#### Program: Wilson Health and Wellbeing Campus (WHWC) Logic Model Services **Health Need in East Merton Outcomes** - Unwarranted primary care variations in quality, access Burden of risk factors and diseases Short term Medium Term Long Term and outcomes - Long term conditions: Higher prevalence of risk factors - Under-provision of services, specifically in areas of MSK, and social determinants especially in BAME; later diagnosis Improved health Improved quality Physiotherapy, Diagnostics, and Outpatient Services Improved and more co-morbidities Reduced cost to of life outcomes - Fragmentation of services: a) Dispersed b) Consequently service quality - Higher mortality and excess deaths: CVD and cancers, commissioners - High levels of inequalities and inequity lack of scale **Better Mental** - Stark contrast in child poverty (x 4 times in East); 45% - Lack integration between health and social care, mental Increased social Reduced cost of wellbeing Merton school pupils living in an area of deprivation and physical health care, clinical and non-clinical support, capital **Improved** provision family support - 1 in 3 children (34.7%) aged 10-11 years overweight or access Community Reduction in obese; A&E attendances (0-4 years) significantly worse than Channelling and optimising social capital, voluntary sector England average social isolation Better prevention and - More young mothers from high deprivation areas assets and community conversations and loneliness reduction in burden of Reduced length Increased risk factors and disease of stay treatment Inputs/ Assets **Outputs Improved** Enterprise hub & compliance barbers, nailbars Hair dresse Activities customer Enablers **Participants** Reduced health incubator experience Reduced inequalities and Carers Support outpatient MCCG staff time inequities "Ordinary" residents Better self attendance LBM staff time Senior leadership and networks customer management **HWBB** and **OMM** satisfaction BAME groups Merton Adult Increased employment OPE expertise Reduced and enterprise Carers intermediate care Programme Director Increased use of Community voluntary sector beds and PMO and Transport employmen: **ESOL** groups Increased community Community Design PM services cohesion and decrease Local businesses Primary Care in crime Reduced Improved use of Work-streams Social Prescribing entrepreneurs, admission to Community and Pharmacy investors primary care residential and voluntary sector One Public Estate Arts & craft- including People with nursing care co-ownership, CAMHS T1-3 Clinicians, providers performing arts LTCs Reduced A&E and customer-owners attendance Child development Children and Communications teams Nursery & Crèche services families Reduced use External financial and dependence Library Services Reduced expertise on social care Young People HARI Alignment of commissioning hospital Fundraiser Community Café/ admissions and CIC/ Charitable entity/ kitchen Older people Adult mental health readmissions SPV Reduction in Increased services **OPE** funding Peer Support and childhood and Qualifications, adult obesity befriending mental ill-health NHS Properties-CHP Increased Substance misuse Training, services **Nork Experience** discharge Attracting talent to Community (sensory) People with Volunteering Community capital and Merton garden revenue funds Reduction ir Workforce misuse Cardiac and Architects and planners DTOC Lifestyle Services pulmonary rehab including stop smoking Wilson site People with Increased community and voluntary sector London Fire Brigade dementia **Falls Prevention** Community Therapies

People with

disabilities

### **Assumptions**

That there will be on-going political, senior leadership and community support for the project (given it is complex, challenging and long term)

MSK, outpatient,

physiotherapy and

podiatry

Consultation and t/t

Diagnostics X-ray,

ultrasound, echo, ECG

- That it will be possible to generate the capital funds required for the Community Campus, and a sustainable and viable business/ financial model is feasible for revenue generation
- That the OPE feasibility study will present opportunities to optimise the utilisation of public sector assets to deliver a sustainable financial position but even more importantly, as a vehicle for integrating and transforming services to work together in innovative and more effective ways

#### **SWOT** analysis

- Strong leadership and political support
- Dedicated roles to take the work forward
- Experienced programme management
- Robust governance arrangements
- Strong partnerships and networks
- Vibrant and diverse voluntary sector
- OPE funding and support
- In-house expertise in defined areas (E&R, PH, CCG- clinical and commissioning)
- Local policies and frameworks Prevention framework, HiAP and STP
- Social Prescribing pilot

community design

capacities

Weaknesses

Supportive community health service provider

Inadequate expertise in fundraising and

Communications plan and comms capacity

Voluntary sector and community not set-up

for co-ownership and funding vehicle and this

financial processes/ models for the

Limited staff available and stretched

capacity needs to be developed

#### **Opportunities**

Better integration across care pathways and outcomes based commissioning

Sports & leisure;

active green spaces

Community hall. functional rooms/

spaces

- Pooled budgets and savings across the sector
- Build community capacity and increase sustainability of services and facilities
- New model of care that is a catalyst for wider transformation
- Optimising One Public Estate, releasing revenue
- Improving the local economy by creating business, employment, volunteering and training opportunities

#### Threats

- Planning application failure or delays
- Delays in the programme might make it no longer feasible
- Failure to find capital and revenue streams for the community design
- Political and public support lost, especially if public communications and engagement are not effective
- Decant of clinical services to suitable locations
- Void spaces
- Access to the site not easy

#### Vision statement

Our Vision is to work with the people of East Merton with the 'whole person' at the centre of, and active in, their own care; helping them to connect and come together to create a healthier, stronger and more resilient 'whole community' which will be empowered, educated in and fully engaged with the 'whole health and wellbeing system' locally.

Integrated care pathways and services

Increased workplace wellbeing Increased knowledge sharing and best

Earlier detection and management of long

#### **Corporate Goals**

Co-ownership

Commitment to quality

Health AND wellbeing

Better care closer to home

# **Operational principles**

- Social model of health and wellbeing
- Relationships and co-production
- Community control Integration across care pathways
- Alignment of commissioning plans and strategies
- Signs of safety model in child protection
- Maximizing impact within resources
- Mutuality
- Adaptive and flexible
- Improving access
- Form follows function

#### Strategic Alignments

- Merton Health and Wellbeing strategy
- Better Care Fund
- MCCG vision and strategy
- Merton Prevention Framework Merton Voluntary Sector Strategy
- Merton State of the sector report
- SW London Sustainability and
- Transformation Plan NHS Five Year Forward View
- National Childhood Obesity Plan for Action
- No Health Without Mental Health

## Core concepts/ values

- Customer-owner
- Whole person, whole community, whole health and wellbeing system
- Think family
- Children's and Young People's voice
- Learn and grow
- Understand
- Engage and Listen
- **Embrace diversity**
- Share
- Stories and history are important
- Dignity, honour and respect
  - Inclusive and non-judgemental
- Art of the impossible