Update 18.11.13

Delivery Plan - Priority theme 3: Enabling people to manage their own health as independently as possible (Progress at November 2013)

Lead Delivery Partner: One Merton Group

High Level Dashboard–do we want to include 1 high level indicator per outcome – in the same way the Merton Partnership monitors outcomes??

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Outcome 3.1:Improve health related quality of life for people with long term conditions (CCG Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Progress to date**	**Lead**
1. Increase the proportion of people effectively supported to manage their own condition	• Implement new pathway for direct access to reablement services for people with LTCs • Implement a multi-disciplinary model of case management and risk stratification for people with LTCs	• Number of GP referrals to reablement Baseline: 0 (no current direct referral pathway) • Number of people with LTC managed through multi-disciplinary case management system. Baseline: 0 No trajectory set for first year as a pilot.	A pathway to enable direct referrals from primary care to the Local Authority Reablement service has been agreed in principle. Stage 1 of the pathway, the establishment of a Community Prevention of Admission Team (CPAT), started formally on 1st October. A review of reablement and rehabilitation services has taken place, following which we expect a date for accessing reablement services through the CPAT team to be agreed. This has been established in most GP practices. Awaiting Enhanced Services returns from all practices to confirm numbers managed through a multi-disciplinary case management system.	LBM
2. Increase the support taken up by carers	•Develop and implement programmes and individual	• Increase in number of carers enabled to provide support	We are continuing to work with Carer's Support Merton to increase awareness of support available to carers.	LBM

of people with long term conditions	support for carers			
3. Improve people's experience of services that support their long term conditions	• Introduction of systematic arrangements for analysis of Practice feedback collected Practice Participation Groups • Option to implement Patient Reported Outcome Measure as a CQUIN within SMCS services contract for 2013-14.	• Quarter by quarter increase in number of people with a positive experience of care for LTCs in primary and community services from Q1 2013/14 baseline	Most GP practices have signed up to a Direct Enhanced Service to deliver this. The GP practices undertake patient surveys in areas identified by their Practice Participation Groups and results are published on the GP practice's own websites. Due to the timings of agreeing the CQUIN in 2013/14 it was not possible to include this. However the 2014/15 CQUIN arrangements are about to be drawn up and so this will be considered as part of the discussions.	CCG
4. Increase the number of GP practices that monitor risk scores for patients to improve clinical outcomes	• Roll out risk stratification tool.	• Quarter by quarter increase in the number of GP practices using the tool, based on Q1 2013/14 baseline	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 support this.	CCG
5. Monitor emergency admissions for key long term conditions, measure and compare accident and emergency admissions and monitor	• Implement urgent care at home scheme	• CCG Outcomes indicator: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) Baseline: TBC	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	CCG

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unplanned hospital admissions.			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. Urgent care at home scheme was implemented but has now been decommissioned as it was not proving cost effective. CPAT may be able to deliver this in the future.	
Outcome 3.2 :Enable people with dementia and their carers to have access to good quality, early diagnosis and support (LA Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Progress to date**	**Lead**
1. Increase the percentage of people over 65 with a recorded diagnosis of dementia	• Improved access to memory clinic and increased screening in primary care	• Numbers of people newly diagnosed with dementia Baseline: TBC	Screening: 90% of patients admitted at St George's to be screened. Screening in primary care is being progressed	• CCG Dementia Lead
2. Improve quality dementia care in a residential setting	• Consultation on local Dementia Care & Support Compact (March 2013)	• Extent of signatures to Compact	This work will be addressed as part of the Jt Commissioning Strategy 2010-2015. Numbers to be obtained from LA Dementia Programme Lead	• LBM Commissi oner
3. Improve early identification of carers and development of an early support plan	• Early identification on diagnosis • Early support plan via Dementia Hub (April 2013)	• Numbers of carers identified • Numbers of carers using Hub	This work will be addressed as part of the Jt Commissioning Strategy 2010-2015. Numbers to be obtained from LA Dementia Programme Lead	• CCG/ LBM Commissi oning
Outcome 3.3:Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support				

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(LA Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Progress to date**	**Lead**
1. Ensure mental health services commissioned are person centred increasing self-defined recovery outcomes	1. An audit of care plans for people on CPA to show evidence of recovery focussed plan. 2.People on CPA have 2 self-defined recovery outcomes recorded on care plans.	1. An audit of care plans is conducted. 2. More than 50% of people have 2 self-defined recovery outcomes.	These were part of the 2012/13 CQUIN and the Trust and Merton fully achieved this CQUIN. These are not part of the 2012/14 CQUIN, but the M7 is: 1. Audit of care plans was completed last year 2. Currently 65% of people have 2 self-defined recovery outcomes	CCG
2. Improve integrated working between primary and secondary care to ensure physical health care needs are met with regular physical health assessments by GPs of mental health service users	1. CPA register shared with primary care. 2. People on CPA to have had a physical health assessment by GP within the last 12 months.	1. Register shared twice a year. 2. More than 75% of all people on CPA to have had assessment.	These were part of the 2012/13 CQUIN and the Trust and Merton fully achieved this CQUIN. These are not part of the 2012/14 CQUIN, but the M7 is: 1. The register has not been shared this year as it is not a CQUIN requirement. However, CPA clients are discussed between the GP and Trust consultants in the regular link meetings 2. Currently 82% of CPA clients have had a GP physical health assessment in Sutton and Merton	CCG
3. Improve	1. Discharge summaries to be	1. 95% compliance	These were part of the 2012/13 CQUIN and the	CCG

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communication between primary and secondary care to ensure mental and physical health outcomes with discharge summaries and care planning reviews are sent promptly to GPs	sent to GPs within 7 days of discharge. 2. CPA outcome review letter to be sent to GP within 2 weeks of CPA review.	2. 95% compliance	Trust and Merton fully achieved this CQUIN. These are not part of the 2012/14 CQUIN, but the M7 is: 1. 97% of inpatient discharge summaries sent within 7 days 2. 79% of CPA review letters are sent within 7 days	
4. Improve access to MH services to enable early diagnosis	1. Improving information on Merton-i. 2. LINk/Healthwatch to hold an event on looking at gaps in MH services. Referral awareness in regard to signposting to most appropriate service.	1. More information stored on Merton Eye and more hits on website. 2. Clear feedback on gaps and next steps action plan. Increase to 50% recovery rate following referral to IAPT. Baseline: TBC	Trust is meeting with the commissioners to identify the resources and actions to meet the 50% target by April 2015	1. LBM 2.LINk/Health watch CCG
5. Improve physical health of those with secondary	Ensure appropriate care setting for those with secondary physical health problems.	Increase in appropriate setting to treat those with secondary physical health problems.	Currently 82% of CPA clients have had a GP physical health assessment in Sutton and Merton. 91% of CPA clients have the primary care QOF diagnosis recorded in their notes	CCG

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health needs				
6. Raise the visibility of the role and contribution of mental health carers	Consultation on compact for local mental health carers.	Numbers of signatures on compact Carers assessments.	Currently 33% of identified carers been assessed in the last 12 months. Merton has very good identification of carers	LINK/ Healthwatch

Outcome 3.4:Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location (CCG Lead)

Key actions	**Milestones**	**Indicator/success measure**	**Progress to date**	**Lead**
1. 1.Improve timely access to good quality diagnosis treatment and care through the development and delivery of Local Care Centres	Development of Local Care Centres at the Nelson and Mitcham	Nelson LCC building works on time with project plan Mitcham LCC development in accordance with project timeline	The Nelson Project Board has now been established. Two visioning events have taken place to gather views on the model of care to be delivered at Nelson LCC. Key elements of this include rapid access to diagnostics as a pathway in its own right as well as to support the rapid access to assessment and treatment of older people and people with complex needs. A new musculo-skeletal pathway has also been proposed forming a Musculoskeletal Clinical Assessment and Treatment Service (MCATS). The outline Business case for Mitcham LCC is currently being drawn up.	CCG

Outcome 3.5:Enable people to stay in their own home as long as possible (LA Lead)

Key actions	**Milestones**	**Indicator/success measure**	**Progress to date**	**Lead**
1. Deliver good quality	A clear reablement pathway understood by multiple	• Number of people helped to stay at home	A review of reablement and rehabilitation services was commissioned and a report has	LBM Reablement

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effective Reablement and rehabilitation support following discharge from hospital which is flexible and where required specialist	providers/agencies/patients and carers.	91 days after discharge	recently been produced. The findings and recommendations from this are currently being considered in order to agree short term and longer terms actions at the next Integration Project Board.	Manager
2. Improve access telecare and telehealthcare	• CCG to confirm pilot project Outcomes for telehealth and telecare	• Numbers of people using Mascot telecare and telehealthcare	Section 256 funding has been used to continue and expand telecare services in Merton. A telehealth pilot for patients with COPD or Heart Failure is planned for this winter.	CCG Commissioner
3. Deliver three year preventative plan in partnership with the voluntary sector – Aging Well	• Announcement of Grant funded projects (January 2013)	• Preventative metrics	LBM have funded Age UK Merton to provide some winter warmth services and Merton CCG are in discussions with Age UK Merton, regarding bidding for some DoH monies to provide some home from hospital services through our Home Services Team.	Head of Commissioning LBM//MVSC
Outcome 3.6:Increase the preferred place of care and death for those who need end of life care services (CCG Lead)				
Key actions	**Milestones**	**Indicator/success measure**	**Progress to date**	**Lead**

1. Raise awareness of options for care and place of death and dying across our population	1. Increase in professionals' and patients' awareness of non-acute EOLC facilities	Increased numbers of people achieving their preferred place of care. Baseline: No form of measuring the total Merton population achieving their preferred place of care exists and therefore the following 2 indicators, taken together, are used: Deaths at home: 34.2% (2012/13 Q2) Patients on CmC who express a preference achieving their Preferred Place of Care (PPC1 or PPC2): No Merton only data was available for 2012/13 but this will be monitored moving forward.	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. Deaths at home: Unfortunately Merton CCG has not yet received this data for 2013/14. Patients on CmC who express a preference achieving their Preferred Place of Care (PPC1 or PPC2): 66% (August 2013)	CCG EOLC Lead
2. Raise awareness of Co-ordinate My Care register and increase the	More people made aware of the register and benefits thereof.	Increasing number of people registered.	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	CCG EOLC Lead

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number of people on the register			Specification includes the requirement for the team to monitor and support the use of CmC in the Nursing Homes for which they are each responsible. The most recent CmC report (August 2013) shows that 990 Merton CCG patients are registered on CmC, and that 72 patients had been registered in the previous month.	

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