Committee: Health and Wellbeing Board

Date: 1 October 2013

Agenda item: 6

Wards: All

Subject: Integrated Care

Lead officer: Simon Williams

Lead member: Councillor Linda Kirby

Forward Plan reference number:

Contact officer: Clarissa Larsen

Recommendations:

A **To note the progress on the Integrated Care work programme.**

---

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report summarises progress to date in integrating services for older people with long term conditions

2 DETAILS

2.1 Merton has established integrated care arrangements for some years among several care groups: children, learning disabilities, mental health, specialist dementia, and substance misuse.

Progress has been somewhat slower for older people, partly because the two-borough PCT Sutton and Merton had some difficulty working with two separate boroughs to achieve this.

2.2 With the creation of a Merton specific Clinical Commissioning Group from April 2013, this has given an opportunity to review arrangements and to make a fresh start.

The benefits for integration are now being set out frequently on a national basis: a better experience for patients, and better use of shared resources between health and social care partners.

2.3 In February 2013 there was a high level meeting between the Chief Executives and Medical Directors of the following organisations:

- Merton Council
- Merton Clinical Commissioning Group

- Sutton and Merton Community Services (part of the Marsden Foundation Trust)
- St Georges NHS Trust
- Epsom and St Helier NHS Trust
- Kingston Hospital Foundation Trust
- South West London and St Georges NHS Trust

2.4 This summit meeting concluded that there should be a pilot integrated care project for older people with long term conditions, with the following objectives:

- Reductions in non-elective admissions to the acute hospitals
- Reductions in lengths of stay in acute hospitals
- Reductions in admissions to residential care and nursing homes
- Improvements in the experience and satisfaction levels of patients

2.5 Following this a project board was set up to take this work forward, consisting of directors from all seven of these organisations. The board has met monthly since then.

2.6 The work has been supported by the Office of Public Management, funded by the Local Government Association and NHS England as part of a systems leadership programme across the country.

2.7 A user consultation event held in July pinpointed the things that users felt would 'make care brilliant' – including:

- Users and carers at the centre of care
- A care-plan for each patient - shared with the service user and carer
- Speedy, reliable services
- More joined up services and information
- Rapid response to crises - and follow-up - preventing hospital admissions
- Better care and better co-ordination across hospitals, mental heath and community services and from GPs.

2.8 The main area of progress to date is the establishment of a shared approach to assessment and planning for individual patients. The council, CCG and community services have agreed to form three geographically based locality teams, with each locality broadly reflecting the catchment area of the three acute Trusts. Locality teams will include GPs and primary care staff, community health staff such as district nurses and therapists, and council staff mainly social workers and occupational therapists.

The council has already seconded three staff into the roles of locality workers from the social care side, and these workers are already working with GPs and community staff for patients identified so far.

Within each locality a sample of patients will be chosen after risk assessment: these will be people with two or more long term conditions including dementia who are also high users of health and/or social care resources. For these patients there will be a care plan jointly drawn up by the patient, carer and a 'key worker' who will be responsible for negotiating with different agencies and making sure that care matches individual needs.

The care plan will set out the patient's aspirations and goals, preferences and how they want to be treated, and will include self-management advice, advice to all the professionals involved and agreements about what to do in an emergency.

2.9 We will be 'test-driving' the new approach with a "simulation event" in the autumn, involving patients, carers, GPs, social workers and other front-line staff – and the approach will be implemented in stages, - trying things out, learning from what goes well and putting right things that go wrong – tweaking the design as we go.

A key element of the new approach will be making sure that staff work effectively together, build friendly relationships and have the confidence to solve problems rather than hiding behind professional boundaries.

We will be training a multi-disciplinary group of professionals to work in new ways.

2.10 We also recognise that the voluntary and community sector is a vital part of the support system for older and frail people, and want to ensure that doctors and social workers are fully aware of what the community sector can offer. A user and carer involvement strategy is being put in place, involving users and carers at every stage, and we will welcome feedback, advice and ideas throughout the pilot.

2.11 We expect the training and simulation to take place in November, following which the new arrangements will go live. We have not put in place organisational re-organisation or merger in advance of this, in the belief that this would delay the start significantly and that it is better to begin with integration at the front line and see if this in turn demands organisational change. We have also not at this stage been able to co-locate staff in these three teams: this is a longer term aspiration but again we believe that it is possible to begin without this.

2.12 Alongside these three locality teams we also expect to re-design some of our community provider services, with an aim of creating an integrated rapid response to the most common causes of community "break down" leading to hospital or care home admissions and to the imperative of timely hospital discharge. At this stage OPM are conducting a study into the various services and responses in the community, with a view to then harmonising or even combining services.

3 ALTERNATIVE OPTIONS

Not to integrate services in these areas. This would not be meeting national and local aspirations for improved patient experience and efficiency in the system

4 CONSULTATION UNDERTAKEN OR PROPOSED

Consultation is taking place with patients as described above

5 TIMETABLE

It is intended to go live with the new arrangements, on the basis of a pilot from which we can all learn and adapt, in December 2013.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

NONE FOR THE PURPOSE OF THIS REPORT

7 LEGAL AND STATUTORY IMPLICATIONS

NONE FOR THE PURPOSE OF THIS REPORT

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

NONE FOR THE PURPOSE OF THIS REPORT

9 CRIME AND DISORDER IMPLICATIONS

NONE FOR THE PURPOSE OF THIS REPORT

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

NONE FOR THE PURPOSE OF THIS REPORT

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

NONE

12 BACKGROUND PAPERS

NONE