Committee: Health and Wellbeing Board

Date: 19th September 2023

Agenda item:

Wards: All

Subject: Health and care system working - challenges and opportunities

Lead officers: John Morgan Executive Director, Adult Social Care, Integrated Care & Public Health

Mark Creelman, Place Executive - Merton and Wandsworth, NHS South West London

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

Forward Plan reference number:

Contact officers: Mike Proctor, Director of Transformation & Deputy Locality Executive Director - Merton and Wandsworth, NHS South West London

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Recommendations:

A. HWBB members consider and note the content of this report.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

This report provides details of current plans to deliver operational resilience across the NHS and social care system this winter and current areas of health and social care joint working.

2. BACKGROUND

2.1. Each year health and adult social care receive guidance from NHSE and the Minister of State for Social Care on how they are required to manage operational resilience for the winter period and are allocated additional funding to support the system in achieving the operational targets.

3. DETAILS

3.1. Both health and social care received this guidance in July this year. It set out expectations for how NHS organisations will work with adult social care in both the planning and delivery of support as part of a joined-up approach to planning across the health and care system this winter.

3.2. We have achieved two key targets in 2023-24:

1. Emergency Departments to achieve 80% of patients being treated in 4 hours by Quarter 4
2. London Ambulance service to complete at least 90% of handovers in 30 min Category 2 conveyances to ED.

3.3. The Urgent Care Recovery Plan has been published and provides a 2-year plan

to deliver improvements for patients across the urgent and emergency care pathway.

3.4 This year's guidance highlights four priority areas:

1. Continue to deliver on the UEC Recovery Plan by ensuring the high-impact interventions are in place.
2. Completing operational and surge planning
3. ICB should ensure effective system working across all parts of the system.
4. Supporting our workforce.

3.5. A self-assessment is currently underway, to help us understand what is already in place and what work we must do to achieve these improvements.

3.6. Health have been allocated £3.26m for 2023-24, which is the same as last year. However, the schemes are expected run all year, rather than just the Winter Surge period (October – Feb). We have worked across the system to agree schemes that meet the criteria and would best support patients and the services they need. The SWL Urgent and Emergency Care Board have agreed the following schemes for Merton and Wandsworth:

3.7. London Ambulance Service – Hospital Ambulance Liaison Officer (HALO) - will review each conveyance with the crews and see whether alterative treatment could have been sought as opposed to conveyance to hospital, support timely handovers, and prevent delays and explore possibilities for proactive redirection. £142,290.

3.8. St Georges – ED Majors capacity – 9 trollies, 12 chairs and associated staffing to support the ED major's department in managing increased activity and reducing 4 hour breaches. £1,489,352.

3.9. St Georges – Transfer of Care Hub – (see Discharge Summit section below) to support smooth and timely discharges from ED and prevent unnecessary admissions, with a range of staff and resources to support the multi-disciplinary team. £300,000.

3.10. St Georges - New Frailty Zone in ED – to manage increased activity from frail and elderly patients and support enhanced operational pressures and reduce risk of escalating patient care and prevent admission. £300,270.

3.11. St Georges – Escalation Beds – 28 General and Acute Beds added to the trust bed base to support admissions and prevent delays with patients waiting to be admitted in busy ED's. £1,000,000.

3.12. The NHSE will also develop an intermediate care framework by the autumn, recommending actions for systems to scale up post-discharge intermediate care services ahead of, and through, winter 2023 to 2024.

3.13. The NHSE letter also sets out associated primary care responsibilities over the winter period. This includes delivering actions from the 'Primary care access recovery plan' that will support winter resilience, particularly:

a) increased self-directed care

b) expanding community pharmacy services

c) improving access to general practice

d) supporting practices to move to cloud-based digital telephony and to access the right digital tools

e) improving online patient journeys

f) enhancing navigation and triage processes

4. PRIMARY CARE CAPACITY

4.1. The 21 GP practices in Merton serve a population of 233,412 registered patients (June 2023). As well as working as individuals the practices have come together to form six Primary Care Networks to work together to deliver some services to their patients. All the practices are also members of Merton Health Ltd. who are contracted to deliver primary care services across the borough.

4.2. Primary Care appointments are available to patients 7 days a week, 8am – 8pm, including bank holidays provided by a mix of individual GP practices, Primary Care Networks, and borough wide Access Hubs. Patients can access appointments through their GP practice, in person, via telephone or online, or through NHS 111.

4.3. Over the six months January 2023 to June 2023 Merton practices provided an average of 85,000 appointment a month, with over two thirds being face to face (in line with the London average for face to face appointments), and 60% being same day appointments.

4.4. Primary Care Networks are required to deliver Enhanced Access services over the Network Standr Hours of 6:30pm – 8pm Monday to Friday and 9am – 5pm on Saturdays. Merton PCNs offer on average 4000 Enhanced Access appointments a month.

4.5. Merton has two Access Hubs that can be accessed by all Merton registered patients. They provide additional capacity Fridays, 4pm-8pm and 8am-8pm on Saturdays, Sundays, and Bank Holidays, offering over 800 appointments a month. These are made up of GP sessions and nurse clinics especially focused on wound care and childhood immunisations. The Access Hubs also play a key part in being able to respond rapidly to changes in demand and provide additional capacity as required, such as over winter or during recent strike action.

4.6. As well as existing staff including GPs, Nurses and Healthcare Assistants, practices and Primary Care Networks are being supported to recruit to a wide range of clinical and non-clinical roles to offer services to their patients. These include Clinical Pharmacists, Social Prescribing Link Workers, Paramedics, Mental Health Practitioners First Contact Practitioners and Care Coordinators.

In Merton over 70 new staff have been recruited into these roles, and this number continues to grow.

4.7. There are a range of recruitment and retention schemes in place to support all roles within the primary care workforce as well as ongoing training and development opportunities for clinical and non-clinical staff.

4.8. There are a range of digital solutions being implemented across practices in Merton to support access and release capacity. These include online consultation services, cloud based telephony, prospective access to records for patients, improvement to practice websites and encouraging uptake and use of the NHS app.

5. ADULT SOCIAL CARE, PUBLIC HEALTH, AND WINTER RESILIENCE

5.1 Adult Social Care, similarly, received a letter from the Minister of State for Social Care to set out the key steps needed so that adult social care systems are resilient and able to provide people and their carers with the support they need this winter.

5.2. Our key contributors from the adult social care sector play a critical role over the winter period, including:

a) reablement
b) residential care domiciliary care
c) extra care and supported living
d) shared lives
e) intermediate care
f) voluntary and community services
g) local authority adult social care staff including social workers and occupational therapists, families, and unpaid carers.

5.3. The actions it contained build on the plans we already have developed, including capacity plans under the Market Sustainability and Improvement Fund (MSIF), as well as capacity and demand plans for reablement and intermediate care.

5.4. It calls on integrated care boards (ICBs) and integrated care partnerships (ICPs), local authorities, health and care providers and the voluntary sector all being actively involved in joint planning for winter and working together to support individuals who draw on care. In Merton this is well established and overseen by the Merton Health and Care Together (MHCT) Partnership. Adult social care will continue to work with health colleagues to ensure an integrated approach across health and social care. This includes:

- keeping under review our BCF capacity and demand plans for intermediate care, considering trends in demand, in line with the BCF policy framework and planning requirements, and submitting refreshed capacity and demand plans in October

- work with partners to further develop the care transfer hub at St Georges Hospital to manage discharges for patients with more complex needs, and a key output of the Merton and Wandsworth Discharge Summits.

5.5. However, there are significant challenges faced every winter in ensuring that our health and care systems' capacity plans can address projected changes in demand including sufficient contingency to meet different demand scenarios and risk.

5.6. Precautionary measures are being taken to protect those most vulnerable from illness during winter following the identification of Covid-19 variant BA.2.86. The COVID-19 autumn vaccinations roll out have been accelerated (from an October start) to now start on 11 September. The decision means those most at risk from winter illness – including people in care homes for older people, the clinically vulnerable, those aged 65 and over, health and social care staff and carers – will be able to access a Covid vaccine in September. Adult care home residents and those most at risk will receive vaccines first.

5.7 The annual flu vaccine will also be made available to these groups at the same time wherever possible. NHS England will announce full details of the accelerated roll-out soon. All who fall into higher-risk groups are being encouraged to accept the offer when invited.

5.8 The new Shingles vaccine Shingrix® will be offered to all people reaching eligible age on or after 1 September 2023. This has two doses of the non-live Shingles vaccine and eligibility for immunocompromised and immune competent has changed to allow individuals to be protected at an earlier age.

5.9 In addition, for children and young adults MMR vaccinations will be offered to pupils returning to primary and secondary school and to students going to university in September.

6. MERTON AND WANDSWORTH DISCHARGE SUMMIT

6.1. A key part of ensuring effective patient flow across the Winter period will be to optimise the efficiency with which the system can discharge medically fit patients back home with minimal delay. Part of this work within the system based around St George's Hospital is to enhance the operational effectiveness of the existing Transfer of Care Hub.

6.2. Partners across health and social care have met three times as a Discharge Summit to understand the flow within the hospital 'The St George's line,' the challenges with current discharges and opportunities to improve. The system partners universally agreed with a Care Transfer Hub model, which links all relevant services across sectors to aid discharge and recovery and admission avoidance. This will include social workers, housing advice and voluntary and community partners working more closely together as a team. The ambition is to have this in place before winter 2023.

7. INTEGRATING COMMUNITY SERVICES ACROSS MERTON

7.1 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.

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

7.3. This provides 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.

7.4. The Merton Health and Care Together Committee is overseeing and steering a project to develop integrated community services in Merton. The aim of this project is to collaborate with all partners to develop or introduce integrated community services in line with national policy and local strategic plans such as the Joint Forward Plan and the Merton Local health and Care Plan.

7.5. Project outcomes and key deliverables include:

- Improved collaborative place owed community services model and a contractual arrangement that is an enabler to deepening integrated care, provides prevention and high-quality community services to the people of Merton.
- Model and deliver community services that reflect 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.
- Focused and informed by population health management and are targeted to reduce known health risks and reduce health inequalities.
- Financially sustainable; deliverable within the cost envelope and achieves the outcomes required.
- 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.
- New sustainable community services in place post contract expiry (not feasible to carryover the existing contractual arrangements).

8. HEALTHLANDS COURT AND THE FUTURE OF INTERMEDIATE CARE

8.1. Following the overall ambition of how our community services are delivered as outlined in the previous section, CLCH have developed a new model of care for

the enhanced home rehabilitation pathway as an alternative to Heathlands Court. This would be better for patients both clinically and supporting improved patient experience.

8.2. The July Merton Health and Care Together (Committee) supported the idea of the proposal, but recommended further engagement and exploratory work should be undertaken, e.g., understanding the impact on primary and social care.

8.3. This has been done over August 2023 with the plan to present the model, comprising of updates following the engagement, to the Merton Committee in September, with a view to the new model being in place before end of autumn 2023.

8.4. This initiative is part of the wider programme of developing more community-based services aimed at treating people at home as far as possible, with integrated local services wrapping around the patient, rather than the patient fitting into the structures and organisational patterns of statutory services.

9. WORKING ON CHILDREN'S SERVICES

9.1. There is a good record of effective joint working between LB Merton and SW London ICB and its predecessor organisations on Children's Services.

9.2. The Integrated Children and Young People's Commissioning Group has run successfully for several years, jointly chaired by senior officers from the Council and the ICB.

9.3. There is a degree of joint commissioning with the local authority as part of the children's community services contract with CLCH being part of the wider Community Services contract held by the ICB. It has been agreed that we will take this further with the appointment of a senior officer (NHS AfC grade 8d/LBM Management Grade 3) to oversee the commissioning of Children's services across the NHS and local authority within Merton.

9.4. A job description has been developed and from the ICB point of view will be built into the current restructuring exercise that is taking place. The new postholder could be employed by either the ICB or the Council depending upon the successful candidate and their preference based on previous employment history.

9.5. The timescale will be to have someone in post by April 2024 to fit with the ICB's consultation on its new structure. We are currently considering whether to appoint an interim worker in the short-term.

10. Alternative options

10.1 Not Applicable

11. CONSULTATION UNDERTAKEN OR PROPOSED

11.1 None directly related to this report.

12. TIMETABLE

12.1 Not applicable

13. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

13.1. London Borough of Merton (LBM) will continue to work with Health colleagues to facilitate an integrated approach to meet the significant challenges faced every winter. LBM will use its allocated winter pressures fund to contribute towards the demands of winter.

14. LEGAL AND STATUTORY IMPLICATIONS

14.1. None directly related to this report

15. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

15.1 Please see the body of the report for information

16. CRIME AND DISORDER IMPLICATIONS

16.1 None directly arising from this report

17. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

17.1 None directly arising from this report

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

18.1

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

19. BACKGROUND PAPERS

19.1