Committee: Health and Wellbeing Board

Date: 8th October 2019

Agenda item: Merton Health and Care Together

Wards: ALL

Subject: Merton Health and Care Together

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

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

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

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Recommendations:

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

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

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

2 BACKGROUND

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

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

- Healthwatch
- Merton Voluntary Sector Consortium

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

3 DETAILS

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

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

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

4 ALTERNATIVE OPTIONS

4.1. N/A

5 CONSULTATION UNDERTAKEN OR PROPOSED

5.1. N/A

6 TIMETABLE

N/A

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7.1. N/A

8 LEGAL AND STATUTORY IMPLICATIONS

8.1. N/A

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

9.1. N/A

10 CRIME AND DISORDER IMPLICATIONS

10.1. N/A

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

11.1. N/A

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

Merton Health and Care Together – attached document

13 BACKGROUND PAPERS

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

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

The agreed vision:

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

The agreed and shared objectives:

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

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

Implementing the plan: Key achievements to date

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

Start Well:

A) Emotional health and wellbeing for children and young people

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

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

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

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

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

Live Well:

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

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

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

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

B) The Diabetes Action Plan

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

C) Improving mental health in primary and community settings

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

D) East Merton Model of Health and Wellbeing

Age Well:

A) Integrated Locality Teams

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

B) Developing an integrated intermediate care pathway

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

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

C) Enhanced support to Care Homes

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

Enablers

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

Digital

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

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

Estates

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

Workforce

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

Communications and Engagement

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

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

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

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