelina and no change to St George's. However, this masks a difference between the boroughs where Sutton, Merton, Croydon and Kingston see increases of up to 30 minutes in driving time compared to decreases or no change for Wandsworth or Richmond.

Residents in Surrey would, on average, experience an increase in journey time of 30 minutes to Evelina and 17 minutes to St George's.

Residents of Mole Valley, Reigate and Banstead, Epsom and Ewell and Tandridge see the largest increases in journey time (20 to 45 minutes additional travel time on average), and the biggest differential between the two potential PTC locations.

The remaining boroughs in Surrey see smaller increases in travel time (12-20 minutes on average) with a negligible difference between the two potential PTC locations.

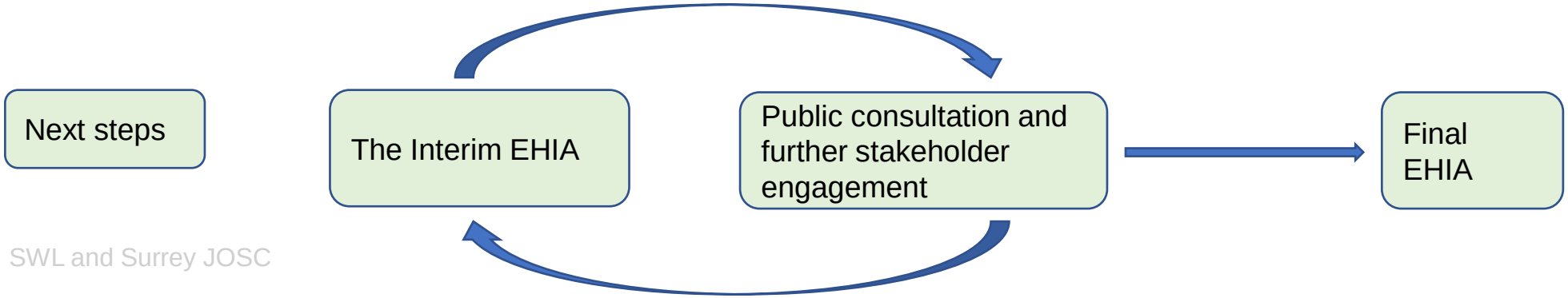
Please see Appendix for travel time analysis methodology

Equality and Health Inequality Impact Assessment: mitigation & next steps

It is important to note that the travel analysis can only capture impacts in terms of travel time. It is not possible to systematically quantify impact in terms of complexity of journey, reliability of transport services and costs. **The most important aspect of the EHIA is the recommendations for mitigation**. The EHIA sub-group has put forward a range of potential systems, processes or programmes that could serve to mitigate the adverse impacts of a longer, more complex, more costly journey.

The main themes include:

1. Systems and processes aimed at helping patients and families plan their journeys to hospital, including provision of inclusive and accessible information and translation services.
2. Systems and processes aimed at reducing the financial impact of travel, such as reimbursement schemes for travel costs (including ULEZ charges) or supporting patients to access other financial support.
3. Transport services provided directly to patients and their families (with clear eligibility criteria) and family accommodation.
4. High quality onsite accessibility arrangements, including parking and drop-off facilities.
5. Other aspects of care planning including flexibility for appointment times, shared care closer to home, strong communication systems between different health and social care teams, and remote (non face to face) appointments (that take into account aspects of digital capability)
6. An excellent implementation plan for the service change process, to support patients through the transfer period, with high quality continuity of care. Implementation plans should consider meeting NHS duties around health inequalities and take a Core20Plus5 approach.



Other impacts

Alongside the duty to reduce inequalities of outcomes, NHS England – London, have, and will continue to give due regard to:

- The wider impact of the decision made
- The need to contribute towards compliance with the UK net zero emissions target (s. 13NC NHS Act)

5. Consultation plan and document, including stakeholder engagement

Overview of engagement to date

Feedback from our engagement work can be found in the appendices.

Early engagement
(March 2020 – January 2023)

→ Fed into the development of the case for change and options appraisal process.

Pre-consultation
(March 2023 – June 2023)

→ Helping us to plan the consultation and understand what some of the key issues may be, so that we can provide information to help people respond, during consultation.

Consultation
(July 2023 – September 2023)

→ Will help us to understand the potential impact that implementing either proposal would have on children, young people, families, staff and individual organisations.

Post-consultation
Decision-making and implementation
(November 2023 onwards)

→ All engagement feedback will be considered, alongside other evidence, to support the decision-making process.

These are indicative timescales and are subject to change.

See Appendix for further information on engagement journey so far

We seek to ensure an inclusive engagement approach

- Working with **experts in the voluntary and community sector** to include a range of views.
- Commissioning specialist expert organisations to ensure we reach EIA groups and children and young people in an effective and appropriate way.
- Learning from Trust and ICB engagement colleagues to develop **relationships** with key stakeholders to be **inclusive of seldom heard**, **minority and deprived population groups**
- **Using intelligence** from the IIA **to inform engagement plans** to focus on those most affected and impacted groups
- Historic engagement (via both surveys undertaken) has reached a **range of ages, ethnicities and geographies**

Planned engagement (during pre-consultation and consultation) will focus on reaching professionals and different groups:

Current and recent service users and their families and carers	**Voluntary and community organisations** i.e. those supporting children and young people and other communities identified here, including Healthwatch	**Staff** Most intensively with those working in these services but also informing wider staff groups to understand any impacts
Health and care partners i.e. connected services and other nearby Trusts	**Children and young people from Black and other minority ethnic communities**	**Children with physical and/ or learning disabilities or autism**
Scrutiny and assurance bodies i.e. Overview and Scrutiny Committees and both Clinical Senates across south London and the south east region	**Focus on all geographic areas patients currently come from**	**Focus on all age band between 0-15 years**

Aims of consultation, engagement methodology and key questions

Following the options appraisal, two proposals have been identified. We believe both would be able to deliver an excellent future service to children. The consultation aims to inform NHS England – London on which proposal adds the greatest value in providing a future facing service for children with cancer.

The **purpose of the consultation** is to:

- engage with as many people as possible in the geography affected by this service change and hear their views on the proposals for the future location of the children's cancer PTC
- understand the impact of implementing either proposal and any mitigations or enhancements that could be put in place
- ensure NHS England - London, as decision-maker, is made aware of any information which may help to inform the options and the decision-making process.

Public consultation is not a vote or referendum, and we are asking stakeholders to consider each proposal in its own right.

Consultation questions will focus on understanding:

- Understanding of the case for change
- Views on key aspects of both proposals such as travel, access and research
- Ideas around how to mitigate or enhance impacts
- Understanding how we could make implementing the change easier for those currently in the service

Engagement methodology

- Writing to current and recent service users and their families/carers
- Online events
- Targeted sessions with the stakeholder group and other charities/VCS organisations already closely involved with us
- Community outreach to children and young people and their families with specific characteristics identified in the equalities impact assessment
- Creative activities on existing sites with children and young people currently accessing services (through working with a play therapy organisation)
- 1:1 interviews/ survey completion on existing sites with parents/carers
- Attending existing meetings in the community
- Survey (including an easy read version)
- Wide use of simple animation to raise awareness and encourage feedback
- Sharing information through existing contacts and networks including Facebook group for RM parents
- Posters with QR codes linking to online materials
- Briefings
- Offering non-digital channels: completion of surveys by post, interviews by phone, printed documents in wards/given out by Royal Marsden volunteers/in flats used by long-stay parents

Pre-consultation activities – progress so far

Activity undertaken

- **Contacted over 300 organisations across south London, Kent, Medway, Surrey and Sussex, to let them know about the project and to encourage feedback, including:**
  - Specialist CYP cancer charities/groups (including parent-led organisations)
  - Youth Forums/Councils/ Parliaments
  - Healthwatch organisations
  - Maternity Voice Partnerships
  - Mental health umbrella organisations
  - Black and minority ethnic forums/ groups
  - Pan-geography organisations supporting; refugees or asylum seekers, addiction and/or substance misuse issues, people involved in the criminal justice system, people experiencing homelessness and gypsies or travellers)
  - Learning disability and autism groups
  - Groups supporting people with physical impairments
  - Carers (young and adult)
  - Community groups in the most deprived areas within the catchment
- **Attended the RMH teenage and young adult forum**
- **Session with POSCU staff**
- **Session with POSCU patient representatives**
- **Working with engagement leads from all three Trusts to reach their patient groups, forums and volunteers**

Upcoming activities

- **Visit to wards to directly engage with CYP and families**
- **Further work with Children with Cancer UK and Young Lives VS Cancer to reach a broader range of families**
- **Session with Overview and Scrutiny Committees to discuss the consultation plan and document**
- **Sessions for staff from all Trusts**
- **Follow up communications to all groups we originally contacted**

Stakeholder feedback is influencing our consultation plans and documents

How we engage

- Having a number of different ways to feedback will be important
- Attention span (as a result of treatment) can be an issue therefore keeping things concise is essential
- Being conscious of the pros and cons of engaging over the summer holidays

Opportunities include

- Possibly having access to newer equipment
- Increase in access to leisure activities

What information we need to provide during consultation

- How to travel to the service safely (i.e. if having to travel on public transport how they can be safe)
- Where to park
- Could there be videos of each environment to physically see what it's like there?
- All communications need to be jargon free with clear explanation and information. This is particularly important for specific groups such as Gypsy, Roma and Traveller families and asylum seeking families who need materials in their own languages
- Reassurance around how any move would be managed so that the impact on treatment is minimised
- How travel costs will be reimbursed and who is eligible
- How research will be impacted/ continue once a decision is made
- How any additional funding will be used to support either proposal

Consultation document

Consultation document: proposed content

- How people can get involved (including hard copy questionnaire)
- What the consultation is about
- Why a change is needed and benefits
- What matters to children, families and staff and how this has shaped the plans
- Information on both proposals (including travel and access implications)
- High level information about options appraisal process and outcome
- How the proposals could affect different communities in south London, Kent, Medway, most of Surrey, East Sussex, Brighton and Hove
- Next steps and making a decision
- What services won't change

Appendices/ other supporting documents

- Factsheets on development, summary and evaluation of the proposals, transition to teenage and young adult service, assurance process, research at each Trust, getting to the two potential sites
- Initial Equalities Health Impact Assessment (EHIA)
- Early engagement feedback report
- Feedback from the Clinical Senate and programme actions.

We are testing and refining this document with key stakeholders to ensure it is fit for purpose

We welcome your feedback

Annex 1

Annex 1: Supporting slides

- Case for Change - references
- Options development and evaluation
- Engagement journey so far
- Travel time analysis - methodology

Case for change – references used in presentation

Transferring critically unwell patients is associated with a risk of physiological deterioration and adverse events[1] and the emotional and psychological stress for parents should not be underestimated[2]. Although specialist transport services have been shown to enhance safety and quality[3], the 2008 "Safe and Sustainable" framework, produced by clinicians and endorsed by the relevant Medical Royal Colleges, states that paediatric oncology and paediatric intensive care have "absolute dependency, requiring co-location". It is this clinical advice, backed up by subsequent expert reviews[4] that underpins the national service specification requirement.

References:

1. Brough, J.M., Smit, M., Absalom, A.R. *et al.* Transferring the critically ill patient: are we there yet?. *Crit Care* **19**, 62 (2015). https://doi.org/10.1186/s13054-015-0749-4
2. Harvey, Edmunds, Ghose. Transporting critically ill children. Anaesthesia & Intensive Care Medicine Volume 21, Issue 12, December 2020, Pages 641-648
3. Gilpin Hancock. Referral and transfer of the critically ill child. BJA Education, 16 (8): 253–257 (2016)
4. NHS England board-meeting-item-9-update-on-specialised-services-c-appendix-2.pdf (england.nhs.uk)

Options development and Evaluation

Longlist to shortlist

In line with NHS formal reconfiguration guidance, a short list of options for the relocated Principal Treatment Centre was developed from a long list of all potential options by applying fixed points (things that cannot be changed) and hurdle criteria (to establish viability).

Following this stage, two options remained: the Trusts running St George's and Evelina London Children's hospitals. Both were asked to complete a formal proposal document outlining how they would deliver the service using set criteria.

Evaluation Criteria

Evaluation criteria were developed with input from a range of stakeholders over 2020/2022, these reflect requirements of the service specification incorporating research, patient and carer experience, capacity and resilience. They also reflected our ambition for the PTC.

This resulted in **four domains for evaluation**: **clinical, research, enabling requirements, and patient and carer experience**. Measurable sub-criteria were developed for each domain, drawing on expertise from clinicians, parents, and managers from in London and outside London.

Weighting the evaluation criteria

Four expert panels comprised of **patient and carer representatives, charities, researchers** from outside London, **clinicians (medical and nursing)** from in and outside London, **managers**, and **experts in specific fields** (e.g. emergency preparedness, human resources) - over 30 people - were established to weight and score the criteria within each domain.

In September 2022, the Programme Board finalised the high-level weighting given to each of the domains. Between October and November 2022, the identified panels for each domain undertook a virtual, two-stage exercise to establish the sub-weights for the criteria within their domain.

Scoring the proposals

In November 2022 both Trusts submitted their proposals, aligned with the domains and sub-criteria. During December 2022, the topic-specific expert panels scored the submissions against each of the sub-criteria for their specific domain. Sensitivity analysis was also performed.

Final scores were calculated for each option using the pre-agreed weighting.

Engagement journey so far

Since 2020, we have been working with children, young people, parents/carers and professionals to help shape our work. A Stakeholder Group involving parents, carers, charities and wider voluntary organisations, and a Clinical Advisory Group have been key to testing and refining our plans.

Activity

- **Fourteen meetings** with the Stakeholder Group.
- Over **60 contacts** with parents/carers /caregivers - a combination of meetings, individual conversations with parents.
- **208** survey and interview responses to an externally commissioned survey.
- **50** survey responses from the Stakeholder Group and current inpatients.
- **Supported a panel of parents to participate in the options appraisal process** helping up to develop and score aspects of the patient experience domain.
- **Supported self-nominated parents** to feedback on the IIA and consultation plan and document.
- **Four meetings** of the children and young people's sub-group with charities and Trust representatives.
- **A Clinical Advisory Group (CAG)** of clinicians from St George's, Evelina London, King's and The Royal Marsden considered and commented on the fixed points, hurdle and evaluation criteria.
- A group of senior managers from the same four Trusts **considered the impacts of the change on staff and the capacity and activity** needed to deliver it.
- **A joint workshop** was held with staff from The Royal Marsden, St George's and Evelina London. This led to more in-depth work with Royal Marsden staff.
- A senior professor and nurse director (independent advisers to the programme) **spoke with nurses and medics from the various services** to gain informal feedback.
- The independent chair of the CAG **spoke with senior researchers from each of the three Trusts** to gather their views on the key considerations for research.

Feeding into and influencing

Case for change and options development	Understanding current experiences of services and what is most important about the current service.
Options appraisal process, including criteria development	Feedback around the sub-criteria scoring for the clinical, patient experience, enabling and research domains changed what was included.
Integrated Impact Assessment (IIA)	Feedback on the document and mitigations as well as challenges around transport and access that need to be considered.
Engagement plans	Supported; the development of FAQs, consultation plan , consultation document, early and pre-consultation questions.

KLOE 1, 4

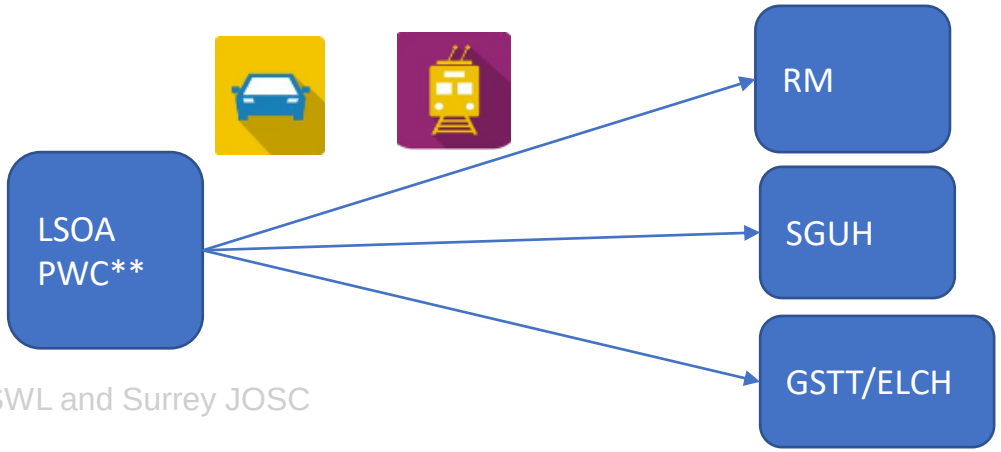
Travel time analysis: methodology

Travel time modelling software was used to generate public transport and car journey travel times for all children (aged 15 and under) living in the PTC catchment to each of the three provider locations, from their "origin" (based on their Lower Super Output Area* (LSOA) of residence). There are 4,000 LSOAs within the PTC catchment area.

Travel times are for the fastest trip departing from resident origin for arrival at midday on a Wednesday. Metrics used in the analysis are median and longest travel times (minutes) and the proportion of the population within a 60 minute journey time of each provider, by public transport and driving.

The modelling uses both road networks and timetabled transport networks. The potential combination of travel modes for each journey by public transport are national rail, tram, light rail, tube, bus, coach, ferry, and walking to and from stops and interchange, and walking alone if quicker. A public transport journey was only measured if a station or stop was reachable within an initial 20 minute walking time (only 0.2% of LSOAs did not meet this criteria).

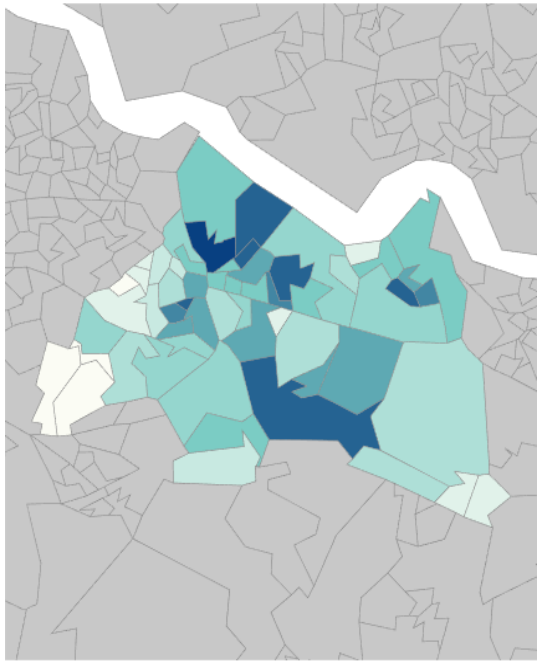
The travel measures are intended to provide a typical indication of the quickest journey from origin to destination for people travelling with no additional requirements. Individual experiences may not completely align with the estimated times.



*** Note: Lower Super Output Areas (LSOAs)** are a small area geography averaging approximately 1,500 people. Each LSOA has a PWC (population weighted centroid) which represents the centre of the distribution of residents across the LSOA.

Population estimates are available at LSOA level and each LSOA is assigned an Index of Multiple Deprivation (IMD) score and an urban/rural classification. This allows for travel time analysis by these classifications. More information on the IMD is in Appendix B

Illustration of Lower Super Output Areas (Dartford)



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Committee: Health and Wellbeing Board

Date:

Agenda item: Better Care Fund Plan (BCF) for 23-25

Wards: Merton

Subject:

Lead officer: Mark Creelman/John Morgan

Lead member: Councillor Peter McCabe

Forward Plan reference number:

Contact officer: Annette Bunka- Assistant Head of Transformation -Integrated Care (Merton)- SWL ICS/ Phil Howell - Interim Assistant Director of Commissioning- Adult Social Care, Integrated Care and Public Health-LBM

Recommendations:

A. ***To approve the submission of the attached Better Care Fund Plan for 23-25, that includes a narrative and a Better Care Fund 2023-25 Planning Template to NHS England by the deadline of 28th June 2023.***

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. Owned by the Health and Wellbeing Board (HWB), the Better Care Fund is a joint plan for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006). There is an annual requirement to submit a Better Care Fund Plan, this year a two year plan has been requested. The Plan is made up of a narrative document along with a planning template that details schemes and services to be funded; financial allocations against each scheme / service; and planned performance against a number of key performance indicators. The submission this year as in last year also requires completion of a demand and capacity template for intermediate care, included in the pack. A slide deck summarising the key elements of the returns is included in the papers.

2 BACKGROUND

2.1. Introduced in 2015, the Better Care Fund Programme is one of the government's national vehicles for driving health and social care integration. It established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:

- minimum allocation from NHS
- disabled facilities grant – local authority grant
- social care funding (improved BCF) – local authority grant
- Adult Social Care Discharge Fund (introduced in November 2022, with an allocation for both local authority and ICB)

3 DETAILS

3.1. Please refer to the presentation slides for an overview and the detailed BCF reports.

4 ALTERNATIVE OPTIONS

4.1. Not applicable as an NHSE requirement

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. The BCF aligns with the Merton Health and Care Together Programme and engagement has taken place regarding this. Details are included in the narrative report. Where any significant changes are under consideration, an engagement process would be included as part of this. Discussion has started across Merton and Wandsworth regarding the use of care home beds for bedded rehabilitation, which are funded from the BCF. Further work will take place and a separate process is being set up for this which is outside of the scope of these papers.

6 TIMETABLE

2023-2025

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. The core Better Care Fund allocation (the minimum NHS contribution) has been uplifted by 5.66%. This uplift has been used to cover increases in staffing costs and other initiatives detailed in the slide pack and template. Whilst this is a 2 year plan, the financial figures included for 24/25 are a proxy and will be updated once budgets have been confirmed.

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. The Better Care Fund is underpinned by an agreement made pursuant to section 75 of the NHS Act (2006). The agreement for 2022/23 is in the process of being sealed, and the agreement for 2023/25 is in progress.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The work being undertaken through the Better Care Fund to reduce health inequalities is described within the narrative, in particular from page 20 onwards and also summarised in the slide pack.

10 CRIME AND DISORDER IMPLICATIONS

10.1. Not applicable

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. Were the plan not to be submitted, or the submitted plan not to be agreed by the DHSC there is a risk that allocated funding for the core (NHS minimum contribution) element could be clawed back. This risk is deemed to be extremely low in terms of likelihood.

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

Appendix A: Summary Slide Deck

Appendix B: Better Care Fund Narrative

Appendix C: Better Care Fund 2023/25 Planning Template

13 BACKGROUND PAPERS

13.1. 2023 to 2025 Better Care Fund policy framework - GOV.UK (www.gov.uk)

Merton
South West London Integrated Care System

Merton Better Care Fund

Plan for 23-25
Merton Health and Wellbeing Board
27.06.23
Phil Howell and Annette Bunka

What is the Better Care Fund?

- National policy framework
- Local single pooled budget to incentivise the NHS and local government to work more closely
- Placing well-being as the focus of health and care services
- A mechanism for joint health, housing and social care planning and commissioning
- Brings together ring-fenced budgets from Integrated Care Boards (ICBs) and local government including some specific funding

BCF Funding 23/25

BCF funding contributions	2022/23 (£)	2023/24 (£)	2024/25(£) *Proxy
Minimum NHS contribution	15,057,573	15,909,832	16,810,328
Improved Better Care Fund (iBCF)	5,009,679	5,009,679	5,009,679
Disabled Facilities Grant (DFG)	1,452,224	1,452,224	1,452,224
Total	**21,519,476**	**22,371,735**	**23,272,231**
Adult Social Care Disharge Fund			
Merton LA	623,258	702,349	1,165,900
SWLICB -Merton Place	850,780	850,780	1,412,295
Overall Total	**22,993,514**	**23,924,864**	**25,850,426**

BCF – National Objectives and Conditions

Merton South West London Integrated Care System

The **national objectives for the BCF** remain the same as 2022-23 and are to:

- i. Enable people to stay well, safe and independent at home for longer.
- ii. Provide the right care in the right place at the right time.

National conditions (that all plans must meet- these have been updated for 23-25)

- A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
- Plans to set out how the services the area commissions will support people to remain independent for longer and, where possible, support them to remain in their own home.
- Plans to set out how services the area commissions will support people to receive the right care in the right place at the right time.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution to the BCF.

Metrics for 23-24

Metric 23/24	Proposed Ambition
Reduction in Ambulatory Care Sensitive Conditions Admitted to Hospital	Modest reduction from 22/23 actuals, to reflect increase in the use of virtual ward from community referrals and increased use of Rapid Repsonse.
Reduction in Falls admissions (New)	Modest reduction to reflect an increase in initiatives particularly in care homes but also in developing a closer working relationship with falls prevention partners.
Discharge to usual place of residence	In line with 22/23 actuals, as hospital pressures continue.
Residential Admissions -Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	The estimated rates for 22/23 indicate this target would not met, so a modest decrease compared to estimated outturn has been put forward for 23/24, as more complex and frailer patients are being discharged.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Increase in this percentage proposed to reflect an improving trend.

Also included in the submission is a detailed demand and capacity analysis for intermediate care, the completion (not content) is a requirement of the submission.

BCF – Local Plans and Priorities

Merton South West London Integrated Care System

The key priorities for integration within 2023/25 BCF Plan mirror the Merton Health and Care Together Programme and build on previous BCF Plans:

- Continued development of **proactive care**, multi-agency working across health and social care to support the vulnerable in their own homes – **Integrated Locality Teams**, closer working with voluntary sector to build capacity and provide support for unpaid carers
- Improved flow from hospital to the community and **integrated intermediate care** (building on home first, virtual wards, recruitment drives in reablement and to support social care maintenance.)
- **Rapid response services** and **enhanced support to care homes**
- Work to **reduce inequalities** (including Community Response Hub, Living Well Services run by Age UK)
- **Disabled Facilities Grant** to support these initiatives.

As part of this plan, linking to the reprovision of community services, there is a chance to look at opportunities for more joint working and closer integration, with a focus on the services that have the greatest impact.

Appendix 1 provides further details of where the funding is spent.

Use of BCF Uplift

Merton South West London Integrated Care System

One of the BCF conditions is that the NHS need to maintain the uplift to Social Care of 5.66% for 23/24 and 24/25.

Alongside cost of living uplifts for some of the existing schemes, the proposals for areas for investment which will be developed further during 23/24 are:

Proposals	2023/24	2024/25* proxy funding
Increase in community equipment budget to meet demand	£110,000	£173,360
Dementia support for hospital admission avoidance, through developing the befriending, respite etc offer.	£37,614	£80,000
Carers services and prevention	£20,000	£50,000
Data reporting and information analysis - It is evident there is a lot more data processing, return completion etc for BCF and ASC discharge fund and this requires capacity.	£40,000	£50,000
Integration transformation support	£30,000	£70,000

ASC –Discharge Fund

Merton South West London Integrated Care System

The funding is focused on achieving the maximum reduction in delayed discharges, with a focus on *a 'home first' approach and discharge to assess (D2A),* with the proposals for investment below. These will be subject to development/review in 23/24.

Schemes	23/24	24/25*Proxy funding
Rapid response/quick start reablement	£218,000	£361,880
Additional social work staffing to support discharge and to in reach into the Transfer of Care (TOC) team	£476,000	£790,160
Carer liaison in hospital to support discharges	£167,000	£277,220
Age UK help at home service	£177,000	£293,820
Handy person & Telecare	£141,000	£173,982
Dementia and nursing beds and 1:1 support in care homes	£310,321	£515,133
Additional community equipment	£100,000	£166,000
Total	**£1,589,321**	**£2,578,195**

Section 75 Agreement

Merton South West London Integrated Care System

- Agreement between local authorities and NHS bodies and can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner/s.
- Pooled budgets combine funds from Local Authority and Integrated Care Board (ICBs) to enable them to fund integrated services.
- Since the introduction of the Better Care Fund in 2015, NHS and local authorities have been required to operate a pooled budget via a section 75 agreement
- Agreements will cover the following areas:-
    - Duration
    - Risk Share
    - Dispute Resolution
    - Governance

Appendix A

Integrated Locality Teams and Proactive Care

Merton South West London Integrated Care System

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)
- 6 health liaison social workers
- Voluntary sector services, including Dementia Hub, Carers Support, falls and other prevention initiatives
- Telecare through MASCOT
- Living Well Service run by Age UK to improve physical and mental wellbeing
- Community Response Hub which initially started in response to the COVID 19 pandemic, but identified an ongoing need for independent advice and support
- New in 23/24- Further support for Dementia and Carers

Improving Flow from Hospital to Community, Integrated Intermediate Care & Rapid Response

Merton South West London Integrated Care System

Single Point of Access (SPA) in place for Discharge to Assess and for Intermediate Care to support people home from hospital sooner. Daily discharge discussions and escalation meetings to support patients to be as independent as possible.

The BCF contributes to:

- Reablement services (with increases in provision to support evenings, weekends and admission avoidance)
- Home and bed based rehabilitation
- Integrated domiciliary packages of care, including temporary funding for 12/24 hr care if needed
- Rapid Response (which has recently expanded through funding from Ageing Well monies) offering rapid two hour response to prevent admission to hospital and work to provide a single seamless service if social care required
- In reach nurses at St George's to help with admission avoidance and complex discharges
- Community Equipment (ICES)
- 7 day working

Work to Reduce Inequalities

Merton South West London Integrated Care System

- Community Response Hub providing independent advice and support.
- Living Well Service run by Age UK to improve physical and mental wellbeing
- Funding the voluntary sector to reduce factors that increase the likelihood of presentation to health or social care, including an enhanced lunch club offer, improving heating and insulation, supporting access to benefits and helping with small grants for energy, food and clothing.
- Reducing isolation especially amongst older men through our music workshops- Tuned In (A single was produced called Uptown Lockdown)
- Contribution to Social Prescribing, which has a particular focus on those areas and individuals where there is social complexity.
- Falls and other prevention initiatives including 'Merton Moves' and 'Get up and Go' Project which is a programme of physical activity available to residents and patients in East Merton and Morden PCN areas to address mild frailty, with a focus on strength and balance activities.

Through the Disabled Facilities Grant (DFG):

- 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 and Emergency Adaptations
- Dementia Friendly Aids and Adaptations Grant
- Helping Hand Service for Low Level Hazards
- Help with Energy Efficiency

Better Care Fund 2023 - 2025

Narrative Plan

London Borough of Merton

Version control	
No	5
Date	15 June 2023

Introduction

This narrative plan summarises the work taking place across multiple agencies to support the residents of Merton to stay well, safe and independent at home for longer and receive the right care, in the right place, at the right time.

This document should be reviewed alongside the completed Better Care Fund (BCF) Planning Template, which is an excel spreadsheet that includes the financial breakdown of the BCF along with the performance plans relating to key metrics and how the area will meet the key planning requirements detailed in the BCF Policy Framework and the BCF Planning Requirements for 2023/25. The submission also includes as it did last year, a demand and capacity template for intermediate care which although is not part of the assurance process for BCF, its completion is part of the requirements.

Organisations Involved in Drawing Up the Plan

This plan has been jointly developed between South West London Integrated Care Board – Merton place and London Borough of Merton (LBM) and supported by Merton Health and Care Together Committee Meeting, the Merton place committee. It aligns with Merton's Health and Care Plan and the work of the Merton Health and Care Together Partnership. This involves a wide range of partners including St George's University Hospital NHS Foundation Trust, South West London and St George's Mental Health NHS Trust, Central London Community Healthcare NHS Trust, Healthwatch Merton, Epsom and St Helier University Hospitals NHS Trust, Merton Health- the GP Federation, Merton Connected – Merton's Voluntary Sector Committee and representation from Primary Care Networks.

The Better Care Fund Plan is built on the refresh of Merton's Health and Care Plan and the draft South West London Joint Forward Plan, both of which have been developed with significant community engagement, with workshops held virtually during August/September 2021 with over 100 attendees from local health, care, voluntary and community sector groups and patient and public representation as well as feeding in the results from surveys, engagement themes and follow-on conversations from a wide variety of resources. More recent engagement has taken place in the development of the Joint Forward Plan to supplement this.

In Merton, the Departments have recently changed from Community and Housing overseeing social services and housing to Adult Social Care, Integrated Care and Public Health. This reflects the importance of integration and prevention within Merton's goals, whilst still making use of the historical alignment with housing, and the work of the Disabled Facilities Grant (DFG) in both the development of plans e.g. the use of the DFG and in every day working e.g. in supporting discharges.

LBM is a non-stock owning authority and works with a range of social and private landlords to meet housing needs.

How Have Stakeholders Been Involved?

Health and care organisations in Merton have been working together closely for many years and there is a huge amount of partnership work underway across a broad range of partners and colleagues including public health, the voluntary sector, Healthwatch, mental health providers, primary care networks, community and secondary care providers, local communities and many others. These organization come together to form 'Merton Health and Care Together'. The pandemic brought us even closer together and accelerated system learning and now as a team to lead Merton in the South West London Integrated Care System (ICS).

Through the Merton Health and Care Together, providers and commissioners in Merton work together to identify and lead transformational change across the system to improve health and social care outcomes for the people of Merton.

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. Our Joint Strategic Needs Assessment (JSNA) (and particular health inequality data) was the starting point for this refresh.

A series of workshops took place over August and September reviewing this work and two workshops in particular focused on the age well programme. This work builds on all the engagement done to develop the original plan, and gave key stakeholders, communities and groups across Merton a chance to discuss collectively what they feel key actions are going forward.

The BCF is a key enabler of this work and the priorities in this submission reflect the work and agreed priorities within Merton's Health and Care Plan, which works alongside the emerging South West London Joint Forward Plan, local Emergency Care Delivery Boards, Transformation Boards and the programmes of work underneath these to support the delivery of the aims and objectives of the Better Care Fund.

Governance

The overarching plan for Merton is our Health and Care Plan, with the BCF a key enabler of this, so the initiatives and services funded through the BCF reflect the priorities agreed within the Health and Care Plan. The engagement surrounding this has been highlighted in section 1 of this plan and this is alongside the multi-agency work that takes place through local Emergency Care Delivery Boards, Transformation Boards and the programmes of work underneath this to support the delivery of the aims and objectives of the Better Care Fund.

Discussions have taken place across the relevant agencies in order to draw up these plans and presented at specific meetings including at the Officers Meeting of the SWL Integrated Care Board (Merton and Wandsworth place), the Management Team at the London Borough of Merton and Merton and Wandsworth Hospital & Community Transformation Programme Board. The governance approval process is for the plan to be presented and supported at Merton Health and Care Together Committee, Merton's place based committee and final sign off at The Health and Wellbeing Board on Tuesday 28th June 2023.

Merton Health and Care Together Committee comprises a wide range of partners including SWL ICB, London Borough of Merton, St George's University Hospital NHS Foundation Trust, South West London and St George's Mental Health NHS Trust, Central London Community Healthcare NHS Trust, Healthwatch Merton, Epsom and St Helier University Hospitals NHS Trust, Merton Health- the GP Federation, Merton Connected – Merton's Voluntary Sector Committee and representation from Primary Care Networks. The governance for the ICB is currently being reviewed, currently the meetings where the BCF Plan has been discussed and detailed above, all report into the Place Based Committee.

In addition to the governance described above to align the BCF with local priorities, the BCF Plans are monitored and reviewed at the BCF and Section 75 Review Meetings, where the CCG and London Borough of Merton are key representatives. This is also where there is oversight of the incorporation of the BCF into the Section 75 agreement.

In Merton, the Departments have recently changed from Community and Housing overseeing social services and housing to Adult Social Care, Integrated Care and Public Health. This reflects the importance of integration and prevention within Merton's goals, whilst still making use of the historical alignment with housing, and the work of the Disabled Facilities Grant (DFG) in both the development of plans e.g. the use of the DFG and in every day working e.g. in supporting discharges.

In developing and implementing the plans for 2023-25, Merton Health and Care Partnership and the Hospital and Community Transformation Board are increasingly important developing the BCF plan and ensuring these plans are implemented and ensuring the involvement of key stakeholders from across all local organisations.

Executive Summary

A number of the challenges during the pandemic have continued, whilst alongside this, the work to address a backlog of activity brought about as a result of the pandemic. This has resulted in a system under pressure and a number of workforce challenges, particularly the ability to recruit and retain staff.

In Merton we work very much on the needs of our local population. Being without an acute trust in our borough, we work closely with other areas across SW London, particularly Wandsworth where there are benefits of working at scale.

There are ongoing challenges to maintain flow, with Trusts reporting more complex and frailer patients being admitted and reduced staffing capacity across the system due to sickness absence and staff vacancies. In spite of this, we have maintained a high performing discharge model and work is taking place to improve proactive discharge planning across Merton. Improvements have already been made with the Transfer of Care (TOC) team at St Georges. This has included further recruitment which has resulted in an improvement in the discharge processes and a reduction to some of the delays in the system. We continue to work with system partners to create more joined up services.

A successful Hospital at Home/Virtual ward pilot programme has been established across Merton and Wandsworth to support the local system pressures and optimise the capacity in hospital and community services, providing care for our patients in the most optimal setting. We view this as a key strategic initiative which will underpin our wider community services transformation programme across Merton and Wandsworth. Therefore, in line with local and national direction we expanded the pilot programme increasing service to take up to 80 beds and accepting referrals from both hospital and the community. By March 2023 the service had seen 493 patients across the service, providing a seven-day service delivered by a multidisciplinary team which includes Consultant GPs, ANPs, Nurses, and Pharmacists. Early evaluations of the service indicate that there have been approximately 3000 bed days saved based on comparison data around average length of stay in the local hospital. In January 2023, the central remote monitoring service started which looks at optimising patients through the use of a technology enabled service.

We continue to review and develop our local service model alongside those in other areas of South West London, and are developing innovation pilots to look at how the service can interface with our acute trust as well as the remote monitoring hub.

The Health and Care Plan sets out how Merton is working together to reduce inequalities and provide truly joined up health and care services with and for all people in Merton, so they start, live and age well in a healthy place.

Through our Ageing Well Programme we continue to work to develop integrated services that provide proactive and preventative care, provide urgent response and intermediate services when required to support admission avoidance and support more effective discharges as well as support the delivery of high quality services for those with frailty, dementia and end of life, striving to keep people independent either in their own home or within a care setting.

To enable more people to maintain their independence for longer, in addition to supporting Home First models, we aim to improve the health and wellbeing of Merton residents through enhanced access to community and voluntary sector services and greater sharing of assets and expertise as well as reduce health inequalities e.g. through the Implementing South West Merton PCN “Tackling Neighbourhood Health Inequalities” project working with Wimbledon Guild and use of population health management to reduce social isolation and improve access to services supporting those with frailty.

Work has started on a redesign of the intermediate care services which should enable a more integrated and cost- effective model. Analysis from our existing services show that more patients could be given rehabilitation and support in their own homes rather than in bed-based rehabilitation facilities. Pilots have started in Wandsworth with St George’s enhancing the therapy offer at our hospital based rehabilitation beds in order to enable people to return home sooner which we hope to learn from in Merton.

A review of community services is also being undertaken in Merton, with a particular focus on the current provision delivered through our community contract with Central London Community Healthcare NHS Trust that is jointly commissioned by the ICB and London Borough of Merton. This will run alongside the discussions regarding the Better Care Fund development for 24/25 but are unlikely to be fully enacted until 25/26.

The funding allocation continues to support social care maintenance, NHS commissioned out of hospital services, managing transfers of care and support actions/services that promote timely patient flow through hospital and back into community settings as well as support for unpaid carers and working closely with the voluntary sector to build capacity in the community.

Merton is addressing health inequalities in a range of ways including use of population health management to enable a focus, both at place and at PCN level and a series of workshops focusing on use of this approach to support those with frailty have taken place, where we are reviewing how we can best make use of population management techniques to provide support to those who most need it, but who may not easily access care.

We continue to support unpaid carers in Merton, and as well as the ongoing implementation of the Carers Strategy, we have two further schemes being

developed in 23/24 to provide advice and support for carers and those with dementia, including expansion of befriending and respite support.

The DFG funding and the BCF overall to support the reduction of inequalities, developing pilots through use of Population Health Management and through Innovation and Inequalities Funding.

Further details are contained in the document below.

Workforce challenges have been present for some time and have been exacerbated by Brexit and the pandemic, so we continue to try and find innovative ways to recruit and to retain and value our existing workforce, including extensive recruitment programmes oversees and training modules to ‘grow our own’ workforce.

National Condition 1: Overall Approach to Integration

After talking to our community in Merton, we have collectively refreshed our vision to: 'Working together to reduce inequalities and provide truly joined up health and care services with and for all people in Merton, so they start, live and age well in a healthy place'

The age well priorities within Merton's Health and Care Plan focus on frailty, on supporting older people to access community resources as well as improving access to and information on integrated services.

As part of the South West London Joint Forward Plan, the focus is to:

- Prevent ill health and support people to self-care
- Reduce health inequalities
- Keep people well and out of hospital
- Provide the best care wherever patients are accessing our services
- Use technology to improve care
- Manage our money
- Make South West London a great place to work
- Deliver the NHS' requirements of the Integrated Care Partnership Strategy.

Across South West London, it has been agreed that a review of each of the BCFs be undertaken. This process has started and will be an opportunity to look at closer integration and further areas for joint working, with a focus on services that have the greatest impact. This will feed into broader discussions regarding integration across services within the ICS.

A review of community services is also being undertaken in Merton, with a particular focus on the current provision delivered through our community contract with Central London Community Healthcare NHS Trust that is jointly commissioned by the ICB and London Borough of Merton.

Leaders across health and social care in Merton hold a shared vision of a more locally focused, person-centred model of care rooted in prevention, health improvement, self-care and earlier interventions for the residents of Merton, so the reprovision of community services is an opportunity for Merton to address this and enable further integration across physical and mental health and social care. It presents the opportunity, through collaboration, to address long standing inequalities and incorporate the wider determinants of health and wellbeing as well as an opportunity to engage the wider community; creating the conditions for voluntary sector and other partners to play key role in health and social care delivery fully utilising Merton's community assets, developing and delivering a model that reflects the key priorities of community care both nationally and locally.

Through our Ageing Well Programme we continue to work to develop integrated services that provide proactive and preventative care, provide urgent response and

intermediate services when required to support admission avoidance and support more effective discharges as well as support the delivery of high quality services for those with frailty, dementia and end of life, striving to keep people independent either in their own home or within a care setting.

Key areas include proactive care and preventative services, Integrated Locality Teams, providing proactive care for those at highest risk by providing personalised care and support in people's own homes, priorities for this include building on online resources so there is a greater understanding of the work of the teams and to expand the support as part of the anticipatory care work to other potentially lower risk cohorts. BCF funding includes:

- A wide range of services from Central London Community Health, our community provider, including those who make up the locality-based community teams (e.g. district nurses, case managers, care navigators, dementia specialist nurses, end of life care nursing);
- Health Liaison Social Workers aligned to PCNs;
- Age UK living well co-ordinators and Alzheimer's Society co-ordinators linked to PCNs as well as other voluntary sector services to support independence;
- Telecare through MASCOT
- Continued support for the most vulnerable through the Community Response Hub
- Improved response to crises and more effective reablement- working with the expanded rapid response service to respond to crises and work more closely across health and social care offers, including use of 24-hour care for short periods if required (linking to virtual wards as appropriate).
- Increasing the capacity within social work and significant recruitment to the reablement team which includes support for admission prevention.
- Integrated working across agencies to support improved quality of care and reduce unnecessary admissions to hospital by offering enhanced support to care homes including a care home support team.

Alongside the broader development of community services, we will be building on our Integrated Locality Teams to develop Neighbourhood Teams in line with the Fuller Report, increase use of the Universal Care Plan (UCPs) as a key tool to support cross agency information sharing and through Population Health Management, target particular interventions of those of greatest need. Discussions have started and Merton feels it is in a good place with the relationships and teams already established. We have been piloting innovative ways to enhance our Integrated Locality Teams through PCN led initiatives. These include PCN led MDTs as opposed to practice-based MDTs which are the current model. These will be reviewed to enable learning to be spread across the borough. More work is being undertaken to increase the development and use of UCPs to support people's wishes and share appropriate information to support them to receive the right care.

Improving discharges with improved joint pathways with integrated teams enabling faster discharges from hospital with the full implementation of discharge to assess and the focus on increased access to reablement alongside domiciliary packages of care where required.

Single Point of Access (SPA) in place for Discharge to Assess and for Intermediate Care to support people home from hospital sooner. Daily discharge discussions and escalation meetings to support patients to be as independent as possible.

The aim is to continue to build on this in 23/25 and maintain the flow within the challenges of increased pressures and workforce challenges.

The BCF contributes to:

- Funding Intermediate Care, both home and bed-based provision, working on home first models through increases in rehabilitation and reablement (linked to discharge to assess) to enable faster discharges from hospital
- Increased capacity over 7 days
- Integrated domiciliary packages of care, including temporary funding for 12/24 hr care if needed
- Meeting the increases in demand for community equipment
- Daily discharge discussions and escalation meetings to support patients to be as independent as possible with in reach nurses to support complex discharges.

Work has started on a redesign of the intermediate care services which should enable a more integrated and cost- effective model. Pilots have started in Wandsworth which we hope to learn from in Merton.

The subsequent sections describe in more detail the specific workstreams in place to provide proactive and preventative care, enabling more people to stay well, safe and independent at home for longer and where support is needed, receive the right care, in the right place, at the right time, whether they are in their own home or a care home. It also includes the work developing population health management to support the reduction of health inequalities and how the BCF is used to fund these areas.

Implementing the BCF Policy Objectives

National Condition 2: Enabling people to stay well, safe and independent at home for longer

The Health and Care Plan sets out how Merton is working together to reduce inequalities and provide truly joined up health and care services with and for all people in Merton, so they start, live and age well in a healthy place.

Merton’s overall approach to enabling people to stay well, safe and independent at home for longer and provide the right care in the right place at the right time is by

providing a range of initiatives to support people in the community and where possible, in their usual place of residence. These include:

- Support for people to access community resources so people get the support they need in the community, e.g., through the continuation of the Community Response Hub funded through the BCF. This connects people who may be struggling financially, or are feeling lonely, isolated or worried about their mental health as well as those trying to stay independent at home or get more active by putting them in touch with support to help them in the community. The Hub supported over 2000 people in 22/23 with support ranging from signposting to referrals for services and further support. Finances, debt and food support form a large part of the initial enquiries.
- Work with the voluntary and community sector partners to expand personalised care approaches, reflected in the prospectus of community partners funding, now called Civic Pride, supported via BCF. This supports the voluntary and community sector programme, aiming to bring together wider funding opportunities to ensure that support is available for all Merton residents. It aims to:
    - invest in and support Merton's local voluntary and community infrastructure.
    - nurture a strong sense of community and reduce inequalities
    - bring together preventative services that provide information, advice and support in the community to strengthen Merton resident's physical, social, emotional, and economic resilience
- This also includes support towards asset-based approaches including social prescribing and Expert Patient Programmes (EPP) as well as support for carers. EPP is a free course for adults living with a long-term health condition or caring for someone with a long term condition with the aim of improving their health and wellbeing by developing and learning new skills.
- Jointly designing services to enable people to receive support at home where appropriate e.g. virtual ward.
- The use and further development of Integrated Locality Teams (ILTs) that provide holistic and personalised support to those most of risk and by providing proactive care from this multi-agency, multi-disciplinary approach utilising/ providing input across primary, community, social and voluntary sector services as needed. These teams are PCN based and wrap around the needs of the person in their own home and help them to remain independent. The BCF supports the funding of these multi agency teams, including health liaison social workers, case managers and community nursing, co-ordinators and the voluntary sector to provide support in the community to these vulnerable patients. These teams form the building blocks of the work being undertaken to develop neighbourhood teams in line with the Fuller Report recommendations. Development work has included developing an online resource detailing the roles and responsibilities of each of the partners in the ILTs that is accessible across all organisations to

support new members of staff who join to help them understand the role of the respective partners and having a joint resource help them develop as a team.

Population Health Management

The ICS is a data driven system that tackles inequalities, improves population outcomes and drives up productivity, supporting social and economic development, with Merton very much in the centre of this work.

Part of this includes an aligned approach to improving population health and use the increasingly rich data available to target those in our communities with the greatest need, to focus more on prevention and population health improvement, using a Population Health Management (PHM) approach. PHM is a methodology, to help frontline teams and system planners understand current health and care needs and predict what residents will need in the future. It involves analysing data and using that intelligence to identify population cohorts (or segments) to allocate resources to those with the greatest need and where interventions will add most value.

Working as a system, our health and care services are working together to design new proactive models of care which will improve health and wellbeing today as well as in the future. This means we can tailor better care and support for individuals, co-produce and design more joined-up and personalised care with our communities (patient segments or identified cohorts) and make better use of public resources for example the development of integrated multi-disciplinary neighbourhood teams (Fuller Stocktake).

In SWL we have Health Insights available as our data/analytics platform, which has been built using Microsoft Power BI and this presents data from various sources using interactive dashboards. We also have a SWL BI/Analytics team who can provide more sophisticated data and analytics functions, as well as create new bespoke dashboards to support our work programmes.

In SWL we have been building our PHM capability. In 2021 we took part in PHM Development Programme which enabled us to set up population health management pilots to look at the data and information together to give us valuable insights in a digested format, which helped us to identify nearly 7,000 people, in either primary care networks (PCNs) or in our places across SWL and together create and design interventions that helped to improve agreed outcomes. During 2022, we engaged with our partners from across South West London to listen and identify examples of good practice, valuable resources, and appetite to use PHM, capturing the variety of development needs. This included ICS partners from PCNs, local authority and borough partners, NHS acute and community services and provider collaboratives and mental health trusts. This stocktake enabled us to set out the steps we need to

take together to create the capability and capacity to use our collective resources more effectively, to add most value to our population and tackle inequity.

As part of this we have worked with our health and care partners to develop and publish the South West London Population Health Management PHM Roadmap, which outlines the steps, recommendations and interdependencies for PHM in SWL.

Merton is addressing health inequalities in a range of ways including use of population health management to enable a focus, both at place and at PCN level and a series of workshops focusing on use of this approach to support those with frailty have taken place, where we are reviewing how we can best make use of population management techniques to provide support to those who most need it, but who may not easily access care.

To enable more people to maintain their independence for longer, we aim to improve the health and wellbeing of Merton residents through enhanced access to community and voluntary sector services and greater sharing of assets and expertise as well as reduce health inequalities e.g. through the Implementing South West Merton PCN "Tackling Neighbourhood Health Inequalities" project working with Wimbledon Guild and use of population health management to reduce social isolation and improve access to services supporting those with frailty.

Along with the introduction of national anticipatory care guidance, we are looking at ways to expand the Integrated Locality Team model into lower risk cohorts to enable more people to benefit from proactive and preventative services and more personalised care, including updating of information to support people to Age Well and build on the expanded offer from rapid response services, enhanced support to care homes, improving dementia and end of life care to enable more people to be supported in their usual place of residence where possible.

Supporting Unpaid Carers in Merton

BCF funding supports an extensive range of services that support people in their caring roles. The BCF supports this work through a variety of schemes including support for the Alzheimer's Society and the Dementia Hub in Merton to support those with Dementia and their carers, funding to support Carers Support Merton, through funding night sitting services from Marie Curie and by contributing to the Civic Pride Grants Programme which invests in and supports Merton's local voluntary and community infrastructure, bringing together preventative services that provide information, advice and support in the community to strengthen Merton resident's physical, social, emotional, and economic resilience and works to address inequalities within our borough.

The Merton Carer Strategy 2021-2026 was approved by Merton's Health and Wellbeing Board in 2020. Under the Merton Carers Implementation Board, four multi-agency subgroups were established using four themes:

- *Identification, Recognition, and Contribution*
- *Health, and Wellbeing of Carers*
- *Realise and release potential*
- *A life alongside caring*

During 22/23 the work of these subgroups was reviewed and success celebrated. Following this, the Board recognised the need to realign some of the priorities to avoid duplication and to maximise effective use of resources. Task and finish groups have been developed to take forward key workstreams in the coming year.

Priorities include:

- updating the information on the London Borough of Merton website and other key local websites such as GP practices
- developing the Young Carers Implementation Plan following consultation with the Head of Family Support & Safeguarding and the Head of School Improvement and young carers themselves.
- Establishing an NHS Commitment to Carers Programme working group aligned with tasks in the Commitment to Carers Programme and GP Quality Markers to take forward key actions for health partners, including work to improve outcomes for patients and carers at hospital discharge
- Mapping the Carers of Adults Pathway and develop a standard operating procedure to help carers and staff to navigate the system, recognising the need for a focus on transition.

Intermediate Care Support in the Community.

The demand and capacity analysis for Intermediate care is included within the planning template for the second year. Learning from last year's submission has been helpful in drawing up the analysis for 23/24, even though some of the format has changed.

The key area where capacity was greater than demand was within the 2-hour Urgent Care Response Team, in spite of significant promotional work to increase referrals into the team. The promotional work continues into 23/24, but from the experience of last year, we have predicted there will still be less demand than there is capacity for this. Where this is the case, the team continue to support other less urgent response calls.

We have predicted an increase in capacity for rehabilitation at home as we start to implement new models of care in 23/24, moving away from bed based support and providing more home based support where possible.

Whilst the current modelling shows that demand is likely to outstrip capacity in some areas over the winter months, the BCF funding will be used flexibly in order to meet increases in demand.

Impact of schemes on metrics

A number of the schemes funded by the BCF to enable people to stay well, safe and independent at home for longer are described above in National Condition 1. In terms of the BCF metrics, reducing unplanned admissions for chronic ambulatory care sensitive conditions and reducing emergency admissions following a fall, there are a range of schemes supporting these aims including proactive care through Integrated Locality Teams and preventative services, providing personalised care and support in people's own homes.

Alongside the broader development of community services, we will be building on our Integrated Locality Teams to develop Neighbourhood Teams in line with the Fuller Report, increase use of the Universal Care Plan as a key tool to support cross agency information sharing and through Population Health Management, target particular interventions of those of greatest need. We have been piloting innovative ways to enhance our Integrated Locality Teams through PCN led initiatives. These will be reviewed to enable learning to be spread across the borough.

The BCF currently funds a number of prevention projects, two of which are aimed active ageing, reducing frailty and reducing risk of falls for Merton residents/patients. These include 'Merton Moves', which is a small scale but innovative coaching programme with Wimbledon Guild that provides older people with six weeks of support to engage in a new physical activity. Locally research previously commissioned highlighted a number of barriers older people may face to get involved in physical activity including incorrect perceptions from others or thinking exercise wasn't for them. This has been mirrored in case studies by Merton Moves that highlight older people's reticence to join mainstream classes and lack of confidence from some to join activities following Covid 19 lockdowns. The project supports/gives confidence and provides practical solutions to older people to join an activity, gives taster sessions at reduced costs and sessions across the borough including Mitcham and Morden. 105 people were supported and signed up to the Merton Moves pledge between March 22 to end of March 2023. The second project is called 'Get up and Go' Project. This is a programme of physical activity available to residents and patients in East Merton and Morden PCN areas to address mild frailty, with a focus on strength and balance activities. The programme has included physical activity classes, a small grant programme to community organisations and 'train the trainer' element. There are currently 9 classes running in Mitcham and 7 classes in Morden. Classes have been developed in collaboration with the community and voluntary sector and range from dance to seated pilates to boccia and new age kurling.

Two further schemes are being developed in 23/24 to provide advice and support for carers and those with dementia, including expansion of befriending and respite support.

Providing the right care, in the right place at the right time, in relation to supporting safe and timely discharge.

Supporting timely discharges is a key element of the BCF and a key priority for Merton. A local workshop with key strategic partners was held in 22/23 with the aim of improving proactive discharge planning across Merton and Wandsworth, and pathways to bring together a programme of work that will review existing pathways and look at opportunities to support integration across partner organisations where appropriate and reviewing our position locally against the High Impact Change Model.

Progress in implementing the High Impact Change Model for managing transfers of care

Merton has a Discharge Transformation programme, working alongside Wandsworth, which includes a review of the progress in achieving the High Impact Change Model.

A discharge task & finish group has been set up, which reports to the Hospital & Community Transformation Board. The group will have a greater focus on reviewing the progress against achieving the best practice discharge standards, set by NHS England, for acute, community and mental health areas. This will help to inform where there are areas for improvement, which are reflected in the High Impact Change Model.

Change 1: Early Discharge planning

Changes to the Transfer of Care hub at St Georges has enabled earlier discharge planning through:

- Case management releasing time for discharge case coordinators to focus on people discharged earlier in their journey.
- Early notification process being implemented (Social Work allocation, Key safes, amenities)
- Daily meetings with system partners moved to the afternoon for people on pathway 1 to prepare for next day discharge.

Change 2: Demand & Capacity

Demand and capacity monitoring is now shared across system partners using a modified RAG system to better understand system pressures and respond quickly through mutual aid with system partners. Home first and MDT working is in place with plans under development to review the current bed-based rehabilitation and increase to a more home-based approach to care delivery.

Change 3: Multidisciplinary working

Multi-disciplinary/multi-agency discharge teams, including the voluntary and community health and care sector; MDT teams through Hospital at Home/Virtual Ward and Integrated Locality Teams, MDTs support proactive care in people's own homes.

Change 4: Home First / Discharge-to-Assess.

Home first/discharge to assess – Enabling an established referral process via single-point of access, improving community support options in therapy and social care options. There are daily communications with the D2A team and TOC hub to better understand people's needs and to identify any information gaps. It is envisaged that even closer working is necessary to integrate these functions further.

Change 5: Flexible working patterns

Flexible working remains a priority for the system and the number of weekend discharges is improving but remains gaps in implementation across system partners.

Change 6: Trusted Assessment

Trusted assessment processes are to be revisited as part of the discharge task and finish group work with frontline staff across the system. As part of this group, housing partners will consider how to improve their links with discharge processes earlier in the process.

Change 7: Engagement and choice

Engagement and choice are key to any development. For example: with earlier discharge planning with people and their family commencing earlier in a hospital stay this would allow more time to consider their available choices. In terms of other engagement regarding service changes, this will be undertaken through the community and hospital transformation programme, as a public and patient engagement process is already in place to support the programme.

Change 8: Improved discharge to care homes.

Improving discharges back to care homes is in process through the full implementation of Enhanced Health in Care Homes initiatives including:

- A positive end-of-year review of the Enhanced Health in Care Homes Framework status, reflecting substantial progress in achieving the standards for older peoples care homes.
- Building relationships across the system and the Care Home Support Team.
- Improved use of Red bag and e Red bag.
- Use of NHS mail, and all care homes having one identified GP lead.
- Rolling out remote monitoring in care homes supported by training and set up in each home.

Change 9: Housing and related services

Detailed within ‘Disabled Facilities Grant (DFG) and wider services section.

A number of initiatives have emerged from this work which has included setting up a discharge sub-group with aims to:

- To review and refine the discharge pathways that they are jointly developed, with shared definitions and understanding of how they work, with clarity and how they apply to each cohort of patient.
- To agree a joined up and integrated care model for rehab, recovery and reablement, to refine how we best work together, not just in Merton and Wandsworth but across neighbouring boroughs too, based on embedding home first principles and working to discharge people to their usual place of residence where possible.
- Improved processes, interprofessional relationships & approaches in line with the high impact change model, and using themes from ‘Make a difference alerts’ and escalation calls to look for opportunities to address the issues within the transformation work.
- Identify actions to improve and streamline discharge performance and operational data
- Review and incorporate shared learning/best practice from other boroughs in our approach.

To support the next stage of this work a discharge summit is due to take place in June to consolidate the work that has taken place so far and work through the next priorities with a wide range of partners.

Work has also taken place across SW London to review discharge processes. The key outputs of this review include the development of A SWL Hospital Discharge Transformation Plan and a SWL Discharge Data Quality and Capture Improvement Plan, which will be used to help develop local plans and strategies.

Improvements have already been made with the Transfer of Care (TOC) team at St Georges which has seen an improvement in the discharge processes and a reduction to some of the delays in the system. We continue to work together across the system to create more joined up services and enable people to receive the right care, in the right place as timely as possible.

Changes have also been made to the discharge and escalation calls to support reducing length of stay and patient flow and review of practice will continue in order to ensure the multi-agency teams are working most effectively together. There are weekly strategic system partners meetings to understand and address discharge delay themes. Capacity and system resilience reporting is shared with all partners is in place to better understand capacity against demand to improve management of flow and priorities include ensuring there is a consistent approach to this across 7 days and what more all agencies can do to support avoiding unnecessary hospital admissions.

The discharge work programme forms a key element of our newly formed transformation structures, to improve pathway definitions and understanding across partners, as well reconciling the number of patients flowing through pathways recording by respective organisations through the work being undertaken to better understand demand and capacity requirements within intermediate care.

We continue to work through and improve on our understanding of why people are admitted to hospital and what more we may be able to do at the front door of hospital to avoid unnecessary admissions and where needed, provide greater support at home. This includes more innovative ways to highlight the 2 hour Urgent Care response services, use of the care home support team to reduce unnecessary emergency admissions from care homes and increase in the use of the Universal care Plans across the system. There have been recent improvements in the number of plans developed and those being viewed by London Ambulance Service and we will work with partners to continue these increases.

A significant transformation piece well underway across Merton and Wandsworth review intermediate care and look at the opportunities for providing more home-based support. This, along with the other developments including Virtual ward, I report into the Merton and Wandsworth Hospital and Community Transformation Programme Board which currently oversees the delivery of the wider transformation schemes, with Merton Health and Care Partnership overseeing those specific to Merton.

The additional discharge funding is being used for:

- Rapid response/quick start reablement
- Additional social work staffing to support discharge and to in reach into the Transfer of Care (TOC) team
- Carer liaison in hospital to support discharges
- Age UK help at home service
- Handy person & Telecare
- Dementia and nursing beds and 1:1 support in care homes
- Additional community equipment.

Intermediate Care in Supporting Discharges into the Community.

The demand and capacity analysis for Intermediate care is included within the planning template for the second year. Learning from last year's submission has been helpful in drawing up the analysis for 23/24, even though some of the format has changed.

We have predicted an increase in capacity for rehabilitation at home over the winter months as we start to implement new models of care in 23/24, moving away from bed based support and providing more home based support where possible.

Whilst the current modelling shows that demand is likely to outstrip capacity in some areas over the winter months, the BCF funding will be used flexibly in order to meet increases in demand.

In order to support the pressures of hospital flow, SWL re introduced the bed bureau over the winter of 22/23. It is not clear whether this will be deployed again for future winters.

A pilot funded via innovation funds is currently taking place to support patients out of hospital sooner. This will be evaluated in 23/24 to help inform the direction of travel and approach.

Discharge to Usual Place of Residence

This is detailed in 'Providing the right care, in the right place at the right time, in relation to supporting safe and timely discharge' section above.

With more complex and frailer patients presenting, the level of complexity on discharge has meant that an increased number of patients have required admission to residential care. The stretch target proposed for 22/23 was not achieved but we expect to broadly maintain the current position, by the further work being undertaken to support home first.

Supporting Unpaid Carers in Merton

BCF funding supports an extensive range of services that support people in their caring roles. The BCF supports this work through a variety of schemes including support for the Alzheimer's Society and the Dementia Hub in Merton to support those with Dementia and their carers, funding to support Carers Support Merton, through funding night sitting services from Marie Curie and by contributing to the Civic Pride Grants Programme which invests in and supports Merton's local voluntary and community infrastructure, bringing together preventative services that provide information, advice and support in the community to strengthen Merton resident's physical, social, emotional, and economic resilience and works to address inequalities within our borough. Details of the strategy work are included in section on national condition 2.

Priorities for 23/25 include:

- updating the information on the London Borough of Merton website and other key local websites such as GP practices
- developing the Young Carers Implementation Plan following consultation with the Head of Family Support & Safeguarding and the Head of School Improvement and young carers themselves.
- Establishing an NHS Commitment to Carers Programme working group aligned with tasks in the Commitment to Carers Programme and GP Quality Markers to take forward key actions for health partners, including work to improve outcomes for patients and carers at hospital discharge

- Mapping the Carers of Adults Pathway and develop a standard operating procedure to help carers and staff to navigate the system, recognising the need for a focus on transition.

Two further schemes are being developed in 23/24 to provide advice and support for carers and those with dementia, including expansion of befriending and respite support.

Work is also taking place to change how people can access services including:

- Pilot a Health on the High Street hub approach.
- Pilot an Ethnicity and Mental Health Improvement Project (EMHIP) hub in Merton.
- Empower the voluntary and community sector to re-engage older people with services as the community hub develops.
- Develop more options for people to personalise their care.
- Build on learning from the vaccination programme to reach all communities and promote all primary care services e.g. pharmacy, optometry.
- Develop new roles and approaches e.g. have mental health workers in each primary care network, working alongside health and wellbeing coaches.
- Better connect professionals across community multi-disciplinary teams.
- Continue the approach, taken during the pandemic, to work with communities and service users to understand voice and lived experience and co-create key messages and inform future plans.

Disabled Facilities Grant

The Disabled Facilities Grant is a key enabler to support people to remain in their own home and supports our Home First discharge model. Adaptations are supported in line with the borough policy and commissioned through a Home Improvement Agency. That contract is in the process of being recommissioned and alongside that process we will be working to further improve how we can work collaboratively as a system to help ensure that the right adaptation solutions are implemented in a timely fashion to support individuals. Our aim is to implement a wide-ranging service, providing information, advice, and support for people seeking assistance with disabled adaptations solutions. This will include providing information and advice on home improvements, energy efficiency and support to apply for grants and other funding.

We utilise the flexibilities to support other activity that helps people return and remain at home. In particular we use DFG funds to support Age UK Merton to provide a Hoarding Service. The service goes beyond deep cleans and making fit for return services, to provide a longer intervention to address the hoarding behaviour rather than just the immediate issues. Merton's Housing Assistance Policy sets out the flexibilities in the use of the DFG e.g. to enable support at a lower level of spend.

In Merton, the Departments have recently changed from Community and Housing overseeing social services and housing to Adult Social Care, Integrated Care and Public Health. This reflects the importance of integration and prevention within Merton' goals, whilst still making use of the historical alignment with housing, and the work of the Disabled Facilities Grant (DFG) in both the development of plans e.g. the use of the DFG and in every day working e.g. in supporting discharges.

LBM is a non-stock owning authority and therefore works with a range of social and private landlords to meet housing needs. We work closely with social landlords through a range of partnership structures to ensure that necessary property adaptations can be delivered in a timely way to facilitate discharge. Engagement with private landlords is managed on a case-by-case basis, reflecting the nature of the market.

Equality and Health Inequalities

Work to reduce inequalities is a thread throughout the BCF Plan. We are working with the voluntary and community sector to support older people to re-engage with and access community resources for their health and wellbeing post Covid. Continuing the Community Response Hub, alongside social prescribing and case management through the Integrated Locality Teams, we aim to ensure we have the services in place to deliver services to match people's needs to deliver person centred care. The JSNA is the core dataset that feeds our understanding but has been supplemented this year by other sources such as the Council's 'Your Merton' consultation, South London Listens and specifically commissioned feedback from ethnic minority and LD communities.

The feedback from the consultations concluded we need to listen to communities and people in Merton in their own spaces and environments to understand their health and wellbeing needs and invest in and empower them. What people have told us is that cultural sensitivity needs to be considered in all work we plan and deliver, and communities need to be part of this. Mental health and emotional wellbeing are vitally important across Start Well, Live Well and Age Well, and we must also consider the impact of Covid-19 on mental health. Prevention and early intervention are key, together with the social determinants of good health and wellbeing, eg employment, housing, finance and social networks. Improved information and communication about local services available is needed across the whole health, care and voluntary sector and efforts to raise awareness about how to access support. We must consider living and working environments, and how developing Merton as a healthy place can improve health and wellbeing. Regenerating high streets and making best use of green spaces is key. Across all our plans we aim to:

- Reduce health inequalities and embed equity.
- Use a population health management approach to drive change.
- Focus on sustainability and making Merton a healthy place.

- Engage with service users, patients and communities so all work is developed with and by people in Merton.

The section ‘ Implementation BCF Policy Objectives’ describes further details on how we will achieve this.

The model supporting home first principles enables more people to retain their independence and services aim to provide a personalised approach to support the individual’s needs and help them access other services to support them.

Work is being undertaken at Merton place and within PCNs to utilise information through population health management to help focus our resources on those with greatest need and who may not currently access services and along the priority of those with frailty, look at how we can support CORE 20 plus 5 initiatives. The analysis to date has been undertaken across South West London which has identified much of what we already know: people in East Merton have worse health and shorter lives and existing health and social care inequalities have been amplified by COVID-19. A range of services commissioned through BCF funding support those in most need in this area and where required across the borough, which are summarised below. There are increasing number of people with complex needs and co-morbidities where programmes such as Integrated Locality Teams provide bespoke personalised proactive support to enable people to remain in the community where possible. Areas of specific note include:

- The Community Response Hub which initially started in response to the COVID 19 pandemic but identified an ongoing need for independent advice and support.
- Living Well Service run by Age UK to improve physical and mental wellbeing
- Funding the voluntary sector to reduce factors that increase the likelihood of presentation to health or social care, including an enhanced lunch club offer, improving heating and insulation, supporting access to benefits and helping with small grants for energy, food and clothing.
- Reducing isolation especially amongst older men through our music workshops- Tuned In (A single has just been produced called Uptown Lockdown)
- Contribution to Social Prescribing, which has a particular focus on those areas and individuals where there is social complexity
- Funding to educate and empower individuals to manage their health and well being including Expert Patient Programmes
- Falls and other prevention initiatives including ‘Merton Moves’ and ‘Happy and Active in Merton’ linking with libraries around digital inclusion

Work to Reduce Inequalities through the Disabled Facilities Grant (DFG) 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 and Emergency Adaptations
- Dementia Friendly Aids and Adaptations Grant

- Helping Hand Service for Low Level Hazards
- Help with Energy Efficiency.

Daily discharge discussions and escalations meetings enable support best designed to minimise any unnecessary time in hospital and aim to maximise the independence of the individual.

Further work using the CORE 20 plus 5 data will be undertaken at a local level to build on the work already being undertaken and we will build on learning from the vaccination programme to reach all communities and promote key services and ways to access support.

The population health management work also being undertaken (described in the National condition 2 section) also supports the reduction in inequalities.

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Committee: Health and Wellbeing Board

Date: 27 June 2023

Agenda item:

Wards: All

Subject: Health and Wellbeing Board Young Inspector

Lead officer: Julia Groom, Consultant in Public Health

Lead member: Councillor Peter McCabe, Cabinet Member for Health and Social Care

Contact officer: Sukpal Uppal, Participation and Engagement Manager, Children Lifelong Learning and Families.

Recommendations:

A. To agree that the pilot of a Young Inspector member of the Health and Wellbeing Board be extended for a period of six months, prior to a formal review.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report proposes that the initial pilot project of having a Young Inspector member of the HWBB, currently filled by Anna Huk, be extended for a period of six months. This will continue to bring young people's voice and perspective to Board discussions prior to a formal review in January 2023.

2 BACKGROUND

2.1 In September 2022, members of this Board received a presentation from Young Inspectors, Lola Kareem and Anna Huk setting out how they saw children and young people being heard in Merton. They presented the findings on the 'Being Healthy' theme of the engagement survey and gave examples of how young people themselves are leading on participation-work. The presentation was welcomed by the Board and the ways in which young people can participate more fully in the HWBB were considered.

2.2 At its meeting in November 2022, the HWBB agreed to an initial pilot project for a Young Inspector to be invited to the Board. This was intended to bring a young person's voice to deliberations and guide how young people can have a say in decision making. The Young Inspector, Anna Huk, was nominated through a transparent process, and appointed by the Chair to attend HWBB meetings over a six month period, including Boards in January, March and June 2023.

3 DETAILS

3.1 In the three Board meetings that Young Inspector, Anna, has attended to date, she has made a valuable and considered contribution to deliberations. She has effectively brought a young person's voice to discussions in a way which has helped inform several areas of work. Her contribution on the ways in which young people engage with the media has been particularly insightful.

3.2 Following this action by the HWBB, all Merton Scrutiny Panels have now also acted to include a Young Inspector on Panels for an initial period of one year.

3.3 It is proposed that the initial HWBB pilot period of six months now be extended for a further six months to January 2024. This will allow for Anna or a subsequent nominated Young Inspector to attend HWBB meetings in September and November 2023 and January 2024.

3.4 During this time it will be possible to review the pilot and gain learning from the wider experience of Scrutiny Panels. It will also allow time to evaluate the implications of a more permanent arrangement on the HWBB terms of reference. If a permanent arrangement is recommended then any required changes to the terms of reference to be brought to the HWBB for agreement.

4 ALTERNATIVE OPTIONS

The alternative would be to bring the pilot of having a Young Inspector attending the HWBB to an end.

5 CONSULTATION UNDERTAKEN OR PROPOSED

As part of the review of the pilot project it is proposed to consult with HWBB members and the Young Inspector and CYP engagement lead.

6 TIMETABLE

The proposal is for the pilot to be extended for six months to January 2024.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

N/A

8 LEGAL AND STATUTORY IMPLICATIONS

The Health and Wellbeing Board has some statutory membership but beyond that is able to determine its own members. It is also a public meeting.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

Young Inspector representation at the Health and Wellbeing Board allows for greater involvement of children and young people’s voice.

10 CRIME AND DISORDER IMPLICATIONS

N/A

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

N/A

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

None

13 BACKGROUND PAPERS

None