Committee: Health and Wellbeing Board

Date: 28 January 2014

Wards: All

Subject: HWB Strategy Priority 3 – Update on Progress

Lead officer: Eleanor Brown, Chief Officer, Merton CCG

Lead clinician: Dr Howard Freeman, Chair, Merton CCG

Forward Plan reference number:

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Recommendations:

A. To note and consider progress on the development and delivery of the Health and Wellbeing Strategy Priority 3: Enabling people to manage their own health and wellbeing as independently as possible.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to update the Health and Wellbeing Board on progress on the delivery of the Health and Wellbeing Strategy Priority 3: Enabling people to manage their own health and wellbeing as independently as possible.

The report sets out the context and priorities within the Strategy and outlines current progress on priorities and next steps for delivery.

2 DETAILS

2.1 Introduction

Merton Health and Wellbeing Strategy 2013/14 includes Priority 3: Enabling people to manage their own health and wellbeing as independently as possible.

The Strategy includes a commitment to further strengthen our partnership approach to preventative strategies.

This report summarises progress to date for HWB Strategy Priority 3

3 PRIORITY 3

Introduction

More people than ever before live with one or more chronic health conditions. Through helping people to manage their own health and wellbeing as independently as possible, we aim to improve the quality of life for people living with health conditions and to help them to live in their own homes as long as possible.

People with long term conditions and those with learning disabilities are intensive users of health and social care services. This has major implications for resources in a time of significant financial pressure. It also means there is a greater need than ever for effective community based services and preventative services. Achieving the highest possible standards of care within increasingly scarce resources is a key priority for Merton.

Life expectancy is increasing and the number of older people in Merton is projected to increase, so the number of people with long term conditions is rising and particularly people having two or more conditions. At any age long term conditions can have a significant impact on a person's ability to work and live a full life and stay connected to the community and those who matter to them. This priority has been broken down into 6 key areas

- Improve the health related quality of life and level of control for people with long term conditions
- Enable people with dementia and their carers have access to good quality early diagnosis and the support to live well with dementia.
- Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support for their mental and physical wellbeing.
- Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location.
- Increase the preferred place of care and death for those who need end of life care services.
- Enable people to stay in their own home as long as possible.

As key lead for this area, Merton CCG have undertake a recent review of metrics that are being reported in these areas and is working with partners to refine the appropriate metrics to measure.

OUTCOME 3.1
Improve the health related quality of life and level of control for people with long term conditions

- **Increase the proportion of people effectively supported to manage their own condition**

The integration project has been focussing on ensuring that the new model of care will enable as many people as possible to manage their own condition. The indicator/success measure will need to be reviewed in line with and when

further progress has been made with the Integration Project and LBM's review of the reablement service in the next 6 months

- **Increase the support taken up by carers of people with long term conditions**

  The Ageing Well Programme launched in April 2013 is focusing on support services for carers provided by Carers Support Merton such as Neighbourhood peer support groups/networks; Self-financed activities for carers as respite; Carry on caring workshops; Emotional Support and Coaching. Currently metrics are being developed to be in place by April 2014 to measure success.

- **Improve people's experience of services that support their long term conditions**

  Within the Integration work, user and carer views has been sought and captured on the proposals. This included an insight into the delivery of the model through user and carer views on what brilliant looks like. Through the implementation of the model of care, for example, key worker training, we have focussed on how we can achieve more joined up working, looking in a more holistic and integration way to support people with long term conditions, which should help improve people's experience.

- **Increase the number of GP practices that monitor risk scores for patients to improve clinical outcomes**

  22 of Merton's 25 practices now have access to the risk profiling tool and have received training in its use. The remaining 3 practices are expected to be using the tool before the end of Q3. All practices have signed up to the Enhanced Service to review patients with two or more long term conditions or dementia and where appropriate support these patients through multi-disciplinary team working.

- **Monitor emergency admissions for key long term conditions, measure and compare accident and emergency admissions and monitor unplanned hospital admissions to outpatients.**

  The CCG monitors performance against a range of key indicators including overall emergency admissions. The NHS Outcomes Framework describes two key indicators: unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) and unplanned hospitalisation for acute ambulatory care sensitive conditions (adults). These are monitored monthly and comparisons made between this year's activity and the same time period for the previous year. After initial increases in the first quarter of 2013/14, since the introduction of MDTs and the launch of Community Prevention of Admission (CPAT), the admissions in these areas have started to fall.

OUTCOME 3.2

Enable people with dementia and their carers have access to good quality early diagnosis and the support to live well with dementia.

- **Increase the percentage of people over 65 with a recorded diagnosis of dementia**

  Currently access to dementia services is only via GP referrals. This needs to be reviewed to encourage more self-referral where possible, as well as help to minimize the stigma associated with dementia.

  The local 'Dementia Hub', and the proposed Nelson Health Centre will facilitate greater access to local dementia services including improving rates of diagnosis. Additionally, in order to effectively progress the dementia agenda at a local level, good local working partnerships are being developed, which include GPs and Social Workers, especially to increase awareness raising. Work is also taking place with Alzheimer's Society to establish Dementia Friendly societies. St George's Healthcare Trust also has a commitment to screen 90% of its admitted patients for dementia.

  Further work is required to understand the reasons behind low presentation of ethnic groups with dementia to ensure equity of diagnosis and access to services across the older ethnic population.

- **Improve quality dementia care in a residential setting**

  In December 2012 workshop held with partners including Merton Chamber of Commerce to establish Merton Dementia Action Alliance (MDAA). Work is underway to produce draft workforce strategy by Jan 2014 for the social care workforce in Merton including training and development in improving dementia care for workforce across all partner agencies

- **Improve early identification of carers and development of an early support plan**

  The Alzheimer's Society had been awarded the contract to deliver the pilot Dementia Hub service. It is based at the former Cumberland Day Centre in Mitcham. This has also been successfully awarded the DH dementia friendly environment funding to refurbish it. The service is open to the wider community, not just social care customers. A number of key staff have been recruited now, including 3 support workers, service delivery has a sizeable caseload of customers. The service includes running a Dementia Café, Dementia Support Groups and Singing for the Brain. The Merton Dementia Hub is the base, but service delivery will extend right across the borough through outreach and joint working with the voluntary and health sectors.

OUTCOME 3.3
Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support for their mental and physical wellbeing.

- **Ensure mental health services commissioned are person centred increasing self-defined recovery outcomes**

  A knowledge gap was identified by commissioners in the NHS and the local authority in terms of an accurate and current picture of the need and patterns of usage of mental health services in Merton, the current levels of investment and the outcomes of that investment, and areas for improvement which include an evidence-based basis for commissioning and de-commissioning decisions. Therefore it was decided that an in-depth review of adult mental health services would be the first step in addressing this outcome The review is currently underway.

  The Merton Mental Health Review (MMHR) is a review of adult mental health in the London Borough of Merton from a *health and social care* perspective. The purpose of the MMHR is to ascertain the mental health need of the adult and elderly population in the borough, identify the gaps in service and make recommendations to Merton CCG and the Merton Council, on how to best address these gaps and provide effective and efficient services. It will also consider the possibilities of integrated health and social care commissioning.

  The objectives of the project are as follows:

1. To review national policies and guidelines in order to establish any recommended best practice where relevant.
2. To assess the mental health and social care needs in the Merton population, identifying vulnerable groups, inequalities and inequity (access issues) in the borough- from a mental health and social care perspective, informed by user and carer attitudes, views and experiences.
3. To map the mental health and social care services and support that exists in Merton in terms of public health prevention and health promotion; primary, secondary and urgent/emergency care; community care and non-health/ social care, and identify if there are any gaps in provision.
4. To review mental health and social care expenditure and mental health outcomes, in order to construct a prioritised list of areas for investment and disinvestment, keeping in mind the need of Merton population and the user and carer perspectives.
5. To make recommendations on commissioning more effective and cost effective services, feeding these recommendations into the commissioning cycles of both the Merton CCG and the Merton Council.

6. To develop an Adult Mental Health Strategy for Merton.

The progress to date on this is as follows:
The first stage in the process is a mental health needs assessment (HNA) which is targeted for completion by the end of this year.

The HNA includes three components:

- A literature review of the current evidence and policies- this is currently at the half way stage
- A qualitative research component- to explore through focus groups and semi-structured interviews, the views, perspectives and experiences of mental health service users, their carers and providers. 31 informants were interviewed and the data was collated and analysed. This component is now complete and the final report is being written.
- An epidemiological analysis- locally collected and nationally available data are quantitatively analysed using statistical methods, to obtain an accurate picture of the need, scale of demand and the utilisation of services in Merton.

OUTCOME 3.4
Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location.

- **Improve timely access to good quality diagnosis treatment and care through the development and delivery of Local Care Centres**

The Nelson LCC is on track to be open by March 2015. The stakeholder map has now been developed and the next phase of the communications plan will involve very detailed stakeholders sessions with interested parties within Merton. A strategic outline business case is being developed for Mitcham health services and it is planned that this will be in place for the end of January 2014. The Health Needs Assessment is underway by Public Health and will indicate the appropriate services that should be in place in this locality.

OUTCOME 3.5
Enable people to stay in their own home as long as possible.

- **Deliver good quality effective Reablement and rehabilitation support following discharge from hospital which is flexible and where required specialist**

  LBM is currently undertaking a review of the reablement service. This is set to be completed by end of December 2013 and will inform the further work on this outcome area.

- **Deliver three year preventative plan in partnership with the voluntary sector – Ageing Well**

  The Adult Social Care Ageing Well Programme was launched on 30 April 2013. The key features of the programme are:

  - Enabling people to live for longer in their own homes and delaying or reducing spend on Council funded social care
  - Based on the evidence of triggers that cause people to go into care homes – such as incontinence, dementia, isolation, loss of mobility, and depression/anxiety.
  - It is outcomes-focused and takes an asset based approach
  - Building social connectedness - instead of relying on services which keep older people segregated from others, it actively encourages people to mix
  - Promotion of stronger local neighbourhoods and putting older people in touch with local people and opportunities
  - Its effectiveness will be measured by a set of metrics - a combination of inputs by voluntary groups, individuals or objective assessment of "wellbeing" among older people against certain key factors and whether the services are actually having a "preventive" effect
  - Cross-borough coverage for outcomes, whether by one organisation or through collaboration between organisations
  - Consultations with older people on what they actually want

  The services funded by the Ageing Well Programme are:

  - **Age UK Merton** – Life After Stroke; Continence awareness and support service
  - **Carers Support Merton** - Neighbourhood peer support groups/networks; Self-financed activities for carers as respite; Carry on caring workshops; Emotional Support and Coaching.
  - **Merton & Morden Guild of Social Service** - 'Fit for Life' exercise programme; Falls prevention programme; Opportunities for volunteering
  - **Merton Community Transport** - Volunteer community car service
  - **Merton Mencap** – 'Evolutions' support service for non-FACs eligible people with autism; Activities club and carers community advice service
  - **Merton Vision** - Buddying programme, emotional support and counselling, training to use equipment

- **Volunteer Centre Merton** - Supported Volunteering Programme for mental health service users and people with learning disabilities, physical or sensory disabilities
- **Wimbledon Guild of Social Welfare** - Community coaching sessions; menu of services; informal drop-in café

OUTCOME 3.6
Increase the preferred place of care and death for those who need end of life care services.

- **Raise awareness of options for care and place of death and dying across our population**
  A new Service Specification for the Community End of Life Nursing Service has been drawn up and agreed with the service provider. This includes the requirement for each Nurse to be responsible for named Nursing Homes and GP Practices to provide education and support in advance care planning and to facilitate patients achieving their preferred place of care and death. In addition, the specification also requires the service to participate in health promotion and education to patients and members of the public to raise awareness around End of Life Care.

  A joint proposal put together in conjunction with Sutton CCG and St Raphaels Hospice, to provide training to Care Home and Nursing Home staff to improve the quality of care for people who are thought to be in the last year of life, won funding from the South London Health Innovation Network and is now being delivered.

- **Raise awareness of Co-ordinate My Care register and increase the number of people on the register**
  The End of Life Care LES, which supports Practices to raise awareness of, and register patients with, Co-ordinate My Care, has been rolled over from 2012/13. 50% of Practices have now signed up to deliver this service.

  The new Community End of Life Nursing Service Specification includes the requirement for the team to monitor and support the use of Co-ordinate My Care in the Nursing Homes for which they are each responsible.

  The most recent Co-ordinate My Care report (August 2013) shows that 990 Merton CCG patients are registered on Co-ordinate My Care, and that 72 patients had been registered in the previous month.

4. ALTERNATIVE OPTIONS

None for the purpose of this report.

5. CONSULTATIONS UNDERTAKEN OR PROPOSED

None for the purpose of this report.

6. TIMETABLE

As set out in the report.

7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Costs of the MP Conference were managed within existing budgets.

8. LEGAL AND STATUTORY IMPLICATIONS

None for the purpose of this report.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

None for the purpose of this report.

10 CRIME AND DISORDER IMPLICATIONS

None for the purpose of this report.

11 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 for the purpose of this report.

12 BACKGROUND PAPERS

None for the purpose of this report.

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