Committee: Health and Wellbeing Board

Date:

Agenda item:

Wards:

Subject: Developing Integrated Community Services Merton

Lead officer: Mark Creelman, Executive Locality Director Merton (SWL CCG)

Lead member:

Forward Plan reference number:

Contact officer: Gemma Dawson, Deputy Director Merton Health and Care Together

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Recommendations:

The Health and Wellbeing Board is asked to endorse and provide support on the project plan to collaboratively develop integrated community services in Merton.

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The existing contract covering community services held jointly by SWL ICB and the London Borough of Merton expires in April 2025. A new contract(s) must be in place that develop and improve outcomes for Merton residents.

1.2. The aim of this project is to work with all partners to develop or introduce integrated community care in line with national policy in the NHS Long Term Plan and local strategic plans such as the Joint Forward Plan and the Merton Local health and Care Plan.

1.3. This paper outlines the project approach to developing a collective vision, outcomes and delivery model for integrated community services in Merton.

1.4. The Health and Wellbeing Board is requested to note the plan and provide any feedback that could strengthen the approach.

2 BACKGROUND

2.1.1 Merton has a solid foundation of joint working to develop integrated care through successful outcome focused commissioning for a wide range of community services spanning across children's, adults and public health services. 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.

2.1.2 However, complexity in how services are commissioned and how they are provided gives rise to duplication and overlap as well as opening up gaps between the teams delivering care. Designing and planning health and social care around the needs of the individual, taking account of their changing needs

over time, will improve their experience of the services they receive and their health outcomes – not just at a point in time, but for the longer term and improve their lives enormously. [1] Merton residents with multi-morbidity are often in contact with multiple health and care professionals and are more likely than those with a single condition to report care co-ordination problems and suffer problems in transitions of care due to poor communication and data flows. This message is reinforced in the feedback from patients and public calling for care to be 'seamless' and coordinated.

2.1.3 For health, care and support to be 'integrated', it must be person-centred, coordinated, and tailored to the needs and preferences of the individual, their carers and family. It means moving away from episodic care to a more holistic approach to health, care, and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered.[2]

2.1.4 Strengthening community services with enhanced prevention and bringing care closer to home has been a long-standing policy ambition across health and social care. Closer working between local government and the NHS has always made sense; health and wellbeing are closely intertwined, and local government has significant influence on many of the wider determinants of health and wellbeing, such as housing, transport, education, leisure and the built environment.

2.1.5 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.

2.1.6 This is an opportunity for Merton to be ambitious and to commission community services which are person centred, support prevention and are fully integrated 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. Lastly, this presents 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.

3 DETAILS

3.1. The scope of the project is to include all the service lines and functions within the existing contract (which spans across children's and adults' services, generalist and specialised roles).

As well as the opportunity to redesign and transform current services and funding, there is the opportunity to add additional or expand areas to improve outcomes for the residents of Merton.

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[1] 'Report of the children and young people's health outcomes forum', Children and young people's health outcomes strategy July 2016 HMIC
https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results

[2] https://www.gov.uk/guidance/enabling-integrated-care-in-the-nhs

3.2. Project outcomes and key deliverables

3.3. - Improved collaborative place owed community services model and contractual arrangement that is an enabler to deepening integrated care, provides prevention and high-quality community services to the people of Merton.

3.4. - Model and deliver of community services that reflects the key priorities of community care both nationally and locally; plurality of provision, greater empowerment and personalised care, greater emphasis on prevention, reduces health inequalities and has regard to the wider determinants of health

3.5. - Focused and informed by population health management and are targeted to reduce known health risks and reduce health inequalities

3.6. - Financially sustainable; deliverable within the cost envelope and achieves the outcomes required.

3.7. - Contractual freedom to enable collaboration and innovation, for care to be delivered locally and driven by local communities in line with the white paper on ICS and the role of place.

3.8. New sustainable community services in place post contract expiry (not feasible to carryover the existing contractual arrangements).

3.9. The approach is a collaborative programme management approach rather than following a traditional commissioning cycle approach to awarding a new service.

3.10. Led by the Merton Health and Care Together Committee, this new partnership of health and care providers, community and voluntary sector leaders and representatives will together steer and oversee the process of determining the shape and form of community services in Merton, sharing the innovation, design and delivery.

3.11. Principles of openness, transparency and collaboration are at the heart of this approach. Supported by dedicated programme management team, the participatory approach will ensure the outcomes and eventual model and monitoring of quality and delivery are owned mutually by all partners in Merton place.

3.12. Through partnership working Merton will:

3.13. Be better equipped to focus on prevention, redesign care together with providers, improve health and wellbeing and unlock more efficient ways of delivering care.

3.14. Encourage a culture of seeing the whole person within their family/network; uniting their physical and mental health, social care and wider housing and employment needs, in short de-commodifying the transactional nature of current services.

3.15. Explore opportunities to pool resources (financial and non-financial), expertise and experience to reduce duplication, unnecessary complexity and fragmentation.

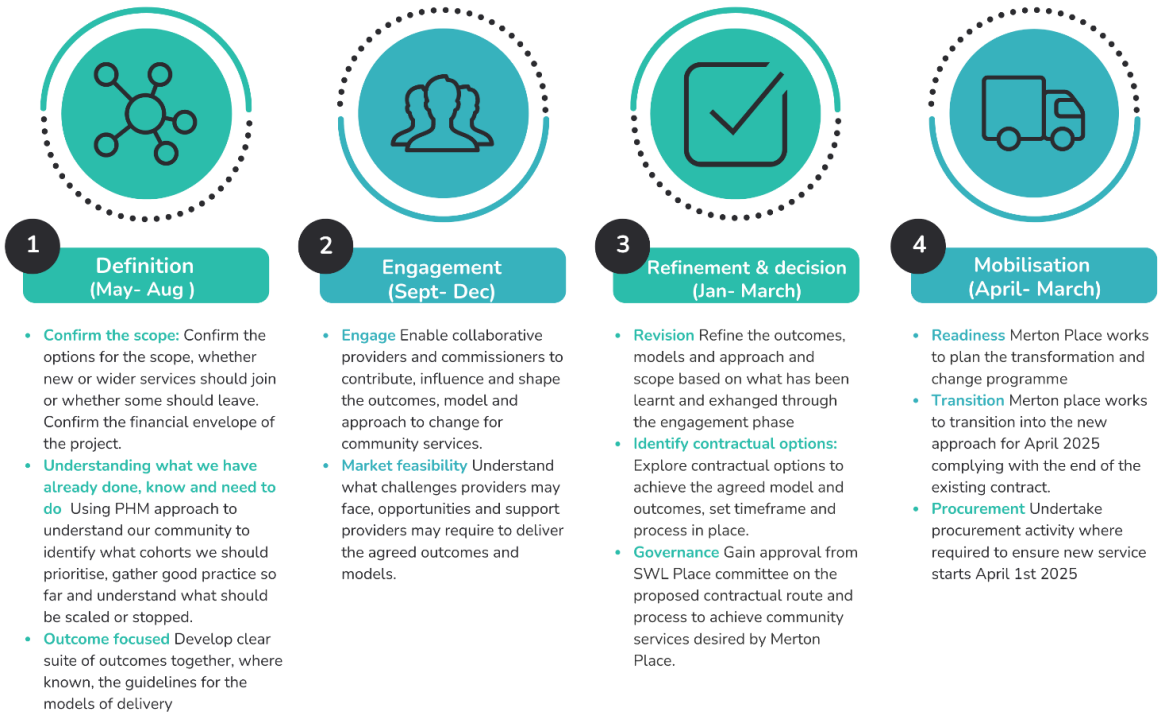
3.16. Opportunity through coproduction to bring to fruition our long held ambitions around empowering people to take a key role in the preservation of their own health and wellbeing.

4 TIMETABLE

4.1. The project has an ambitions timeframe for delivery aiming to achieve consensus on the vision, outcomes and outline model(s) by December 2023 to enable the maximum amount of time for mobilisation into the new way of working by April 2025.

4.2. The infographic below outlines the high level project timetable split into four key phases.

4.3. The engagement phase has started with a newly formed task and finish group comprised of representatives from across the partnership to collectively design events both in person and online to engage health and social care professionals in the design of future community services. The task and finish group is also working with engagement leads to ensure wider public and patient and service user involvement in the design, it is to be a coproduced inclusive space.



5 FINANCIAL, RESOURCE AND PROPERTY IMPLICATION

6 LEGAL AND STATUTORY IMPLICATIONS

7 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

7.1. An Equality Impact Assessent will be completed on proposals and be included in the final paper for the governance stage (January-March to ensure that all proposals maximise the opportunity to reduce health inequalities and avoid any unintended consequences.

8 CRIME AND DISORDER IMPLICATIONS

9 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

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

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

11 BACKGROUND PAPERS

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