Local Government Association

NHS England

Better Care Fund planning template – Part 1

Please note there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Merton**
Clinical Commissioning Groups	**Merton Clinical Commissioning Group**
Boundary Differences	**None significant**
Date agreed at Health and Well-Being Board:	**Main meeting 28th Jan 2014. Agreed by HWB Chair's action 13th Feb 2014**
Date submitted:	**14th Feb 2014 – First Draft**
Minimum required value of ITF pooled budget: 2014/15	**£3,299,000**
2015/16	**£12,198,000**
Total agreed value of pooled budget: 2014/15	**£7,719,000**
2015/16	**£12,198,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Merton Clinical Commissioning Group**
By	Eleanor Brown
Position	Chief Officer
Date	13/01/2014

Signed on behalf of the Council	**London Borough of Merton**
By	Simon Williams
Position	Director of Community and Housing
Date	13/01/2014

Signed on behalf of the Health and Wellbeing Board	**Merton Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Councillor Linda Kirby Cabinet Member for Adult Social Care and Health
Date	13/01/2014

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Introduction

Merton Clinical Commissioning Group (Merton CCG) and the **London Borough of Merton** (LB Merton) realise the opportunity that joint commissioning and the Better Care Fund can provide; To meet the health and social care needs of the local population in an integrated and shared way. This Better Care Fund Plan (BCF Plan) details our commitment to joint working, the approach we have taken, and ultimately how the changes and expansion to services which benefit our population align with our population needs (as addressed in our local JSNA and Health and Wellbeing strategy).

For Merton CCG the Better Care Fund plan and the implementation of the service changes and schemes, forms the core of a wider 2-year operational plan linking with our key delivery areas as well as the vision and strategy for south west London as outlined in our 5-year strategic plan.

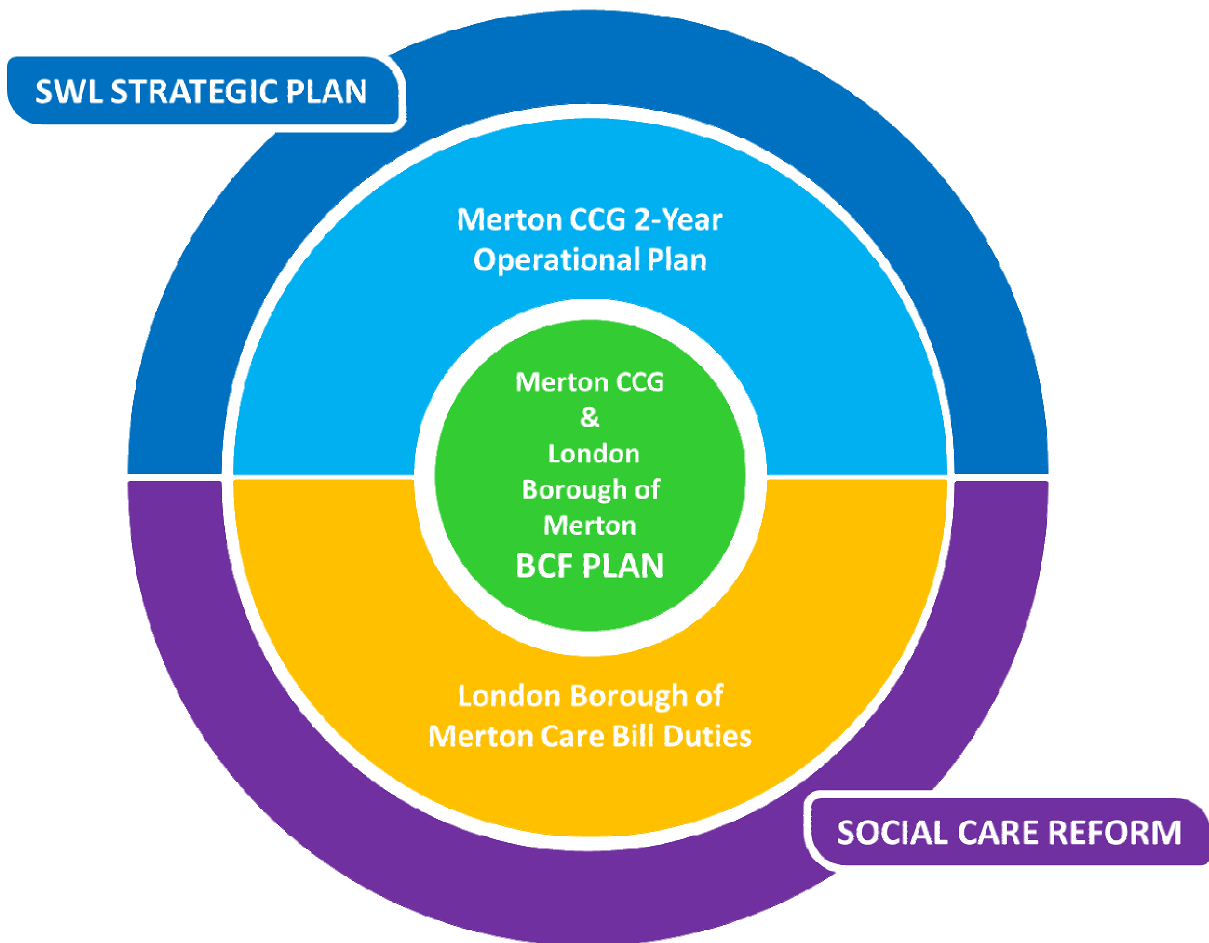
As outlined in Merton CCG's 2-year operational plan our key delivery areas which align with our BCF plan include:

1. Older and Vulnerable Adults
2. Mental Health
3. Keeping Healthy and Well
4. Early Detection and Management
5. Urgent Care
6. Children and Maternity

Merton CCG is committed to focussing efforts on a wider transformational service redesign which will deliver a financially sustainable health system over 2 years. Merton CCG has recognised that a sustainable health system can only be achieved in partnership across our health and social care economy.

Similarly the London Borough of Merton realises that the Better Care Fund is a key area which compliments the central objectives of the Social Care Reform. The London Borough of Merton also recognises that following on from consecutive years of significant spending cuts and now the new statutory duties to be met through the Care Bill, commissioning in isolation will not meet the borough's social care needs.

Both organisations have demonstrated their commitment to integrated commissioning since as early as 2010, the London Borough of Merton and commissioners established the first One Merton Group. In 2012 we decided in partnership with the London Borough of Merton and our service providers, to set up our **Integrated Care Project**. In the past we have taken a Merton health and social care have taken a joint commissioning approach with some of service areas and have seen great gains; with long established polled budgets and partnerships in learning disabilities, mental health and children's, schools and families.



The Merton Integrated Care Project Board has reported progress on a quarterly basis for the past 12 months at the Health and Wellbeing Board (HWB). Four members of the Health and Wellbeing Board are also members of the Integrated Care Project Board to ensure that there is a direct communication between both groups. This has complimented our discussions, work and future strategy for our Health and Wellbeing Board, who have helped to steer the direction of our plans, and have endorsed these plans both in principle and in commitment to deliver our vision and objectives in partnership. Therefore this plan has been developed and signed by LB Merton and the CCG. Fundamentally, this Better Care Fund plan aligns with the needs of the population as identified in Merton's JSNA and HWB Strategy.

In summary, the BCF plan and subsequent implementation is integral to the commissioning intentions and overall strategy for both Merton CCG and the London Borough of Merton. We consider the Better Care Fund as a catalyst to delivering integrated care. Overall the Better Care Fund is an opportunity for us to address the greatest health and social care challenges in Merton jointly, in alliance with our Health and Wellbeing Board and other stakeholders such as community service, acute service providers, third sector providers and most importantly our service users.

a) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it.

Engaging with our health and social care providers

Our approach to service provider engagement

Merton CCG and LB Merton have been progressive in their approach in engaging and involving service providers in how services should be developed and redesigned to meet the integration agenda and meet the rising demand for health and social care. Given that Merton as a locality does not host an acute provider and shares a community provider with Sutton, a complex multi-stakeholder environment results creating even more weight to ensuring that health and social care providers are involved in parallel with designing services. Whilst commissioners in Merton will provide the momentum, strategy and framework for service-level change, Merton CCG and LB Merton are acutely aware that service providers bring good insight into frontline issues and solutions. In addition it is recognised that workforce planning and step-changes in multi-professional working across health and social care organisational boundaries, can only be overcome through a carefully managed and ongoing engagement between commissioners and providers.

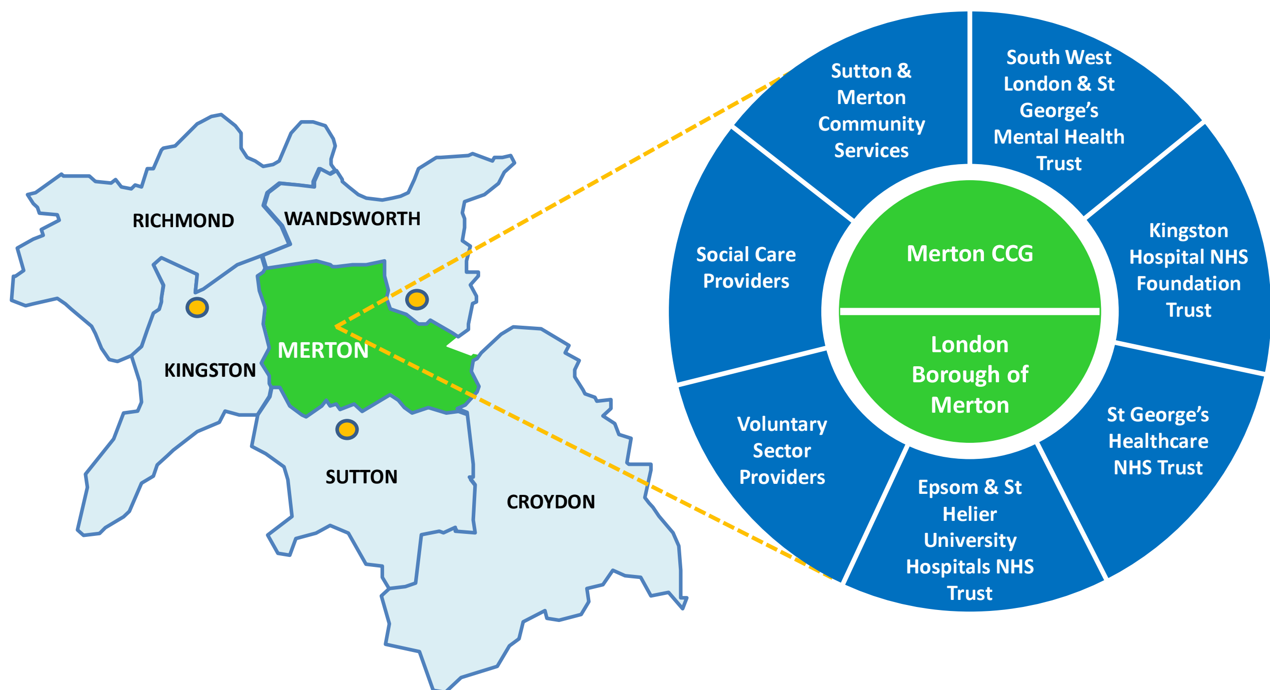


Figure 1: South West London locality map and the seven providers engaged with Merton commissioners

In response to increasing pressures and in anticipation of a general policy direction, in February of 2013 Chief Executives and Medical Directors of the commissioning and major provider organisations in Merton met at their own Integrated Care Summit. In consensus the principle of integration was agreed, with a particular focus on creating

fully integrated care for people with long term complex conditions. To prime our effort an **integrated project board** of Executive Directors from each of the organisations was set up to take forward this work in partnership. It was agreed that services would be co-designed through this consultation process, with commissioners leading the financial envelope and commissioning intentions for services. **The principles for co-design of integrated services** are reflected in both the intentions of commissioners and the plans and outcomes generated from the integrated project board. These are:

- THE USER AND CARER AT THE CENTRE OF SERVICE DESIGN
- OUTPUTS WILL BE ACTION-ORIENTATED AND EVIDENCE-BASED
- EVOLVING AND LEARNING FROM PRACTICE AND WILLING TO CHANGE
- USE COST-EFFECTIVE SOLUTIONS AVOIDING VAST UP-FRONT INVESTMENT
- BULID COMMUNITY CAPACITY AND ENCOURAGING SELF-MANAGEMENT
- LEARNING FROM AND ENGAGING WITH THE VOLUNTARY AND COMMUNITY SECTOR

The project board has met monthly since formation and has been supported by the Office of Public Management (professional services consultancy) funded by the LGA and NHSE as part of a systems leadership programme across the country. The project is being supported by a jointly appointed Integrated Care Project Director since December 2013. The board has held design workshops involving senior and frontline staff from all seven organisations, users, carers and voluntary sector colleagues. This workforce-level engagement has also included GPs and social workers, all working together to design a new approach to meeting care needs without professional or organisational boundaries. This has included joint training events to address the role of the 'key worker' in integrated service models. Merton's recognises the importance of leadership, and the right approach from clinicians and staff in all organisations.

Since formation the integrated project board has engaged to identify four priority objectives to deliver upon. These are:

1. REDUCING (GROWTH OF) EMERGENCY ADMISSIONS
2. REDUCING LENGTH OF HOSPITAL STAY
3. REDUCING PERMANENT ADMISSIONS TO CARE HOMES
4. IMPROVING SERVICE USER & CARER EXPERIENCE

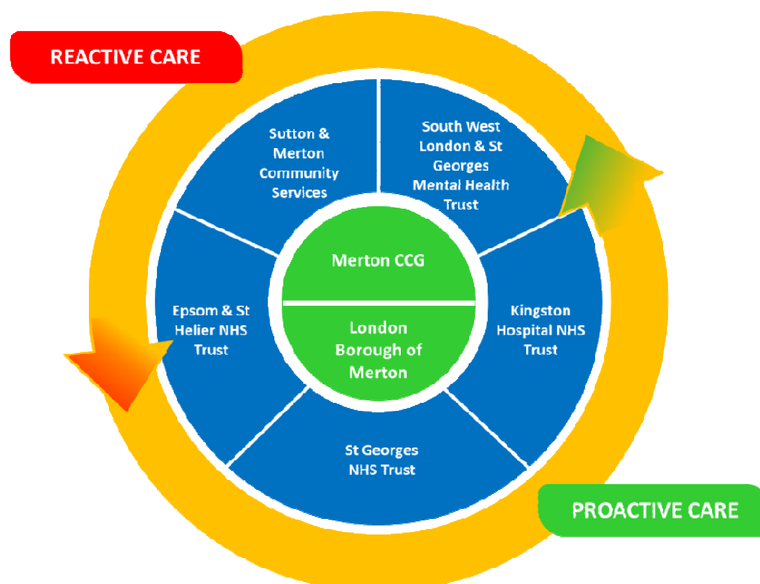
These four objectives have been identified as overall benefiting all stakeholders in the health and social care economy and ensuring that integrated service models are sustainable and future-proof. The project board identified that in order to meet these objectives collectively the integrated service models approach needed to meet the growing pressure on services, and the health and social care economy as a whole. In particular clinical and service leads identified that services should be designed to:

1. The proactive care approach

Keep people out of acute services and in the community preventing unnecessary contact with acute services and promoting better care in the community and primary care, in order to reduce the likelihood of requiring acute services.

2. The reactive care approach

Reduce likelihood of avoidable emergency admission in times of deterioration or crises by ensuring that appropriate and responsive care and support is available in the community, including access to specialist care. In addition, reduce service users' length of stay in acute services, encouraging a smooth discharge with appropriate support in the community to deliver high quality care, promote rehabilitation and reablement, preventing readmission into acute services or subsequent admission into care homes.



All stakeholders are committed to the Proactive and Reactive Care approaches. Consequently the BCF scheme and the redirection of investment to expand or implement new integrated services seek to address these approaches.

b) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our patient, service user and public engagement progress and plan

As part of the process of designing a new approach to integrated care in Merton, we have held a number of events which have included consulting and engaging staff, clinicians, the voluntary sector, service users and carers.

Users and carers have been involved from the early stages in the design of our integration project, and an evolved learning approach is one our guiding principles which underpins the way we design integrated care.

Engagement activities

The following activities took place to engage patients, service users and the public in the development and design of integrated services:

Date	Major Events
August 2013	**Event 1: 'What would brilliant look like?'** We held this event with users and carers as well as the voluntary sector to identify what would define a brilliant integrated care system in Merton. Feedback and suggestions from this event were captured and this input has been used to develop the local model.
October 2013	**Event 2: Engage Merton** We ran an event called 'Engage Merton' in partnership with HealthWatch Merton. Patients, members of the public, service users, carers, clinicians and other stakeholders were involved in discussions about the Commissioning Intentions for 2014-2015 and the Engagement Strategy and Implementation Plan for 2013-2015. The findings from the event enabled us to set priorities, form Commissioning Plans and develop an Engagement Strategy. The event identified 'seldom heard' groups including, housing associations, individuals from the traveller community, members of the public without internet access, amongst many others, and developed ideas for engaging with these groups going forward. Feedback also provided us with greater insight into how the voluntary sector can support the integration agenda in Merton. This can be seen in Appendix 1.
November 2013	**Integrated Care Model Simulation** We ran a simulation of the process, involving service users and carers, GPs, social workers, clinicians as well as managers from acute hospitals, community and mental health providers. During the simulation a group of service users and carer acted as advisors to each of the professionals who were playing the role of a 'key worker.' They

	were also part of a group participating as voluntary and community groups. This event helped to test the 'Merton model', acted as a learning event for professional development, and gained knowledge from the perspectives of all the people who were involved.

In addition to our events we have completed the following:

- We have been developing and drafting guidance for key workers and the multi-disciplinary teams based on learning from our simulation and training event. We have welcomed comments and suggestions for improving guidance which we expect to develop as learning progresses.
- A place has been available for a voluntary sector representative on the Project Board; however Merton Voluntary Service Council has been unable to take this up during an inter-regnum. Their interim Chief Officer will join the Project Board at its March meeting.
- We are partners to and support the Merton Compact.

Planning our future engagements with the public, service users and patients

The following activities are planned in order to ensure that there is continued engagement from our local community:

- Health-watch has offered to create a user-friendly way to signpost health and social care colleagues to the range of activities within the voluntary sector, and we plan to pursue this. They are also supporting us with two events to include the views of patients in the Merton which are scheduled for March
- Users and carers made the important point at our simulation event that for many isolated older or frail people, being asked to contribute and take part in activities that help others, offers a real sense of purpose and dignity that has a direct effect on mental and physical health. We will have to develop a mechanism to take this forward, through our continued engagement with our community
- Feedback from our simulation and key worker training was that a care plan should empower the user and enable them to see who else is involved in their care. We plan to ensure service users are involved in the testing of these care plans, through a pilot scheme
- Merton community mental health services already have an excellent model of MDT working and care planning which the integration project will build on
- Our events have highlighted the issue of information governance, information sharing and patient consent. We plan to develop a clear and easy to understand process for this in conjunction with patients and service users, and embed this into our PPI work stream reporting to the ICPB
- Continue to implement the engagement strategy plan which has been informed by patient, public and service user suggestions through our 'Engage Merton' event,

and embed this into our PPI work stream reporting to the ICPB

- LB MERTON is currently reviewing its own structure and engagement processes and expects to consider ideas with partners in March

Our commitment to engaging with the public, service users and patients will be managed by the Patient and Public Involvement (PPI) subgroup who will report into the Integrated Care Project Board (see governance section), who will have the ability and authority to make strategic plans to address any outcomes resulting from engagement. The PPI group will additionally be responsible for bringing together all the stakeholders who need to be involved in planning and monitoring such engagement activities and for reporting the outcomes to parallel subgroups such as the workforce and culture, and operational subgroups.

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Merton Engage Event Summary	Appendix 1
CCG QIPP plan	Appendix 2
Terms of Reference for ICPB	Appendix 3
7 Day Working	Appendix 4
Risk Stratification Guidance for GPs	Appendix 5

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Health needs and inequalities to be addressed in Merton

The population of Merton is young in comparison with the rest of England. Over 65 year-olds make up just under 12% of the population, projected to increase by 21% by 2021. The numbers of 85 year-olds and over is set to rise by nearly 41%, however.

In 2011, 35% of the population were from BAME groups (Black, Asian and Minority Ethnic). The extent of ethnic diversity has increased markedly over the last 5-10 years with new emerging communities; Polish, Urdu and Tamil communities; and is expected to rise over the next 10-20 years. The level of ethnic diversity across Merton is recognised to increase the complexity of delivering services in the following ways:

- Wider and diverse range of long-term conditions and complexity of need such as rates of smoking, obesity, ischaemic heart disease and diabetes
- Diverse needs with respect to accessing care and self-management resources, such as language and cultural barriers
- Care that addresses cultural differences to care such as for mental health conditions including dementia

Deprivation levels are low and residents have a higher life expectancy than the England average. For adults, levels of obesity, smoking and healthy eating are estimated to be better than the England average, although the estimated level of physical activity among adults is worse.

There are however stark inequalities in health and lifestyle within Merton, for example, life expectancy for men living in the least deprived areas of the borough is almost nine years higher than for men living in the most deprived areas. The difference for women is thirteen years. Circulatory disease and cancer are the top reasons for early death and, consequently, circulatory disease (including stroke and cancer plus diabetes) are among the main causes of long-term illness and disability.

Since 2008 there has been an increase in unemployment with 7.8% of residents claiming out-of-work related benefits. This however does remain lows than London and England as a whole. In addition, where people live and the quality of their home has a substantial impact on their health, wellbeing and social outcomes, and there is a high level of

housing needs amongst households in Merton.

In terms of geographical variation, broadly Merton is divided into two localities; East and West Merton, where there are significant variations in age, deprivation, care needs and subsequently life expectancy. In East Merton life expectancy is 9 years lower for males than in West Merton and for women, 13 years. In East Merton, the population is younger, but the needs of the population who are aged 50-65 years is rising. There is therefore a need to **proactively** identify or screen for and preventatively manage care needs and long term conditions. In West Merton, the population is more affluent but is ageing, with rising burden of long term conditions and complex needs. This cohort will likely benefit from **proactive** care, but will also need service which are able to respond **reactively** as this population is more likely to deteriorate escalating to urgent and out-of-hours care needs.

Our vision is to improve health and social care outcomes for the population of Merton by commissioning services tailored to the needs of individual patients whilst addressing the diverse health needs of our population and reducing geographical, age and deprivation-related variation.

Ultimately our vision should deliver ***the right care, at the right time, in the right place with the right outcomes***.

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Mrs Jones' story

Mrs Jones is an 83 year old retired schoolteacher who lives alone and has no relatives living locally. She has had COPD for the past 10 years and has increasing problems with breathlessness and mobility. Over the weekend she develops a cough and fever and then has a fall whilst feeding her cat. She calls the London Ambulance Service who take her to St George's Accident and Emergency department where she is has a full geriatric assessment. This reveals that she has no fractures and access to her GP records helps the team identify that she is suffering from an exacerbation of COPD causing confusion and reduced mobility. This requires treatment with antibiotics and steroids and means she will be less able to look after herself for a period of time. It is agreed that hospital admission is not needed, however Mrs Jones does not feel confident or safe to return home alone. The "in reach" team arrange for her to spend a couple of couple of nights in a "step down" bed under the care of the locality based multi-disciplinary team. She is introduced to the community nurse who will act as her key worker and together they agree a care plan. This includes support from the voluntary sector to ensure her home is warm when she returns and provide domestic support until she is well enough to do this herself. A clinical management plan, aimed to reduce exacerbations and identify any deterioration early, is developed with the help of her GP. Once Mrs Jones is feeling better in her own home the voluntary sector continues to support her by introducing her to an exercise class for older people which helps her maintain her fitness and her mobility and where she makes some new friends.

The vision for integrated health and social care services

Broadly the long-term vision for integrated health and social care services for Merton will align with the following:

- The 5-year strategic vision and strategy for south west London as a whole
- The Joint Strategic Needs Assessment for Merton
- The Health and Wellbeing Strategy for Merton
- Needs and wants of patients and services users
- The Targeted Operating Model for LB MERTON

The key changes to the pattern and configuration of our services over the next five years are:

- We will have an integrated care system. This will involve the integration between health and social care services, as well as the integration between acute and specialist care services with community and primary care services
- Our integrated system will be enabled through contractual commitments for providers in order to ensure organisational boundaries and professional barriers do not hinder our vision
- Our community-based services will focus on delivering an expanded service to older adults and vulnerable adults such as the frail elderly, focussing on reablement and independence, as well as prevention of escalation
- Our service offering for individuals with mental health conditions including dementia, will be focussed on delivering a joined up health and social care package, with a focus on prevention of escalation where possible
- Keeping our population healthy and well, focussing on prevention and self-management
- Focussing our resources and services on early detection and managing through risk stratification and case management
- Delivering a 7-day service to enhance care in the community and prevent delayed discharges from acute service
- Expanding urgent and out-of-hours care where a 24/7 approach is required across health and social care services
- Person-centred care where shared working and communication between community, primary care, specialist and social care workers is seamless and the norm

Therefore the vision for integrated health and social care service includes the following features:

Seamless care delivered by truly integrated health and social care providers

- Patients, service users, the public and service providers experience integrated service models and service design without organisational boundaries
- A shared focus on outcomes drives how individuals, workers and organisations interact positively
- Both commissioner and service provider leadership promote and execute care pathways where the transition of care from one organisation to another, or between one professional to another is well coordinated, requiring excellent communication, shared record-keeping and appropriate accountability between professionals
- Information about an individual is shared across organisational boundaries and IT systems, subject to the individual's consent, so that professionals can understand the whole of the person's health and social care
- Health and social care models which ensure that patients can receive care 7 days a week and where appropriate 24 hours a day with specialist input required to keep them healthy, safe, independent and out-of-hospital (where appropriate)
- A community provider organisation with good links with acute and third sector services, deliver out-of-hospital care transitioning patients seamlessly through services. These teams will work in parallel with primary care, identifying the cohorts of the population with the highest need through risk stratification activities. Case management of these patients/service users becomes the core to the out-of-hospital service model, identifying patients who need **reactive care** and those who need **proactive care** or both and provide continuity of care
- An integrated system is developed through service reconfiguration, workforce planning, investing infrastructure, modernising services through review and redesign, utilising procurement vehicles and setting up new contractual arrangements with providers to work more closely together, in to develop the vision of truly integrated health and social care economy

Services able to deliver proactive care

- A service model where coordination of people (service users) is delivered to identify those who are vulnerable or could benefit from care which focusses on prevention, self-management, education and training, increase in quality of living and life expectancy promoting overall wellbeing
- A service model where skilled workers coordinate ongoing proactive care in there multi-professional locality teams, each 'facing' acute care trusts in neighbouring localities (Wandsworth – St. George's Hospital, Kingston – Kingston Hospital and Sutton – St. Helier's Hospital). Each locality team will work with their locality network of GP practices, with access to specialist support in the community as required. Multi-professional teams are 'blended' to provide appropriate disciplines, skill mix, leadership and accountability to provide a proactive approach to care

- Risk stratification and case management activities across multi-disciplinary teams will deliver proactive care, identifying and managing individuals at risk of deterioration, admission to acute care services or care homes or receiving care which does not address the needs of the 'whole person'
- Each identified person will have a strong relationship with their GP or key worker is able to lead as their care-coordinator, helping them to receive timely and consistent support and care from a multi-professional and multi-organisational team

Services able to deliver reactive care

- The service model is able to reduce likelihood of avoidable emergency admission in times of deterioration or crises by ensuring that appropriate and responsive care and support is available in the community, including access to specialist care
- In addition, the service model is able to reduce service users' length of stay in acute services, encouraging a smooth discharge with appropriate support in the community to deliver high quality care, promote rehabilitation and reablement, preventing readmission into acute services or subsequent admission into care homes
- Services are particularly focussed on a 7 day a week and 24/7 model of delivery where appropriate, and therefore embeds out-of-hours capacity and appropriately skilled 'night' staff to ensure a reactive approach to care in the community, relieving the pressure on emergency departments. In particular, seamless communication and interactions with local urgent care services, NHS 111 and primary care will be delivered. This will also include the rapid deployment of social care provision in the community where required
- Escalating care needs or crises are identified and responded to swiftly by dedicated multi-professional teams with sufficient capacity to enable people to stay at home unless acute specialist care or intermediate or respite care is required. These community teams work closely with acute care colleagues to avoid emergency and unplanned care admissions
- The capacity of rehabilitation and reablement services, professionals and skill will be increased in the community, to ensure that needs addressing independence and functionality are addressed, preventing admission to hospital, ensuring discharge from hospital is timely or preventing premature permanent admission to care homes
- Rehabiltation and reablement capacity is supported by intensive short-stay intermediate care (non-home based) to reduce likelihood of admission to hospital or promote earlier discharge from hospital. This service will be kept to an essential minimum (continuing to promote home-based care where appropriate) and referral criteria will be strictly controlled by service leads to ensure that only people with a potential to return to the original state of independence and functionality are managed through this service. This is to prevent 'bed-blocking'
- Greater specialist support to be delivered in the community in collaboration with

primary care, by enhancing relationships and communication between acute care professionals, primary care and community-based professionals. This includes responsive and timely specialist advice and support given to primary care professionals to prevent admissions and promote discharge from hospital, and the ability for GPs to 'fast-track' diagnostics (including community-based diagnostics) and clinical review for 'at risk' individuals

An experience for people (service users) which promotes their independence and allows them to be in control of their care

- Each person (and their carer) pursues the goals which matter to them, and are in control of their care as much as they want and is possible
- Care is personal, person-centric and responsive to the uniqueness of each individual and their health and social circumstances
- Each person (and their carer) is enabled to manage their own care themselves as much as possible, to make full use of community resources and access their social capital
- Care plans and support involves the person's carer, ensuring that their needs are met, intensive support and education are given, and respite is proactively providing, preventing carer fatigue and isolation
- Each person who experiences the care pathway is involved in developing a simple single plan of their care which is understandable to them, identifying and promoting what is important to them and to achieving their goals. In addition the plan identifies the key steps and professionals to be involved should their condition or status deteriorate
- Each person's vulnerability and safeguarding needs are assessed and acted upon at each contact, becoming embedded in their case management and their care plan
- In 2015 social care will ensure there is greater engagement with those who fund their own care and more information and advice will be provided

Services which are sustainable and future-proof

- Our vision is aligned with our JSNA and HWB strategy because we understand that the BCF is a lever to meet the needs of our population more effectively particularly in times of increasing demand and expectation. In particular our BCF schemes address supporting our population with two or more long term conditions and complexity of conditions, with an aim to increase life expectancy and quality of life. In particular, our JSNA/HWB strategy recognises the variation in health and social status across the borough, and through delivering our vision of the BCF we intend to see health inequalities addressed.
- Overall, we believe that the BCF is just the enabler of integrated commissioning, and that as our vision is realised, we will jointly be able to improve outcomes for

people. The particular conditions outlined in our JSNA which will be addressed through our BCF schemes include: asthma, chronic obstructive pulmonary disease, ischaemic heart disease, heart failure, diabetes and patients with dementia. We also believe that our capacity to deliver higher quality and sustainable care in these areas depends on seamless working between health and social care services as well as creating capacity to deliver such care 7-days a week with out-of-hours capacity able to manage escalation and crises.

- Services are to be designed to ensure that the workforce is suitably skilled and trained. This will also include the correct leadership and accountability relationships to deliver integrated care, as well as the awareness and training required to deliver care across disciplines, organisations and teams including with primary care (where GPs are indeed commissioned by another central body, NHS England)

- The vision of integrated care will be embedded in the culture of the workforce and workforce planning, and will align with the strategic workforce objectives for South West London as part of the Out-of-Hospital Programme and 5-year strategic plan. This includes ensuring that where the workers transition from acute care positions into the community, they are appropriately trained to deliver integrated care, and may over time lead to a rotational workforce. This will provide an opportunity to increase the baseline skill of the workforce in the community, ultimately enabling greater capacity for community-based care

- The set of service schemes to be delivered through the Better Care Fund, will ensure that they align with achieving QIPP and CQUIN targets for Merton CCG and similarly target savings identified by LB Merton. For example, the gross savings identified for 2014/15 for planned care is £600K and for Urgent and Intermediate care is £620K. Most of this is expected to be realised through services delivered through the better care fund. This means that net savings will be identified in existing services marked for expansion and new services to be developed will have only been identified where cost-effectiveness can be justified and delivered

- We have already been discussing our BCF plans with our service providers. Our vision is to ensure that this level of collaboration with our providers continues through the Integrated Care Project Board, so that the providers are prepared for the changes and are true partners in the transition

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?

- How will you measure these aims and objectives?

- What measures of health gain will you apply to your population?

Aims and objectives of Merton's Integrated system

The following describe the primary aims and objectives of Merton's integrated system:

Transform the relationships between organisations

- Create the leadership and workforce culture, and processes/operations for integrated working between professionals
- Develop an organisational structure which enables integration, has the associated governance set up to deliver this and manages the risk associated with this
- Create the opportunity to involve stakeholders from the beginning, transition planning together and ensuring that services remain sustainable and safe for service users and patients
- Overcome organisational boundaries. This includes between health and social care commissioners, as well as acute and community provides.

Reconfigure the service model

- Focus services towards identifying those in need or at risk
- Establish the Reactive care and proactive care pathways
- Ensure care is not divided artificially between care provided by different providers and professionals
- Enable shared responsibility for delivering a 'package of care' to individuals, with health and social care components
- Move to a three-locality model (from a two-locality model) for community services so that social care and healthcare services 'facing' each of the acute providers (St. George's, St. Helier's and Kingston Hospitals), working alongside locality-based networks of GP practices
- Supporting primary care to work in parallel with the integration agenda, and where appropriate host the relationships for multidisciplinary working
- Expanding service input from the voluntary/third sectors services, connecting service users/patients to improve their 'social capital' in the local community of Merton, improving broader wellbeing and societal outcomes
- Creating the service model infrastructure and planning to truly provide joined up care; IT systems, data sharing and information governance; workforce planning, education and training; governance and leadership to support multi-professional working

Increase the quality of care

- Working together to focus efforts on identifying and supporting the most vulnerable people in the population through risk profiling
- Taking a shared health and social care approach to managing complex and long term conditions, and an individual's associated lack of independence or disability
- Improving the coordination of an individual's care through key professionals and activities: case management by an MDT team, leadership from an accountable professional such as the GP, assigning a key worker
- Ensure adequate support, education and respite is available for informal carers and family, as well as formal carers

Increase individual's ability to be managed at home and remain independent

- To build on our Expert Patient Programme to promote independent self-management
- Proactive care able to recognise the value of prevention and intensive support through risk stratification and MDT-delivered case management, as well community-based rehabilitation
- Increase community capacity to deliver services and promote reablement
- Increase community capability of delivering care and expertise at home, or close to home, including through access to community-based specialist care, and through up skilling of exiting and incoming workforce
- To build on the council's established brokerage service and consider applications for integrated care.
- To decommission domiciliary care following principles of outcome based commissioning

Prevention of escalation requiring emergency or acute care

- Reactive care able to prevent escalation, preventing avoidable admissions to A&E and non-elective beds
- Ensure services deliver appropriate care 7-days a week, with selective services having increased or new capacity to deliver out-of-hours care
- Ultimately relieve some pressure from acute services, expanding community-based

Deliver savings

- To ensure that the integration of services and joint working creates economies of scale. This will be achieved through working collaboratively
- The BCF plan is an opportunity to provide 7-day services and selective 24/7 services (out-of-hours)
- Expand community capacity – overlapping, high skill, bringing specialist care into the community, up skilling key professionals e.g. community nurses, care assistants

Deliver the long-term vision

- Commit and ensure an integrated system is developed through service reconfiguration, workforce planning, investing infrastructure, modernising services through review and redesign, utilising procurement vehicles and setting up new contractual arrangements with providers to work more closely together, in to develop the vision of truly integrated health and social care economy

Measuring our aims and objectives

Delivering on national conditions

We intend to measure our full compliance against the national conditions:

- Continued protection of social care services
- Adapting our service model and working with providers to ensure 7-days services are in place (through contractual arrangements and procurement as necessary)
- Ensuring our commitment to data sharing is progressing through our procurement of this change through our CSU
- Ensuring the robust implementation of arrangements to identify a lead accountable professional for multi-disciplinary teams coordinating community-based care and case management

Delivering on national and local outcome metrics

We intend to measure our progress against the national and local outcome metrics and our identified targets:

- We will refer to the published baselines as available
- We will manage this through our financial and performance subgroup which will also feed into the operational subgroup, and ultimately into the Integrated Care Project Board

Developing metrics which are customised to Merton and south west London

In line with the national metrics, our Integrated Care Project Board (stakeholder and service provider representation) identified our four key priorities, which will monitor through our performance and finance subgroup reporting in to the Integrated Care Project Board (see governance section):

In addition:

- In south west London, through the activities of our Out-of-Hospital Programme (lead by the Chief Officer of Merton CCG, Eleanor Brown), we have developed a tracking tool in collaboration with the CSU. The tracking tool helps us to track our performance as individual localities and as a whole across south west London
- Through the tracking tool, we are able to monitor our progress against the reduction of emergency admission, and any subsequent shift into urgent care, unplanned non-elective admission rates and outpatient activity
- We are already seeing initial reductions in our emergency admission rates and NEL activity, we believe as a result of our progress on our out-of-hospital strategy as individual localities

Connecting with and reporting to appropriate bodies

- The governance structure and reporting lines (as discussed in the governance section- 2(e)) will ensure that our alignment to our aims and objectives are on track. The boards and executives will then be charged with the responsibility to implement modifications as necessary through their own reporting system
- We intend to continue to connect in and input to the SWL two-monthly Out-of-Hospital Programme Board, which ensures that we can compare our progress with our neighbouring localities and share knowledge, accelerating our progress in BCF and the strategic plan

Progress against the needs identified in our JSNA and HWB strategy

- Through our reporting and engagement with the HWB, we expect to ensure that our progress is closely monitored against and aligned with our JSNA ambitions and our HWB strategy, and broadly the public health outcomes which need to be achieved for Merton
- Specifically we expect to see a reduction in health inequalities and variations in geographic, age, ethnic diversity and deprivation

- Overall we expect to see increasing access to care for vulnerable groups and lower incidences of safeguarding issues

Commissioning for provider sustainability

- Through the redirection of investment and resource, we expect our providers under less pressure and able to deliver higher quality care, moving more towards the 'zero-harm' principle and the London Quality Standards
- Overall we expect to see an expansion in the capacity and capability of community services, with a workforce shift
- Given the above two aims and objectives, we would expect to see an indirect high satisfaction for the acute and community-based workforce, with a positive effect to up skilling the workforce

Engaging with the public, patients and service users

- Being held to account by our service users and their expectations, through our engagement process. Our patient and public involvement subgroup and IPB membership.
- Measuring our patient and service user experience

What measures of health gain will you apply to your population

The overall health gains we expect to make in our health economy will be met assessing our progress against the NHS, social care and public health outcomes framework:

Monitor achievements against the NHS outcomes framework

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from periods of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

Monitor achievements against the social care outcomes framework

- Enhancing QOL for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Monitor achievements against the public health outcomes framework

- Improving the wider determinants of health
- Health improvement - people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
- Health protection - the population's health is protected from major incidents and other threats, whilst reducing health inequalities
- Public health and preventing premature mortality - Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Joint commissioning between Merton CCG and LB Merton, developing the governance and shared working arrangements that surround this and developing our integrated system, has been the core of the changes we have achieved to date. Through this planning process we have identified primary themes which need to be addressed through our integrated schemes and the wider Better Care Fund/pooled budget.

Enabling this is our commitment to developing an integrated system, which is not only to change the service model and the community services we will offer, but also the following systemic changes that need to occur to sustain this integrated system and see it's continued success. We will be:

- Creating the culture for integration
- Planning and developing a workforce for integration
- Co-designing with our patients, service users and the wider public
- Engaging and working with our service providers to transition
- Improving the quality of our services
- Evaluating our performance

The key themes we will address through our integrated BCF schemes are:

- Integrated locality teams
- Community beds and rehabilitation
- Prevention of admissions
- 7-day working
- Carers breaks
- Protecting and modernising social care
- Investing into the infrastructure of integration

The following table outlines the Better Fund Schemes to be jointly commissioned by Merton CCG and the London Borough of Merton.

The schemes have been developed to meet the needs of the adult population of Merton, where integrated commissioning between health and social care is able to deliver the greatest benefits and outcomes, as well as meeting the national conditions (where relevant).

It is intended that commissioners, with continuing engagement with stakeholders (including providers and current service users/expected service users) will continue to further develop and implement these schemes during 2014/15.

Seven day working

Expected outcome metrics:

- Delayed transfer of care
- Reducing emergency admissions
- Effectiveness of reablement
- Reducing admissions to residential and nursing care
- Patient and service user experience

Component workstreams:

7 day working in social care	
Scheme Description	This scheme will expand the capacity to arrange care packages in the evening and on weekends, and increase capacity to support discharge from acute hospitals. The service will also be restructured to match the three geographical localities of health (To facilitate this, there will be and expansion in the Mascot telecare system and the MILES reablement service (see *Protecting and Modernising Social Care*)
Expected Outcome Metrics	• Delayed transfer of care • Reducing emergency admissions • Effectiveness of reablement • Reducing admissions to residential and nursing care • Patient and service user experience
Endpoints	• **Clinical** – patients and service users will not be admitted to an inpatient hospital ward unless medically necessary, enabling customers to have their needs met in the least intrusive manner, and as close to their familiar home environment as possible. • **Operational –** joint working between health and social care staff with enhanced hours presence will enable a more productive response to customers, who will be given the right care and support at the most effective time. The project will reduce the spikes in activity caused currently by Monday to Friday working.

Timeframe for delivery	• There will be a phased introduction of this scheme to allow for consultation and recruitment:
	  ○ Rota redesign and job planning: 2 months
	  ○ Staff engagement and consultation: 3 months
	  ○ Recruitment of additional posts (*where required, concurrent with above*): 2 months
	• Implementation of new ways of working: 2 months.

Key success factors	• Out of Hours Brokerage Officers to source and set up care packages. • Occupational Therapists to implement reablement programmes and techniques and/or provide equipment, minor adaptations and Telecare prior to service packages and /or admissions to residential/nursing or hospital beds. • Out of hours admin support to update the data base on a real time basis. • Additional carers to provide short term intensive home care and night sits. • Mobile Response Officer to provide back up and immediate installation of telecare monitoring system. • Carers and users feedback.
New to existing investment ratio	
7 day working in health	
Scheme Description	Currently community nurses are operating for seven days, and this scheme will expand the existing service to include community rehabilitation staff. Rehabilitation will be provided by therapists, which will support safe discharge from an acute setting over weekends, as well as facilitating rehabilitation and reablement to begin sooner.
Expected Outcome Metrics	• Delayed transfer of care • Reducing emergency admissions • Effectiveness of reablement • Reducing admissions to residential and nursing care • Patient and service user experience
Endpoints	• Discharges from acute settings happen across seven days of the week, based on medical suitability for discharge and not the availability of packages of care in the community. • Rehabilitation and reablement packages are agreed ahead of discharge and begin as soon as person is within the community setting, regardless of the day of the week that this falls upon – overall the length of stay in the acute setting is reduced and outcomes are improved.
Timeframe for delivery	• This service will be have a phased introduction, assuming a six month lead time for any required recruitment of additional staff and implementation of new ways of working.
Key success factors	• Implementation of three geographical localities and integrated MDT working to provide ‘wrap-around’ care. • Implementation of 7 day working in social care.
New to existing	

investment ratio

Community beds and rehabilitation

Expected outcome metrics:

- Delayed transfers of care
- Reducing emergency admissions
- Effectiveness of reablement
- Admission to residential and nursing care
- Patient and service user experience

Component workstreams:

Older People's Assessment and Rehabilitation Service (OPARS)	
Scheme Description	This is a remodelling of an existing service, that incorporates the development of community based rapid access to diagnostics and MDT delivered holistic assessment and treatment pathways for frail/ older people. The model will be rolled out in a staged approach over two years: The interim model aims to extend the medical assessment capabilities of the team in the form of a consultant geriatrician and provide further capacity. The service will link back to locality MDTs for pro-active work, with care planning and support in the community. The full model will correspond with the opening of the new Nelson Local Care Centre (LCC) and be located within the community hub This service will facilitate early discharge and follow up in the community through developing links with ED teams
Expected Outcome Metrics	• Reducing emergency admissions • Admission to residential and nursing care • Patient and service user experience
Endpoints	• Community hub consisting of a MDT able to provide holistic, patient-centred, assessment, diagnostic and treatment services to be based at Nelson LCC. • Led by Interface Geriatrician with a team consisting of OT, Physiotherapy, Nursing (including Mental Health

	Specialist Nurse), Social Worker and Voluntary Sector presence within the facility. • Service structured to be able to deliver outpatient assessments in different work streams: Urgent (within 48 hours) and Routine (within 3 weeks). • Aim of service to conduct comprehensive assessments, implement early interventions and prevent unnecessary hospital admission.
Timeframe for delivery	• Interim model (prior to Nelson LCC becoming operational) to be implemented in 2014/15. • Second phase including the move to a community hub in the Nelson LCC to be implemented in 2015/16.
Key success factors	• Opening of Nelson LCC on schedule to host community hub. • Successful transition from current model to interim model, and them from interim to full model within the specified time frames.
New to existing investment ratio	
Prevention of admission / step-up beds	
Scheme Description	This scheme involves the commissioning of 4 additional Intermediate Care beds from current 16.5 beds for Merton (note: 33 across Merton and Sutton). These beds will be used to provide suitable prevention of admission provision, enabling people to remain in a non-acute setting where appropriate. The service is to be offered 7 days per week, through an MDT, to meet fluctuations in demand.
Expected Outcome Metrics	• Reducing emergency admissions • Reducing admissions to residential and nursing care • Patient and service user experience
Endpoints	• Four additional Intermediate Care beds identified and commissioned within Merton (current service is jointly commissioned between Merton and Sutton) • Reduction in admissions to acute settings enabling people to remain closer to home for longer where clinically appropriate • Medically led, integrated multidisciplinary team, made up of health and social care staff, with dedicated nursing and therapy teams • Dedicated wider MDT (e.g. pharmacy, dietetics, chiropody, diabetic nurse, continence service) and linkages to the voluntary sector and rapid access to diagnostics.
Timeframe for delivery	• Additional capacity to be procured as part of the contracting round for 2014/15
Key success factors	• Availability of additional bed capacity within Merton. • Agreement reached with Sutton CCG to alter the block contract with Sutton and Merton Community Services (SMCS) provided by the Royal Marsden NHS Foundation Trust.

	• Availability of any additional required nursing staff with appropriate skillset. • Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care.
New to existing investment ratio	
Step Down Beds	
Scheme Description	This scheme will involve commissioning an additional four beds to support early discharge from hospital. It is proposed that there will be clear referral criteria to ensure that the beds are used as effectively as possible, combined with protocols for discharge to community-based services.
Expected Outcome Metrics	• Delayed transfers of care • Admission to residential and nursing care • Patient and service user experience
Endpoints	• Four additional step-down beds identified and procured within Merton. • Referral criteria and discharge protocols established and implemented.
Timeframe for delivery	• Sourcing and commissioning of suitable beds within Merton – by April 2014.
Key success factors	• Availability of additional bed capacity within Merton. • Availability of any additional required nursing staff with appropriate skillset. • Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care.
New to existing investment ratio	
In reach into St George's – 72hr Intensive Rehabilitation	
Scheme Description	Service to support early discharge through the provision of intensive rehabilitation in the community. It will link existing ward-based discharge co-ordinators with services available in the community to facilitate discharge from the acute setting. The capacity of the service to provide rehabilitation at an earlier stage will be increased, broadening the coverage.
Expected Outcome Metrics	• Delayed transfers of care • Effectiveness of reablement • Admission to residential and nursing care • Patient and service user experience
Endpoints	• Three WTE nursing positions appointed, covering seven days per week, to support the in reach programme and provide intensive rehabilitation support for those medically fit enough for discharge. • This will be developed from an existing 'winter pressures' scheme, so staff will need to be transitioned from temporary and fixed term contracts to permanent contracts.
Timeframe for	• Review of existing scheme – by April 2014.

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delivery	• Transition of contracts from temporary to permanent, including consultation and engagement with staff – 2 months. • Recruitment into additional posts (where required) – 3 months.
Key success factors	• Agreement of service specification with St George's Hospital to ensure that there is no overlap between the in reach service and the role of the ward-based Discharge Coordinator
New to existing investment ratio	
Integrated Complex Older Patients Pathway (ICOPP)	
Scheme Description	The pathway concentrates on the prevention of admission for patients in A&E and the Acute Medical Unit over 65 years of age and is being jointly developed with Sutton. The scheme will include providing a range of roles that offer specialist medical input, signposting of services and timely access to reablement and social care services. This is an expansion of the scheme that is being developed on Sutton to cover residents of Merton attending St Helier Hospital.
Expected Outcome Metrics	• Delayed transfers of care • Reducing emergency admissions • Effectiveness of reablement • Admission to residential and nursing care • Patient and service user experience
Endpoints	• Additional posts identified and recruited into (including Consultant Geriatrician, Navigator, Physiotherapist, Occupational Therapist, Healthcare/Rehab Assistants) • Integration with LB MERTON to facilitate timely discharges.
Timeframe for delivery	• Review of level of implementation of existing scheme – by April 2014. • Recruitment into additional posts (where required) – 3 months.
Key success factors	• Agreement of contracting and ways of working with Sutton CCG. • Availability of appropriate staff with skills.
New to existing investment ratio	
Community Rehabilitation Service	
Scheme Description	This proposal will provide additional capacity to enable the service to meet the additional referrals from CPAT (*see 17*) and the MDT in providing more proactive management of patients
Expected Outcome Metrics	• Reducing emergency admissions • Admission to residential and nursing care • Patient and service user experience

Endpoints	• Two / three WTE nursing posts appointed. • Capacities of community rehabilitation team expanded to support and facilitate schemes such as the CPAT (*see Prevention of Admission)* and enable hospital admission to be avoided and, where an admission has occurred, discharge to home with a suitable package of care.
Timeframe for delivery	• Recruitment into new posts – 2 months.
Key success factors	• Availability of nursing staff with appropriate skillset. • Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care.
New to existing investment ratio	

Integrated Locality Teams

Expected outcome metrics:

- Delayed transfers of care
- Reducing emergency admissions
- Effectiveness of reablement
- Admission to residential and nursing care
- Patient and service user experience

Component workstreams:

Community nursing posts	
Scheme Description	In total this would extend to four new nursing posts, organised across the three integrated localities. These new posts would bring in additional skills to support proactive case management. Bringing together of existing community and social care staff (including the staff of specialist teams) to support all adults and in particular high risk patients, providing integrated packages of care, supported by key workers co-ordinating support from the MDT.
Expected Outcome Metrics	• Delayed transfer of care • Reducing emergency admissions • Effectiveness of reablement • Patient and service user experience
Endpoints	• Four WTE nursing posts appointed. • Increased specialist support within MDTs to provide support allowing greater numbers of adults to remain in community settings. • Facilitation of greater integration within the three localities through increasing seniority of skill mix.
Timeframe for delivery	• Assessment of existing workforce skills gaps and detailed definition of required new roles – 2 months (*tied in to outputs from schemes approved and funded by Health Education South London*). • Recruitment into new posts – 3 months.

	• Reorganisation and development of new ways of working – 2 months.
Key success factors	• Availability of nursing staff with appropriate skillset. • Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care. • Implementation of 7 day working in social care (*see Seven Day Working*).
New to existing investment ratio	
Dementia nurses	
Scheme Description	New scheme to provide specialist support to those with moderate to severe dementia, their carers and professionals in contact with those with dementia across community teams. This will include education, support and advice as well as signposting to other services and making referrals into other appropriate services.
Expected Outcome Metrics	• Delayed transfer of care • Reducing admissions to residential and nursing care • Patient and service user experience
Endpoints	• Six WTE dementia nursing posts appointed. • The additional posts will facilitate the raising of awareness of dementia across the integrated MDTs, and support the aligning of services for those with dementia and their carers. • Nursing posts will support the implementation of the *Merton Dementia Hub.*
Timeframe for delivery	• Assessment of existing workforce skills gaps and detailed definition of required new roles – 2 months. • Recruitment into new posts – 3 months. • Reorganisation and development of new ways of working – 2 months.
Key success factors	• Availability of nursing staff with appropriate skillset. • Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care. • Implementation of *Merton Dementia Hub.*
New to existing investment ratio	
Expert patient programme	
Scheme Description	6 Expert Patient Programme (EPP) courses have been funded in 2013/14 on a non-recurrent basis. This proposal is to recurrently fund a total of 8 courses per annum, enabling 120 patients to benefit from the course each year. Research shows that people who have trained in self-management tend to be more confident and less anxious. They make fewer visits to the doctor, can communicate better with health professionals, take less time off work, and are less likely to suffer acute episodes requiring admission to hospital.
Expected	• Reducing emergency admissions

Outcome Metrics	• Patient and service user experience
Endpoints	• Increased incidences of self-care within Merton, leading to an increase in general health and wellbeing across the borough through fewer illness-affected days and reduced avoidable attendances and admissions to hospitals. • EPP schemes extended to an broader range of conditions.
Timeframe for delivery	• Identification of suitable conditions for inclusion within the EPP: 3 months • Design and development of courses, including the input and sign off from relevant local clinicians and integrated MDTs: 6 months. • Identification of suitable cohorts for invitation to the EPP courses (with input from risk stratification programme): 2 months (*concurrently with above*).
Key success factors	• Timely identification and procurement of partner to deliver the EPP courses. • Links with locality integrated MDTs to ensure consistency of messaging.
New to existing investment ratio	
Telehealth	
Scheme Description	This proposal will utilise telehealth for suitable patients with heart failure and/ or COPD with the overall aim of supporting these patients in their own home and being able to pick up early warning signs of a potential deterioration or exacerbation so that early intervention may avoid further deterioration and potential admission to hospital. This scheme will be provided as a part of the existing MASCOT services.
Expected Outcome Metrics	• Reducing emergency admissions • Admission to residential and nursing care • Patient and service user experience
Endpoints	• All patients with agreed conditions identified as suitable are being managed proactively through telehealth arrangements to avoid unplanned inappropriate attendances/admissions to hospital.
Timeframe for delivery	• Detailed service specification to be developed in April 2014. • Initial procurement and roll-out of telehealth will take place during 2014/15, to include a pilot period. • Roll-out of telehealth will take place from April 2015.
Key success factors	• Identification of provider of telehealth equipment. • Development of SLAs with telehealth provider.
New to existing investment ratio	
End of life care	

Scheme Description	This is an expansion of an existing scheme with additional investment to start in 15/16 in two specific areas: • • Delivery of a case management approach for non-specialist palliative care cases within the district nursing service (3x case managers) • • Increase extent of the hospice at home service (6x nurses).
Expected Outcome Metrics	• Delayed transfer of care • Reducing emergency admissions • Reducing admissions to residential and nursing care • Patient and service user experience
Endpoints	• Assessment of existing workforce skills gaps and detailed definition of required new roles – 2 months (*tied in to outputs from schemes approved and funded by Health Education South London*). • Recruitment into new posts – 3 months. • Reorganisation and development of new ways of working – 2 months.
Timeframe for delivery	• Identification of suitable conditions for inclusion within the EPP: 3 months • Design and development of courses, including the input and sign off from relevant local clinicians and integrated MDTs: 6 months. • Identification of suitable cohorts for invitation to the EPP courses (with input from risk stratification programme): 2 months (*concurrently with above*).
Key success factors	• Availability of nursing staff with appropriate skillset. • Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care. • Implementation of 7 day working in social care (*see 1*).
New to existing investment ratio	

Prevention of Admission

Expected outcome metrics:

- Delayed transfers of care
- Reducing emergency admissions
- Effectiveness of reablement
- Admission to residential and nursing care
- Patient and service user experience

Component workstreams:

Interface Geriatricians	
Scheme Description	A geriatrician will provide ten clinical sessions per week, focussed on the delivery of a case management approach for non-specialist palliative care cases.
Expected Outcome Metrics	• Reducing emergency admissions • Effectiveness of reablement • Admission to residential and nursing care • Patient and service user experience
Endpoints	• One WTE Consultant Geriatrician appointed to interface geriatrician role. • Case management clinical session are scheduled.
Timeframe for delivery	• There will be a phased introduction of this scheme with an estimated start date in October 2014
Key success factors	• Availability of Consultant Geriatrician with appropriate skills.
New to existing investment ratio	
Community Prevention of Admission Team (CPAT)	
Scheme Description	This team became fully operational in October 2013 and provides rapid holistic assessment within 2-4 hours in the patient's own home, providing a management plan, where appropriate, for ongoing management in the community.

	During 2014/15 there will be further development of the community prevention of admission team to increase the referrals from out of hour's services, 111 and the London Ambulance Service through inclusion within the directory of services. This is linked the CCG QIPP Plan. Please refer to A ppendix 2. **New investment - expansion into nursing homes:** Development of an urgent response system with Merton nursing and residential homes to pro-actively identify patients at high risk of deterioration/ admission to hospital and support the nursing/residential homes with a management plan and where required additional support. Currently educational support is provided but not specific support for homes at this level of input. Existing CPAT service will be commissioned to extend to undertake this service.
Expected Outcome Metrics	• Reducing emergency admissions • Effectiveness of reablement • Reducing admissions to residential and nursing care • Patient and service user experience
Endpoints	• Build on skills and competencies within CPAT and expand links to incorporate an urgent response across a wider range of community services (including social care, including support to nursing homes, referrals from LAS and 111).
Timeframe for delivery	• Agree skill mix/model of expanded CPAT – within 2 months. • Assessment of existing workforce skills gaps and detailed definition of required new roles – 2 months (*tied in to outputs from schemes approved and funded by Health Education South London*). • Agree support from other services to maintain any support required post 72 hours – within 2 months. • Agree contracting arrangements – within 2 months. • Recruitment into new posts – 2 months. • Go live with substantive team – by 01/04/14.
Key success factors	• Availability of nursing staff with appropriate skillset. • Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care.
New to existing investment ratio	
Rapid Response Team at St Helier and STAR Team at St George's	
Scheme Description	The aim of this scheme is to maximise the opportunities for admission avoidance at Emergency Department (ED) by using specialist skills to facilitate timely, safe and appropriate discharge of patients from ED and prevent unnecessary hospital admission within existing teams. Intervention will be patient-centred to ensuring the most appropriate treatment in the right environment. Initially both services will be reviewed to understand their relative

	effectiveness. The Rapid Response Team at St Helier is provided by SMCS and operates for extended hours. A major component of the scheme is the redesigning of the STAR team pathway at St George's Hospital to maximise screening and assessment prior to admission, so that those who can be safely managed in the community are transferred to the care of community teams/ new OPARS (*see 15*). Currently a number of patients are being admitted for the purposes of assessment. This project will be managed collaboratively with Wandsworth CCG (host commissioner of St George's Hospital).
Expected Outcome Metrics	• Reducing emergency admissions • Admission to residential and nursing care • Patient and service user experience
Endpoints	• Redesigned the STAR team pathway in St George's to maximise the screening and assessment undertaken at A&E (prior to admission). • Improve links to social care and support to discharge patients rapidly, including social care input into STAR/Rapid Response team.
Timeframe for delivery	• Agree approach with Wandsworth CCG (host commissioner for St George's Hospital) and Sutton CCG (host commissioner for St Helier Hospital) – by April 2014. • Undertake service review, including completion of benchmarking exercise and clinical audit – by April 2014. • Service redesign exercise in collaboration with respective host commissioners and signed off via Clinical Reference Group – 3 months. • Implementation of new ways of working – 2 months.
Key success factors	• Development of collaborative relationships and agreements with Wandsworth CCG and Sutton CCG. • Accuracy and availability of reference data in order to carry out benchmarking. • Effective negotiation with acute, community and social care providers.
New to existing investment ratio	
Psycho-geriatric sessions	
Scheme Description	This is a new initiative for specialist input to provide proactive support to patients using links within MDTs in the three localities. The input from the specialists will amount to advice and support to MDTs, as opposed to direct provision of case management. This support will be available as a resource for Older Persons Assessment and Rehabilitation Service (*see Community Beds and Rehabilitation*), Community Prevention of Admission Team (*see above*) and Intermediate Care.
Expected Outcome Metrics	• Delayed transfer of care • Effectiveness of reablement • Reducing admissions to residential and nursing care

	• Patient and service user experience
Endpoints	• Three case managers appointed. • Increased proactive management of older people with complex needs in a community setting through the provision of specialist advice into integrated MDTs in the three localities.
Timeframe for delivery	• Recruitment into new posts – 3 months.
Key success factors	• Availability of nursing staff with appropriate skillset. • Implementation of three geographical localities and integrated MDT working to provide 'wrap-around' care. • Implementation of Older Persons Assessment and Rehabilitation Service (*see Community Beds and Rehabilitation*), Community Prevention of Admission Team (*see above*) and Intermediate Care.
New to existing investment ratio	
AgeWell Prevention	
Scheme Description	A joint programme between LB MERTON and the voluntary sector was launched in May 2013 to support people to live at home in their communities for as long as possible. Some of the organisations participating in the programme include the Wimbledon Guild, Merton Community Transport, Age UK and Carers Support Merton and cover initiatives such as a volunteer driver's scheme, supporting people to manage their incontinence, and coaching people and carers through crises and difficult times.
Expected Outcome Metrics	• Reducing emergency admissions • Patient and service user experience
Endpoints	• Older people within Merton are supported to remain in their homes as long as medically appropriate and it is safe for them to do so. • Inappropriate emergency admissions to hospital are reduced through additional support offered to people and their carers through crises and difficult times.
Timeframe for delivery	• This scheme is currently operational, though recurrent costs will be funded from through the Better Care Fund in 2015/16.
Key success factors	• Continued engagement from existing stakeholders.
New to existing investment ratio	

Protecting and Modernising Social Care

Expected outcome metrics:

- Delayed transfer of care
- Effectiveness of reablement
- Reducing admissions to residential and nursing care
- Patient and service user experience

Component workstreams:

Domiciliary packages of care	
Scheme Description	This is a continuation of existing services that will ensure 24 hour access to care packages. The meeting of demand for care packages from health sources will be guaranteed; offering timely and prompt service in the community as an alternative to hospital admission and on discharge.
Expected Outcome Metrics	• Delayed transfer of care • Effectiveness of reablement • Reducing admissions to residential and nursing care • Patient and service user experience
Endpoints	• Care packages are available 24/7 for those who would otherwise be at risk of admission to hospital. • Care packages are available 24/7 to facilitate discharge from an acute setting.
Timeframe for delivery	• This scheme is currently operational, though recurrent costs will be funded from through the Better Care Fund in 2015/16.
Key success factors	• Continued engagement from existing stakeholders. • Enactment of the Care Bill has limited impact on the service in the current configuration.
New to existing investment ratio	
Merton Independent Living and Enablement Service (MILES) reablement and discharge service	
Scheme Description	This service comprises of a range of services including discharge support, reablement, and some crisis support where other providers are unable to meet demand or swift restarts of packages.

	The service is currently being revised to match the 'discharge and assess' model, and increase the number of users being offered reablement.
Expected Outcome Metrics	• Reducing emergency admissions • Delayed transfers of care • Admission to residential and nursing care • Patient and service user experience
Endpoints	• Revised model in line with Merton Council's 'discharge and assess' model. • Increased numbers of people entering the service being offered reablement services, improving outcomes.
Timeframe for delivery	• Review of existing service – 3 months. • Development of new service delivery model – 3 months. • Consultation and engagement with staff and service users – 3 months. • Implementation of revised service delivery model and transition to new ways of working – 3 months.
Key success factors	• Enactment of the Care Bill has limited impact on the service in the current configuration. • Key stakeholders engage with review and redevelopment process in a timely manner.
New to existing investment ratio	
Additional staff to meet new Care Bill duties	
Scheme Description	The Care Bill, when enacted, will update and increase the statutory responsibilities of LB MERTON and, in order to meet these obligations additional staffing will be required. Some of the responsibilities overlap with the aims of the BCF as there is a health and wellbeing element, so the pooled budget will be utilised for these posts.
Expected Outcome Metrics	• Reducing emergency admissions • Delayed transfers of care • Admission to residential and nursing care • Patient and service user experience
Endpoints	• Staffing levels to allow for compliance with new obligations arising from the Care Bill.
Timeframe for delivery	• Assessment of implications of care bill on existing services and staffing levels – by April 2014 • Gap analysis of skills and staff numbers – 2 months. • Recruitment into posts (where required) – 3 months. • Implementation of new ways of working (*concurrent with recruitment*) – 4 months.
Key success factors	• Care Bill is enacted in a similar form to that which is being read currently in parliament. • Availability of staff with appropriate skills.
New to existing investment ratio	

Carers' Breaks

Expected outcome metrics:

- Reducing emergency admissions
- Admission to residential and nursing care
- Patient and service user experience

Component workstreams:

Increased Night nurses to support carers	
Scheme Description	This scheme will increase the capacity of the Night Nursing Service, providing additional skilled support which is available to carers between the hours of 7pm and 7am in order to prevent unnecessary emergency admissions. This will primarily be through remote advice provided from a hub, extended to mobile / visit support in appropriate cases. The scheme is integrated with Merton Social Services.
Expected Outcome Metrics	• Reducing emergency admissions • Admission to residential and nursing care • Patient and service user experience
Endpoints	• This will be developed from an existing 'winter pressures' scheme, so staff will need to be transitioned from temporary and fixed term contracts to permanent contracts.
Timeframe for delivery	• Review of existing scheme – by April 2014. • Transition of contracts from temporary to permanent, including consultation and engagement with staff – 2 months. • Recruitment into additional posts (where required) – 3 months.
Key success factors	• Transition from temporary staffing to permanent contracts. • Continued availability of existing enabling factors (such as estates).
New to existing investment ratio	

Investing into Integration Infrastructure

Expected outcome metrics:

- Delayed transfer of care
- Patient and service user experience

Component workstreams:

Data sharing project	
Scheme Description	This scheme provides funding towards a multi-agency project to develop information sharing across health and social care across south west London, commissioned from South London Commissioning Support Unit. Organisations must put processes and systems in place to ensure that NHS number 'completeness' is maintained at or above 97.5% as the primary identifier in communications. It includes funding to facilitate the use of the Coordinate My Care system as a platform to hold common care plans developed by the integrated locality teams, ahead of larger-scale information sharing progress.
Expected Outcome Metrics	• Delayed transfer of care • Patient and service user experience
Endpoints	• NHS Number becomes the primary method of data sharing for customers/patients between teams within the three integrated MDT localities. • Meeting or exceeding of the targets set out as part of the *Better Care Fund* for NHS Number completeness. • Seamless data sharing within integrated locality teams and between health and social care partners.
Timeframe for delivery	• An upload of NHS numbers was provided by the NHS Personal Demographics Service (PDS) through their batch trace service in the later part of 2013. This produced a matching of around 75% of our current customers and these NHS numbers have been uploaded to *Carefirst.* • April 2014: NHS number added as a field on the Initial Contact forms designed to accommodate the new Adult Social Care Collections. • By 31/12/14 – Complete additional 'batch upload' to match users with NHS numbers through a detailed listing of first names and surnames, once complete the matching figure will increase to at least 80%.. • By 31/12/14 – Gain access to PDS directly through either an NHS organisation or through another borough that has Registration Authority (i.e. Enfield) to allow staff to look up NHS numbers for new customers where

	NHS number is not known. • By 31/12/14 – Identify and implement 'smart cards' for staff to access to the PDS, provide training to staff and agree targets for NHS Number completeness.
Key success factors	• Second batch upload process increases NHS Number completeness to expected level (approximately 80%). • Access to PDS achieved either through a suitable NHS organisation, or alternatively through another borough that has a Registration Authority.
New to existing investment ratio	
Integration Costs	
Scheme Description	This scheme provides funding towards costs associated with integration between health and social care, including project running costs and posts.
Expected Outcome Metrics	• N/A
Endpoints	• Appointment of the following jointly appointed (between LB MERTON and Merton CCG) roles: Project Director, Joint Commissioning Manager, Clinical Lead. • Organisational Development carried out to facilitate greater integration.
Timeframe for delivery	• Merton Integrated Care Project launched in February 2013, with first meeting of the Merton Integrated Care Project Board – this now meets on a monthly basis. • Refer to the Merton Integrated Care Project programme plan for a detailed delivery timings.
Key success factors	• Availability of staff with appropriate skills. • Agreed governance structure between LB MERTON and Merton CCG for the integration project.
New to existing investment ratio	

d) Implications for the acute sector

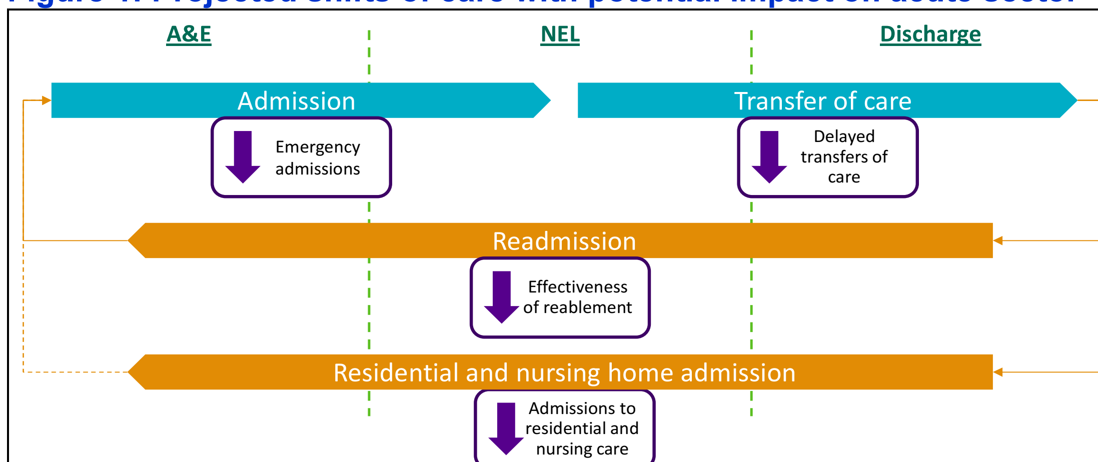
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The introduction of the BCF is likely to have far reaching implications in terms of the way that health and social care is provided in the future. Many of the resultant changes are likely to be felt most intensely by acute providers. Recognising this Merton, through bodies such as the Merton Integrated Care Project Board, has engaged with provides to ensure that there is a shared awareness of the likely changes.

When the changes to integrated care are fully implemented, the whole-system effects are expected to provide benefits to acute providers in the area. A reduction in the numbers of emergency attendances and admissions will relieve pressure on trusts' A&E departments, better enabling them to meet the 4-hour A&E target and also reduce the amount of activity that is funded at the marginal rate (currently 30% of tariff). Through reducing delayed transfers of care patients will be discharged when they are 'medically fit', meaning only the most appropriate patients remain in hospital and instances of 'bed-blocking', with its associated negative consequences[1], are reduced. Overall, however, shifting activity from the acute to alternative settings could have a negative impact on acute trusts' financial positions and future sustainability. LB MERTON and Merton CCG understand, and through the Merton Integrated Care Project Board and further conversations with providers to manage this risk.

Projected shifts of care, and where the BCF outcome metrics influence this, are shown in the diagram below.

Figure 1: Projected shifts of care with potential impact on acute sector



[1] The risks associated with any hospital admission are well recognised, such as the increased chance of contracting a Hospital Acquired Infection (HAI) and bed-based reduced mobility / muscle strength. These risks are particularly significant for older patients, where there are additional risk factors around psychological harm and increased dependency.

Net savings from activity shifts

Merton currently performs within the upper quartile for non-elective (NEL) admissions, and experiences low levels of delayed transfers of care, compared nationally. This baseline is encouraging for Merton, and reflects:

- the work that has already been put into QIPP, CQUIN and other similar initiatives
- our strong relationships with both community and acute providers locally and commitment to patient care
- the demographic profile of the population in Merton which overall enjoys a greater life expectancy and better health than the national average

Therefore plans to shift activity from acute settings start from a solid base and will initially focus on maintenance and stabilisation of existing gains, throughout 2014/15. New schemes will then become operational and deliver additional shifts in 2015/16 as the BCF is fully implemented. It is recognised that where schemes prevent admission to hospital, or facilitate more timely discharge then there will be a resultant reduction in bed-days, and the impact of this is felt by acute providers. Merton will maintain a flat growth in acute activity against a demographic population growth of 2.1% and a non-demographic[2] growth of 1.6% locally.

Efficiencies of £600k have been identified for 2014/15 through the QIPP planning process, which will involve activity being shifted from acute to alternative settings (primarily through avoidance of attendance and increased provision of care in the community). The BCF therefore represents a considerable new commissioning lever that will facilitate these savings being realised. For 2015/16 £900k worth of efficiencies have been identified (subject to further refinement). While many of these savings will be achieved through new schemes starting, and the expansion of schemes that will be launched in 2014/15, some of the increase over the previous year will be achieved through economies of scale arising from increasing integration between health and social care. In addition as services and new ways of working become more established there will be a consummate increase in the quality of offerings.

Although Merton CCG is in a stable financial position and is able to invest in new initiatives throughout 2014/15, facilitating the realisation of additional efficiencies identified in 2015/16, this position would be at risk were schemes not to deliver projected performance. As many of the schemes included within the BCF are interdependent between Merton CCG and LB MERTON, a risk-sharing agreement has been reached (though this will be subject to ongoing refinement and a contractual agreement, see section 2e for further information). This will ensure that both partners are able to take greatest advantage from the fund, and that in the case of non-performance one organisation would not be disproportionately disadvantaged, as well as taking joint responsibility for the whole health and social care economy.

Engagement and transition planning

[2] Non-demographic growth includes all areas of demand growth not explain by demographic factors, for example changed patient and service user behaviour, technological advances, and increased access to care.

The majority of care for Merton patients is provided at St George's Hospital (part of St George's Healthcare NHS Trust, hosted by Wandsworth CCG) and St Helier Hospital (part of Epsom and St Helier University Hospitals NHS Trust, hosted by Sutton CCG). A smaller amount of activity is carried out at Kingston Hospital NHS Foundation Trust. As all of these trusts are outside the geographical area of the borough Merton CCG does not act as a host commissioner for any, but acts as a strong associate commissioner for all contracts. All three of the acute trusts are represented on the Merton Integrated Care Project Board which has a remit for the practical planning and designing of integrated services locally (see section 2e for a full description).

To date, high level individual meetings have been held with all of the acute trusts outlining the potential forecast impacts of the BCF plans. There is recognition that locally there will be a cumulative impact on acute trusts from multiple BCF plans, especially given that Merton residents are cared for at trusts that the CCG is not a host commissioner of. Therefore joint meetings will be held with Sutton CCG and Epsom and St Helier University Hospitals NHS Trust, and also with Wandsworth CCG and St George's Healthcare NHS Trust, to discuss more detailed implications and undertake in depth transition planning. In addition, synergies will be sought between the BCF and operations plans of Sutton and Wandsworth, in order to maintain a coherent and viable local health and social care economy. At this stage there will be an opportunity to discuss and understand any risks to provider sustainability, and the potential for provider (or commissioner) failure.

In particular, consistency will be maintained with the Sutton Integrated Complex Older Persons Pathway, and how this may be extended to Merton residents who are cared for at St Helier, given that the community services provider delivering this service is also shared between the boroughs.

In addition to transition planning carried out collaboratively between host commissioners and acute providers, CCGs across south west London, including Merton, formed the 'South West London Strategic Commissioning Collaborative' ("the SWL Collaborative"). One aim of the SWL Collaborative will be to develop a coordinated five year strategic plan for the whole health economy across the area, which will include initial transition planning with relation to the BCF.

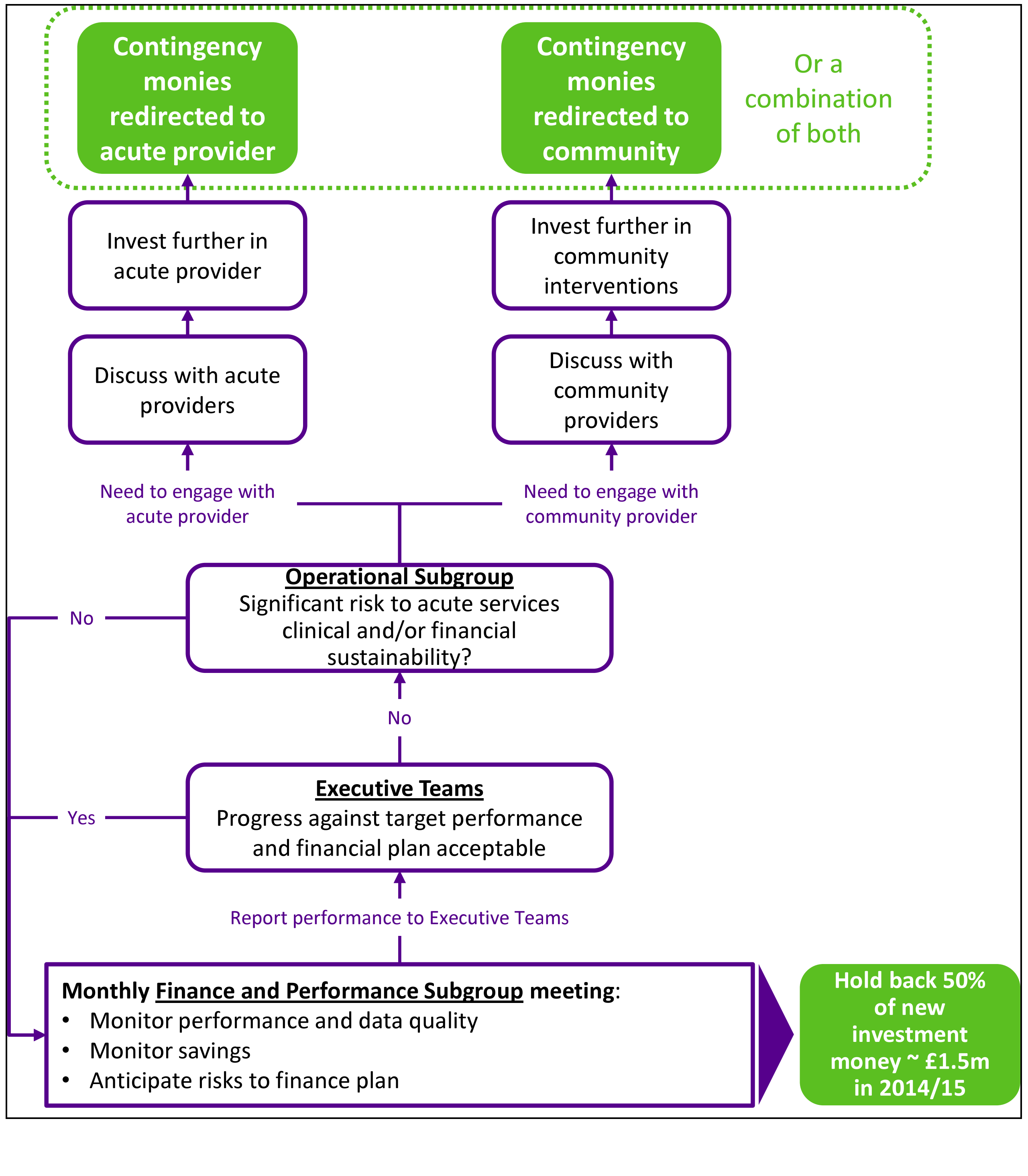
Contingency planning

Contingency planning has been agreed in Merton at an early stage of planning for the implementation of the BCF. As described above, a risk-sharing arrangement between Merton CCG and Merton Council has already been reached. The approach to developing new schemes, where investment into new schemes will be made during 2014/15 from non-recurrent funds is also outlined. By the end of 2014/15 performance of schemes will be assessed, and those that are not delivering the required levels of savings, activity shift, or both will have the ongoing viability assessed.

A contingency framework is outlined below which describes the ongoing process for assessing the performance of schemes, and the decision-making process where the expected level is not being achieved. Merton has committed to the 'holding back' of 50% of the total BCF pooled budget in 2015/16 and, in the case of non-performance of schemes, the monies will be redirected where required based on the decision process

outlined in the framework.

Figure 2 Merton contingency planning framework



e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Approach to governance and responsibilities

Overview of governance arrangements

Merton has some history of integrated working between local health and social care, which has rapidly accelerated since February 2013 with the formation of the Merton Integrated Care Project Board, and the subsequent enactment of the *Health and Social Care Act 2012* in April 2013. Governance structures have therefore been developed and implemented that enable close working between health and social care locally. Some of these predate the announcement of the BCF.

In common with other areas, the **Merton Health and Wellbeing Board** (HWB) has a statutory responsibility for ensuring that commissioning intentions of both Merton Council and Merton Clinical Commissioning Group are aligned[3], coherent, and meet the priorities set out in the **Joint Health and Wellbeing Strategy**. The Merton HWB has a statutory (mandatory minimum) membership, defined in the *Health and Social Care Act 2012*[4], that includes senior leaders from across health and social care services and meets on a bi-monthly basis.

The **One Merton Group (OMG)** is an executive level joint group that reports to the Merton HWB. The OMG has a remit to provide strategic direction to integrated services locally. It brings together senior representatives from Merton Council (Director of Community and Housing and Director of Children's and Families), Merton Clinical Commissioning Group (Chief Officer and Director of Commissioning and Planning), and the Public Health (Director of Public Health), The OMG meets monthly.

The **Merton Integrated Care Project Board** has a remit to facilitate the practical aspects of integrated working locally and reports to the OMG. It brings together stakeholders to co-design local integrated services; this includes providing direction to, and coordinating the output from the six workstream subgroups:

- Finance and performance
- Merton Model / Operational
- IT and data sharing
- Workforce and culture
- Patient and Public Involvement (PPI)
- Quality

The Merton Integrated Care Project Board membership includes representatives from Merton Council, Merton CCG, the community services provider (Sutton and Merton

Community Services), local acute and mental health providers and relevant voluntary sector services. The Merton Integrated Care Project Board meets on a monthly basis. A full membership can be found in the terms of reference which are included in Appendix 3 of this template.

Governance structure and lines of reporting and communication

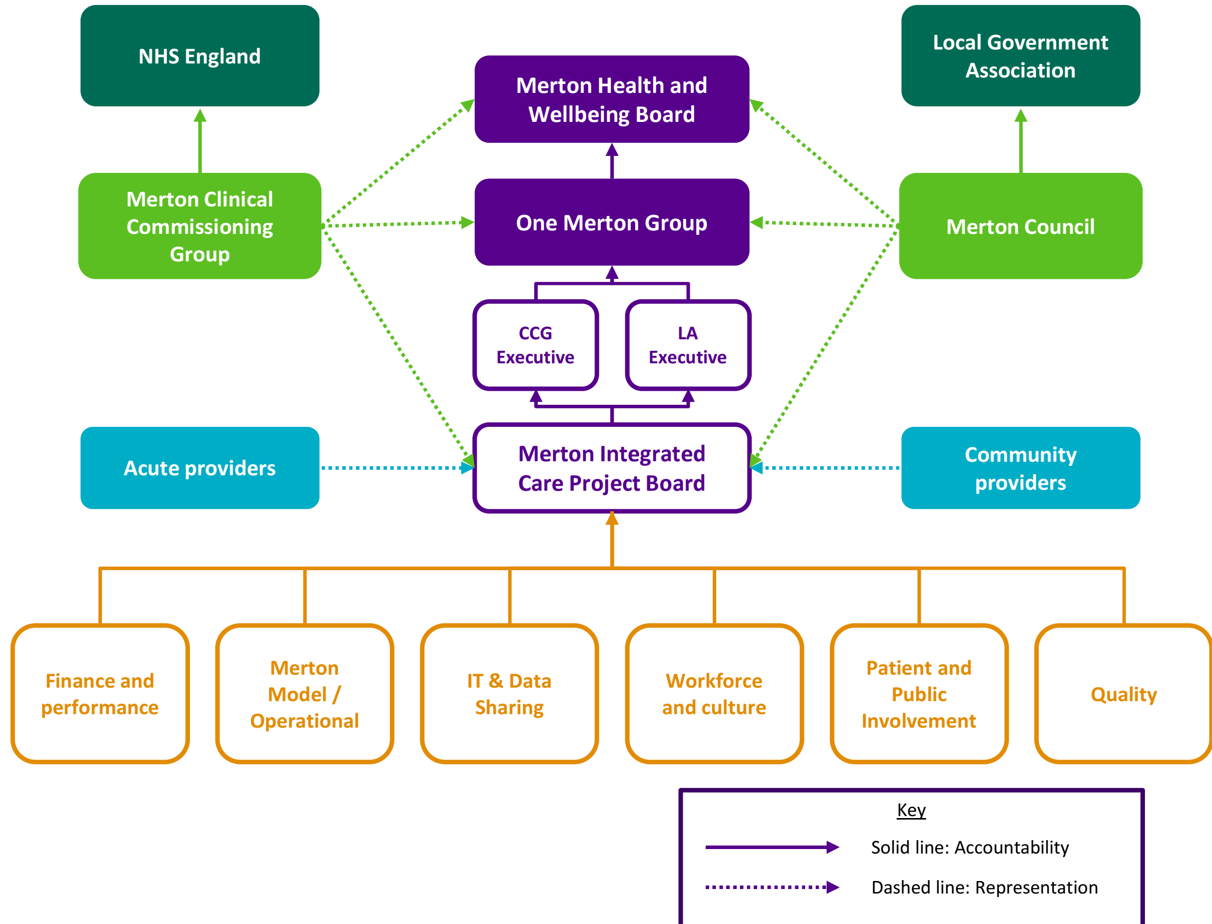


Figure 1: Merton BCF demonstrative governance diagram

Risk management

While the introduction of the BCF presents a considerable opportunity to facilitate greater integration between health and social care services, it also creates greater interdependencies between organisations with different statutory obligations. These obligations are set out in the *Health and Social Care Act 2012* for Merton CCG, and will be defined for Merton Council by the *Care Bill 2014* which, at the time of writing, was at the second reading stage in the House of Lords.

In recognition of these obligations, and the level of investment that is to be made both as individual organisations and from a joint pool, risk-management and risk-sharing agreements have been developed collaboratively. For the purposes of planning initial investments, it has been agreed that, in the case of non-performance, financial risk will be shared on an equal (i.e. 50:50) basis. This will be formalised with a contractual agreement for risk sharing between Merton Council and Merton CCG, to be developed during 2014/15 in anticipation of the full BCF being implemented in 2015/16. For a full

list of identified risks and discussion of the risk-management and risk-sharing agreements, please refer to Section 4.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Our Definition of Protecting Adult Social Care Services

Enables social care to continue to operate in a way that ensures that the whole system works effectively, and that core social care services are not undermined. This will be done through the integration agenda, sharing a pooled budget, reconfiguring services and rearranging the workforce.

Please explain how local social care services will be protected within your plans

Our Commitment and Plans to Protect Adult Social Care Services

- To mitigate the impact of savings that the council has to find
- Funding for core services which are essential to the whole system, at the same time modernising them
- Working together to find efficiencies that also benefit social care
- Continued joint investment in prevention
- The framework for this the efficiency and investment framework developed and piloted in Merton and no used nationally

Activities which will facilitate the protection of social care services

The following details specific activities which will facilitate the protection of social care services:

- The scheme on prevention, Ageing Well, is one protection element. By adding £80k of funding in 2015/16, the BCF will protect the Ageing Well programme, for which the Council is planning to reduce funding in future years. Outcomes for the programme will be agreed between the BCF partners
- The council will ensure 24 hour access to Domiciliary Care Packages. The council will meet the demand from health sources, offering timely and prompt service in the community as an alternative to hospital admission and on discharge
- LB Merton is planning to achieve efficiency measures where the effect upon capacity of hours delivered will be minimal. The additional funding from BCF will

help protect the service and also includes funding for night sits, and the extra demand for visits resulting from successful avoidance of hospital admission

- The New Duties scheme is as per the national guidance whereby the amount is proportional to the nationally announced figure. It is expected to be spent mainly on staff to undertake the additional assessments required
- A scheme is being prepared to expand the council's capacity to arrange care packages during the weekend (8am-5pm) and in the weekday evenings adding a care package from (5pm-8pm). This scheme is also expected to include greater responsiveness from the MASCOT Telecare service
- The 7-day working proposal is to expand the hours of the community rehabilitation team, which works with people in intermediate care beds in specific nursing homes, and also in people's homes. This will mean that both the health and social care elements of the reactive stream will move to 7 days. This provides the basis for integrating these two services (and others in the reactive stream) on an even footing
- Merton has agreed with host commissioners that it will be involved in contract review meetings and local communications between partner providers to ensure there is a continued focus on Merton despite the fact that it is not a host commissioner for acute trusts

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

7 Day Services to Support Discharge

Strategic commitment

Merton already performs in the upper quartile for NEL admissions; therefore to improve performance further, there must be a step-change in the way that services are provided. There is a shared commitment between LB Merton and Merton CCG to reorganise and expand existing services to operate for seven days of the week, and an appreciation of the interdependencies between health and social care services in achieving these aims.

Locally agreed plans

Achieving truly integrated seven day services is core to Merton's plans for future services. The approach will see the development of complementary services in health and social care, integrated to provide patients and service users a seamless service as the BCF is fully implemented. To meet this objective a specific pillar of the BCF, as outlined in Section 2c (description of planned changes), will focus on transitioning services to seven-day working; meaning admissions to an acute setting can initially be

avoided and discharge is not delayed merely because it is a weekend. Fundamentally the service model will change contractual arrangements with community and social providers will need to change and the ways the community and indeed the primary care workforce will change.
Although Merton currently has a low level of delayed transfers of care, moving to a seven-day model of working offers the opportunity of significant advances in this respect. The seven day working model of care is expected to be fully operational by the end of 2014/15, and the period of implementation will be used to understand emerging levels of integration between services and drive improvements where required. Underpinning the changes is the move to three integrated MDTs organised into geographic localities. Through the BCF, Merton is making considerable investments to support the development of these locality teams, and they will become the vehicle that delivers seamless, integrated and consistent care for seven days.

The role of the Merton Integrated Care Project Board is to provide practical support for the local integration of services. Section 2e described the governance arrangements in relation to the BCF, and included within this is the reporting structure between the different committees and statutory bodies (such as the Merton HWB). Through this representation and reporting, the key points in the Joint Health and Wellbeing Strategy can be met in a practical sense. Our operational subgroup, enabled by the finance and performance, quality and workforce and culture subgroups, will be responsible for further planning, mobilising and delivering our plans for seven-day services. In addition, the integrated care project board, and the executive teams will assess our progress to deliver this, directly against our performance on the national metrics.

Social care plans

LB Merton is proposing that social care services undergo a full restructuring to ensure that 'the right staff, with the right skills, are available in the right place at the right time'. This change will allow for additional capacity to arrange care packages in the evening and on weekends, preventing the historical delays associated with discharging from acute settings Friday through to Sunday. Reorganisation will enable **additional social care staff** to be based at St Helier and St George's, while services such as **intensive home care and night sits** will facilitate timely discharges and receiving individuals with social care needs back into the community over seven-days. Through making services available for greater periods of the week, social care related additional bed days in hospital can be reduced. In order to aid integration, teams will be structured into three localities, mirroring the organisation of health services. This can be seen in Appendix 4

Health plans

Merton CCG already commissions some services that operate for seven days, such as **community nursing** (provided by SMCS). Along with this service being expanded, two new seven-day services will be commissioned: **community rehabilitation** and **intermediate beds** located within nursing homes. The later service will be offered to patients with a high potential to return to their home after a short spell of intermediate care to rehabilitate intensively to an acceptable level of functioning in the home environment.

The aim of these services is that acute trusts will experience no difference when discharging patients no matter what day of the week it is. Services such as intensive

rehabilitation in people's homes and additional rehabilitation in intermediate settings will facilitate timely discharge from the acute setting. Expanding community nursing keeps people in their homes for longer, avoiding potential emergency admissions where there is no other alternative.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Using the NHS number

NHS commissioned services are using the NHS number as the primary identifier for correspondence. Primary care, through contract changes effective from 1st April 2014, will also use the NHS number to communicate with other services.

Local Authorities do not currently use the NHS Number as the primary identifier for correspondence across all health and care services but have plans in place to do so.

In the interim, LB Merton will increase the number of NHS numbers recorded within our system and ensure that all outputs and reports have both the NHS number and the Carefirst Number automatically uploaded. A complimentary training process for IG will accompany this change.

The reason that local authority workers cannot use the NHS number as the primary identifier at present is twofold:

1. 97.5% compliance has not been achieved in terms of NHS numbers in our Carefirst system
2. The Social Care database Carefirst is not capable of allowing both the Carefirst number and the NHS number to be used in conjunction. Currently the system will only accept one primary identifier.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by.

Our data sharing committment

Local Authorities are in the process of procuring a system with the CSU that will allow LA workers to accept both the NHS number and Carefirst number. We hope to have completed full system implementation within 2 years.

Implementing data sharing to date

The following work to date has been completed on implementing the NHS number as the primary identifier:

- An upload of NHS numbers was provided by the NHS Personal Demographics Service (PDS) through their batch trace service in the later part of 2013. This produced a matching of around 75% of our current customers and these NHS numbers have been uploaded to Carefirst
- CSU access to the Patient (PDS) will be required to find missing NHS numbers (as not all will be captured by the batch trace process). The CSU are currently liaising with Enfield, who has become a Registration Authority, about the possibility of accessing PDS through them, in line with information governance duties
- The NHS number has also been added as a field on the Initial Contact forms designed to accommodate the new Adult Social Care Collections (Zero Based Review – ZBR); which will go live in April 2014

Future plans to mobilise data sharing

The Action Plan going forward includes the following to be completed by December 2014:

- The next stage is to do one more batch upload to try and match more customers through a more detailed listing of first names and surnames separately. Once this second upload is complete we hope the figure will increase to at least 80%
- They then need to gain access to the PDS directly through either an NHS organisation or through another borough that has Registration Authority (Enfield) to allow staff to look up NHS numbers for new customers where NHS number is not known. Once access to the PDS has been agreed they will need to set up identified staff with the smart cards that will allow access
- As part of the ongoing process for keeping the NHS numbers up to date they will run regular reports that will identify missing NHS numbers. These reports will be circulated to the relevant managers for action as part of our regular data quality monthly reporting. They will also consider developing an NHS number for completeness performance indicator

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. Secure email standards, interoperability standards (ITK))

Our commitment to APIs and Open Standards

The following organisations are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)):

- Merton Council
- Merton Clinical Commissioning Group

- Sutton and Merton Community Services (part of The Royal Marsden NHS Foundation Trust)
- St George's Healthcare NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust

Systems with API capabilities

SIMON – WE NEED YOUR INPUT HERE

The systems currently in use which have open API capabilities include:

- Staffplan (Homecare Roster) – LB Sutton
- Teleconfirmation (Server) – LB Sutton
- SPOCC – LB Sutton
- CareFirst – (integration can be achieved with CareConnect, the OLM API tool) – Merton
- EMIS Web – Sutton, Merton & Croydon CCG's
- Vision - Sutton, Merton & Croydon CCG's

Systems with open standards

The systems with Open Standards include:

NHS Mail is widely used across our partnered NHS organisations, supported by N3 Connectivity, for the secure transmission of patient confidential data, and the Local Authorities that we intend to share data with have implemented third party email gateway security solutions such as:

- Proof Point – LB Merton

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2

Our commitment to IG Controls

The following organisations are committed to ensuring that the appropriate Information Governance Controls will be in place.

- Merton Council
- Merton Clinical Commissioning Group
- Sutton and Merton Community Services

  (part of The Royal Marsden NHS Foundation Trust)
- St George's Healthcare NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust

We are committed to ensuring that appropriate IG controls will be in place. We are committed to obtaining and maintaining a minimum of level two on all IG Toolkit requirements. We are committed to upholding the values of Caldicott 2, and to fulfilling our duty to share.

- The confidentiality of service user information will be respected
- The duty to share will be met in order to ensure that members of the care team have access the data that is necessary for the delivery of safe and effective care
- Information that is shared for indirect care purposes should be anonymised.
- The rights of service users to object to their data being shared will be respected

We have designed our organisational structure in such a way to give sufficient precedence and priority to information governance, through the IT and data sharing group.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Multi-disciplinary working, risk stratification and case management

The following four component activities with the central professional, the key worker; who acts as the accountable lead professional; is the mainstay of the principle of our out-of-hospital strategy, the expansion of our community-based service model and development of inter-relationships between community services, social care services and primary care.

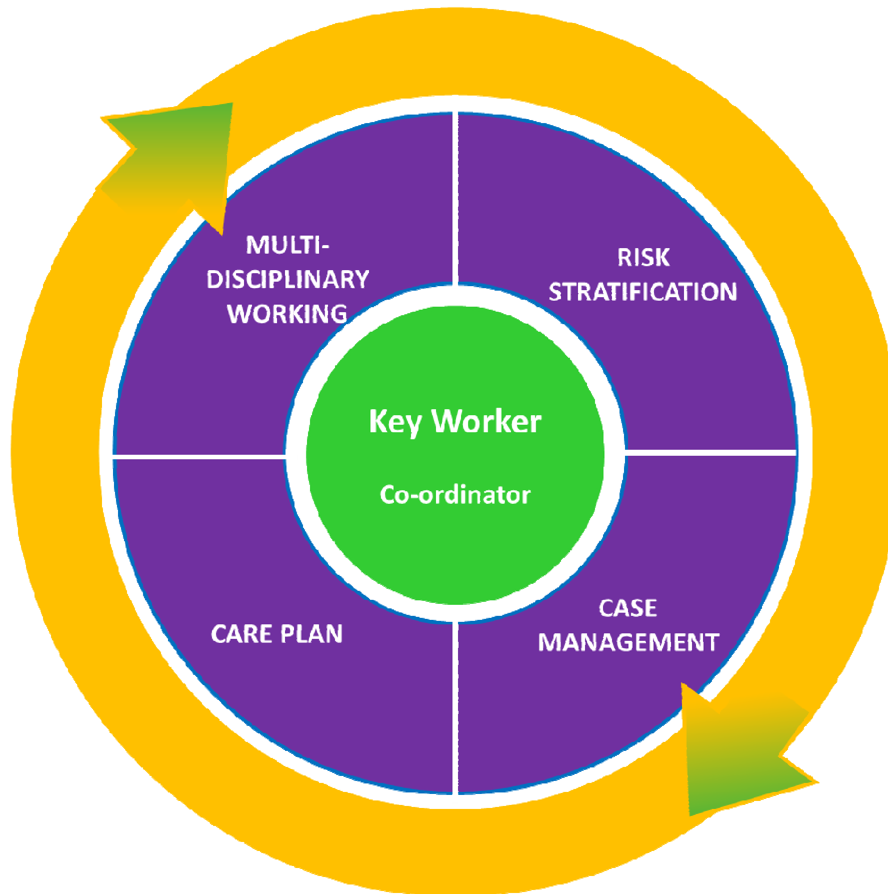


Figure 1: The key activities and central professional underpinning integrated working

All our 25 GP practices in Merton are already undertaking risk-stratification profiling (through engagement with Merton CCG) to identify patient's at high risk of (a) deterioration and subsequent escalation in the community; potential to spend in acute care (b) patients who are frequent attenders in acute services (emergency admissions); already a spend in acute care. The software installed is ACG SOLLIS (appendix 5) and practices have been trained in using this to identify the high risk cohort of the population. Initially, practices and leading GPs were guided to identify patients who were aged 75 years or older with 2 or more long term conditions. This yielded approximately 300 patients per practice on average, a total of 7,500 patients across the population, but with a potential skew towards West Merton where an older cohort of the population reside. This total number was considered surprising, and commissioners reviewed the value of this narrow risk profiling, by reflecting on the Kaiser triangle:

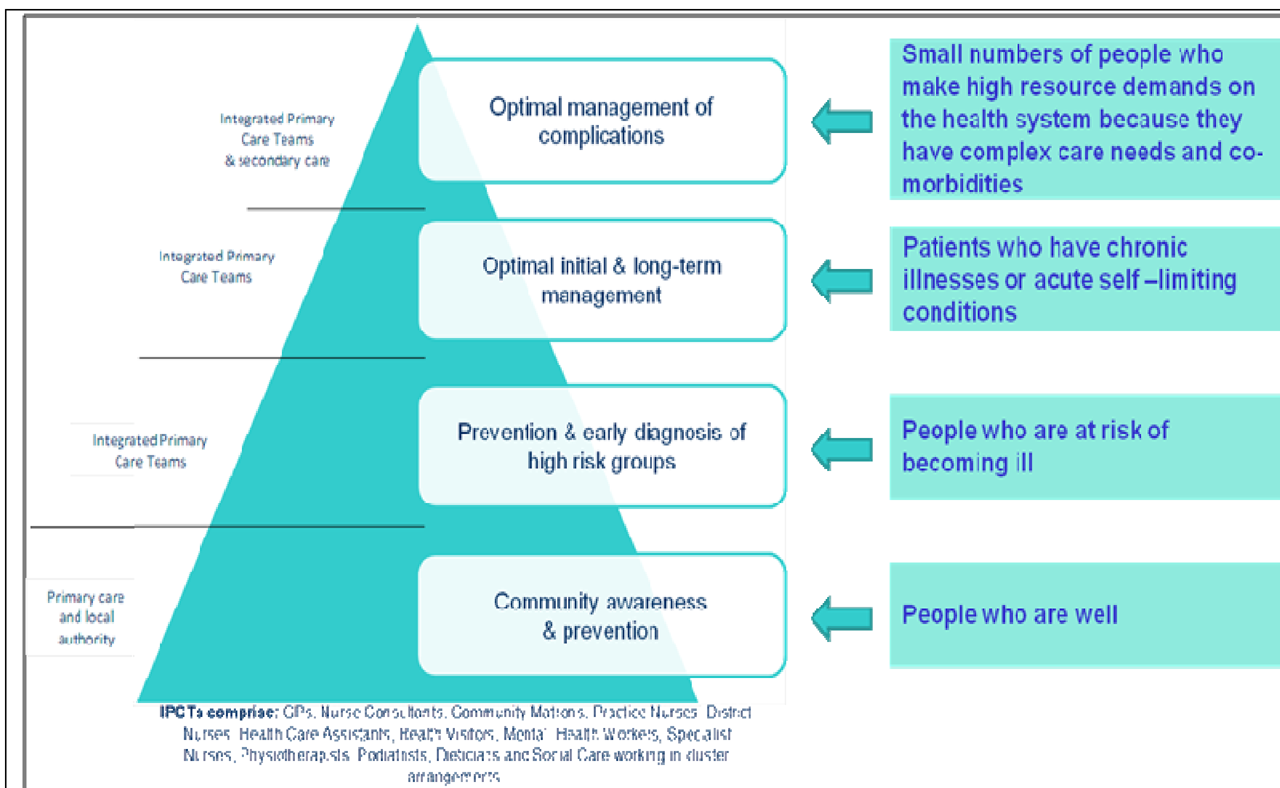
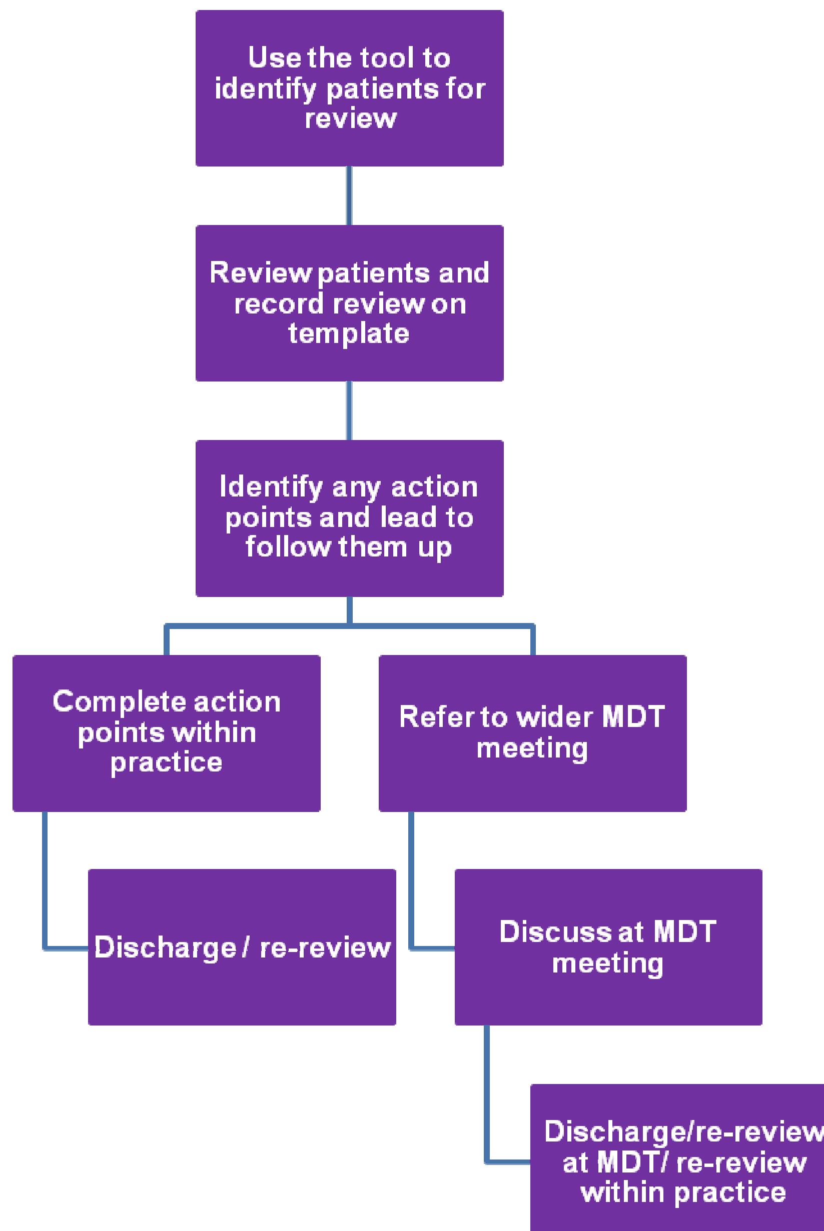


Figure 2: 'Kaiser' Triangle indicating high resource and spend to volumes of population

Commissioners and clinicians have therefore since decided that a less narrow profiling of the population is required, in order to identify a larger volume of the population, and thus more potential for health gain and reduction in spend. Therefore GP practices are now profiling all patients with 2 or more chronic conditions in patients aged 18 years and above. This is expected to yield a higher volume of patients with a high and/or complex health need. This is likely to reduce the variation as a result of age and geography, now including younger patients in East Merton, who have a significantly lower life expectancy than those in West Merton.

GP practices and GP leads in Merton are using the risk stratification profiling as per the following flow chart, linking in with multi-disciplinary teams:



Virtual case management will form the core activity of multi-disciplinary meetings where primary care and community clinicians, alongside social care professionals will review ways in which to deliver care to patients, and jointly agree action plans. A key worker, with an appropriate professional background will be assigned and ultimately be responsible for co-ordinating the care of the individual and providing first-line support to the person and carer in terms of communication, initially assessing ongoing need, developing expectations of care and reflecting this in their care plan. The key worker will also be responsible for communicating progress or further need back to appropriate professionals, including clinicians who need to be connected in with ongoing actions, as well as to the wider MDT team. Ideally this will take place through a shared record system, using the NHS number as a unique primary identifier, and through the appropriate channels in relation to the level urgency (telephone, email, meetings etc.). The latter data sharing component of this way of working is expected to take longer to achieve (as discussed in section 3.c).

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers.

The risk management approach to developing an integrated system has been developed jointly with all key stakeholders. Risks have been identified, discussed and tracked on a continuous and frequent basis throughout the project, through the ICPB. The risk register has been developed in partnership by Merton CCG and LB Merton, with an understanding that the risks and associated impacts are shared between both parties and that there is a requirement to balance those risks on both sides, as well as maintain current services as planned and maintain statutory responsibilities.

Risks were identified around reputation, service capacity, protection of adult social care, financial sustainability and financial risks related to performance including consideration of contractual arrangements.

Risks are recognised and defined through the following workstreams:

- Finance and Performance
- Merton Model / Operational
- IT and Data Sharing
- Workforce and Culture
- Quality
- Patient and Public Involvement

Each risk is discussed and analysed through the Merton Integrated Project Board so that all parties have a clear understanding of the risk likelihood and potential impact(s) on the overall programme. Risk meetings are to be held on a frequent basis with flexibility to increase that frequency should the need arise. Mitigating actions are developed for each risk and are tracked on an ongoing basis. Contingency planning has been built into the financial models and the governance structure has been designed in such a way that allows full visibility of risks to all parties and a tiered escalation route via the Merton Integrated Care Project Board, LA and CCG Executive teams and the Health and Well Being Board should an issue arise.

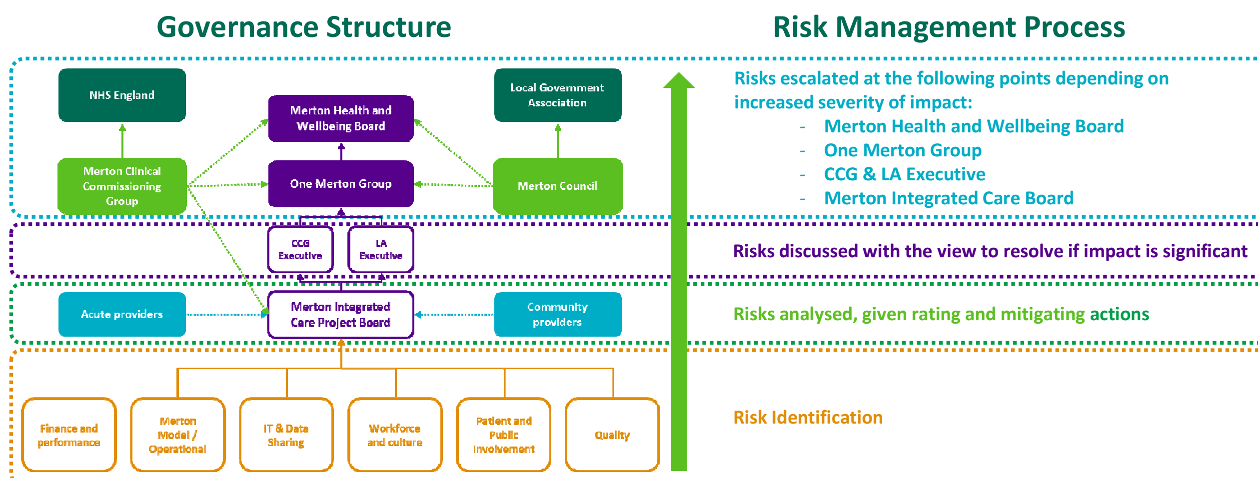


Figure 1: High level risk management escalation process against governance structure

The following risk register has been developed, reviewed and finalised by all key stakeholders. These risks are reviewed on an ongoing basis and will continue to be tracked and managed throughout the duration of the programme.

Risk	Risk Rating	Mitigating Action
The BCF fails to deliver forecast shifts to activity in 2015/16, driving financial pressures in commissioners and providers.	Medium	Robust project management including a separate work stream focused solely on Finance and Performance. CCG is negotiating clearly with acute providers to ensure that there are robustly modelled plans. All providers are assuring CCG QIPP plans
Shifting of resources towards community providers destabilizes one (or more) acute providers due to the cumulative impact of multiple BCF plans across the area	High	Impact will be monitored through SWL Collaborative Commissioning and overall 5 year strategic plan
Introduction of Care Bill results in a significant increase in the cost of provision of care from 2016 onwards and impacts on current planning	High	There is some central government funding proposed for this but it is still unclear as to whether all of it is within the BCF. Local system will keep impact and costs under review. DH has promised that under New Burdens deal that all new duties will be fully funded so primary mitigation is to hold government to this promise. Secondary mitigation to tailor services to resources.

Complexity of measuring success of individual initiatives leading to an impact on the pay by performance element of the BCF	High	Each scheme is being measured to an aggregate level to ensure appropriate savings can be attributed to each scheme
Failure to deliver data sharing project between health and social care undermines integrated service delivery	Medium	Separate work stream solely focused on this work stream with commitment from all partner organisations for this to happen
Tension arises between partners on the definition of 'protection for social services with a health impact'	Medium	Local definition of protection of social services. Regular meetings of senior teams in CCG and council, led and attended by CCG Chief Officer and council Director of Community and Housing. All schemes in plan fully debated and understood. Transparency over financial plans on both sides including savings. Shared performance metrics so impact of schemes and performance of whole system can be monitored
Existing programmes, such as QIPP and social care efficiency programmes, lead to 'double-counting' of savings	Medium	All schemes have been reviewed to ensure that the data sets used triangulate with each scheme to ensure that there is no double counting. The finance and performance group will also monitor these schemes on a monthly basis. Additional scrutiny will take place by an external agency on QIPP/BCF assurance
Merton is not a host commissioner of an acute provider	Low	Merton CCG have strong working relationship with all lead commisoners for the local acute trusts. All current plans are shared and it is expected that the Integration Project Board monitor progress on a monthly basis
Scheme(s) deliver less than 70% of performance resulting in recovery plans being implemented and control over schemes is ceded to NHS England	Medium	A realistic savings target has been applied to the BCF and as such this means that there is system confidence that the scheme can be delivered

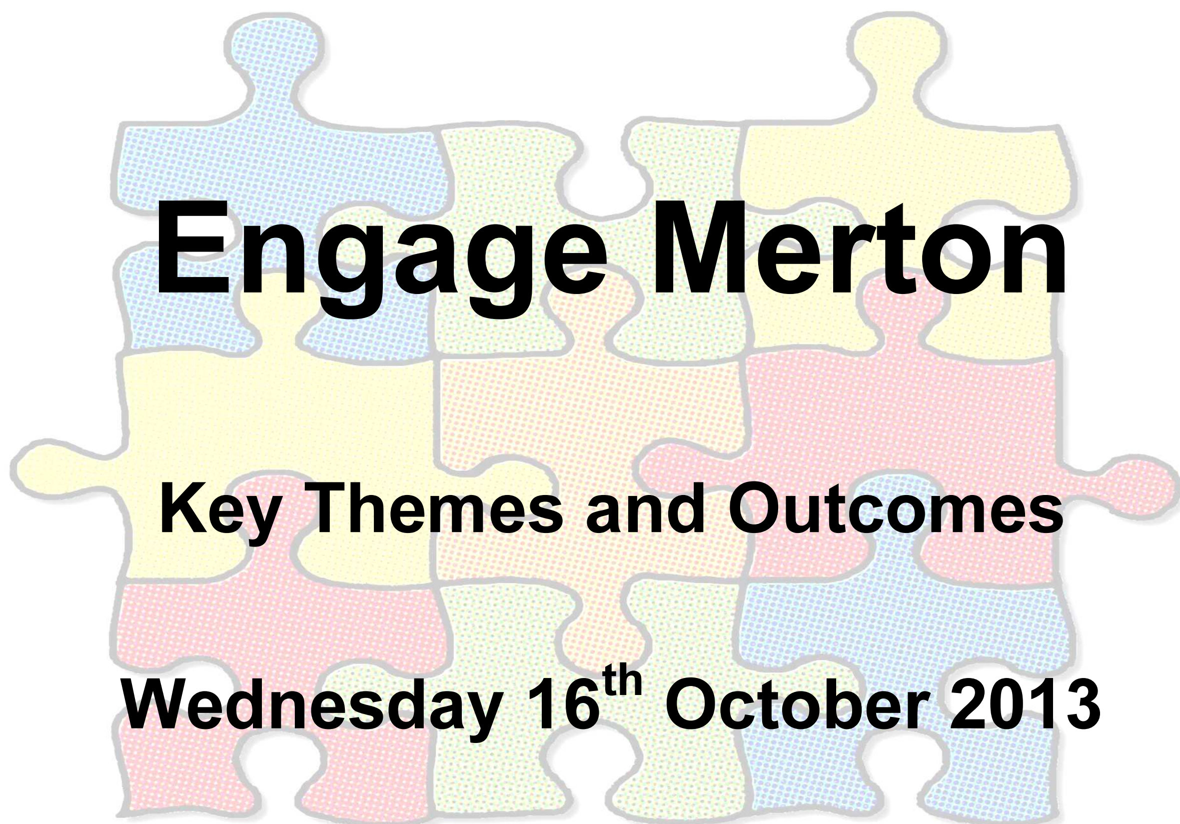
Increasing demand on services (through demographic factors such as an ageing population as well as increased service expectation) means that targets cannot be met	High	All schemes have been reviewed to ensure that the data sets that are being used to triangulate vwith each scheme to ensure that there is no double counting. The finance and performance group will also monitor these schemes on a monthly basis where all providers are present
Existing good performance in Merton (i.e. in upper quartile performance of non-elective admissions) makes achieving further performance improvement, and accessing associated funding, more difficult	High	A realistic savings target has been applied to the BCF and as such this means that there is system confidence that the scheme can be delivered. In addition all schemes hae been clinically endorsed by the Clinical Reference Group within the CCG
Sutton and Merton Community Services contract has only been renewed for one year therefore impetus for long-term changes in way of working may be lacking	Medium	The provider is expected to meet the terms of it's contract and this is measured robuslty on a monthly basis. The provider is expected to want to work closely with the plans to ensure it is in a commercially strong psition in preparation for retendering. The provider are a member of the Integration Project Board and will be held to account in that forum
Health and social care working practice may not change as rapidly as required by QIPP/BCF plans	Medium	There is a separate workforce and culture work stream as part of this project and will address this issue - includining training and development
The BCF is a new policy change requiring new ways of working between stakeholders (i.e. LAs, CCGs and HWBs) which could require support to develop, and culture may not change sufficiently or fast enough to deliver plans	Medium	The Merton Health and Social Care economy has a long term history of integrated working and it has delivered significant improvements in mental health, learning disabilities and children's service. The Health and Well Being Board, One Merton Group, Integration Project Board are well established, have excellent attendance and working relationships are strong. Leadership and teams are committed to integration as are members of the CCG. Training and development is part of the enablers to deliver the plan.

The risk register will be kept as a live document between Merton CCG and LB Merton and regularly updated and presented, as part of the governance activities.

Appendix 1

right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group



Engage Merton

Key Themes and Outcomes

Wednesday 16th October 2013

Author: Clare Lowrie-Kanaka, November 2013

Introduction
On October 16th 2013, Merton Clinical Commissioning Group (CCG) ran the Engage Merton event in partnership with Healthwatch Merton. Patients, members of the public, service users, carers, clinicians and other stakeholders were involved in discussions about the commissioning intentions for 2014-15 and the engagement strategy and implementation plan for 2013-15.

The aim of the event was to communicate and discuss Merton CCGs proposed commissioning intentions, the engagement strategy and its implementation. To listen to the views and suggestions of those who attended, to enable the CCG to build personalised health services that reflect the diversity of individuals and of the local community.

The findings from the event have enabled us to set priorities, form commissioning plans for 2014-15 and an engagement implementation plan for 2013-15. This report summarises the views received during and after the event, highlights key themes, the actions taken by Merton CCG and outcomes to date.

Who is Merton Clinical Commissioning Group?
Merton Clinical Commissioning Group is responsible for commissioning or 'buying' healthcare services for the people who live or work in the borough.

It has been set up as part of new NHS reforms designed to give patients more power and choice, access to higher quality healthcare, and gives frontline professionals greater freedom and a stronger leadership role in their communities.

Our group of 26 GP practices work together with our partners in the local NHS - pharmacists, dentists, hospitals and mental health providers, Merton Council and local community groups, to improve health and wellbeing, reduce health inequalities and ensure everyone has equal access to healthcare services.

Who is Healthwatch Merton?

Healthwatch Merton is the new independent consumer champion created to gather and represent the views of the public. Healthwatch Merton plays a role at both a national and local level, and will make sure that the views of the public and people who use local services are taken into account.

Merton Council awarded the Healthwatch Merton contract to Merton Voluntary Sector Council because of its excellent knowledge of the borough, and its commitment to engaging on a daily basis with its diverse communities.

What Took Place?

Individuals took part in an all day event. The morning started with an introduction to Merton CCG, given by Eleanor Brown, Merton CCG Chief Officer. Followed by a presentation on the draft Commissioning Intentions for 2014/15 from Adam Doyle, Merton CCG Director of Commissioning and a presentation on Communications and Engagement, from Jenny Kay, Merton CCG Director of Quality. After each presentation, participants were given the opportunity to share their views and make suggestion for improvement.

After lunch, participants had the opportunity to take part in two of the following workshops:

- Merton CCG Question Time
- Patient Participation Groups
- Patient Experience: How do we respond to Equalities?

Who Took Part?
57 participants from outside the organisation took part in the event, 19 individuals from within Merton CCG and the Commissioning Support Unit supported the day's events and workshops.

There was representation from:

- Local Council representatives
- Hospital and Community Trusts
- Faith groups and organisations
- Disability groups and organisations
- Patients and the public
- Mental Health groups and organisations
- Black and Minority Ethnic groups and organisations
- Carers groups and organisations
- Older people groups and organisations
- Children, Young People and Families groups and organisations
- Community and voluntary groups and organisations

You Said
These are the key themes only. For a full breakdown on what participants said throughout the day, please see appendix 1.

About the event:
Using the event feedback forms, participants told us:

- 94% said they would recommend a similar event to a friend or colleague
- 58% said they now have a good understanding of Merton CCG's commissioning intentions, 35% said they were not sure
- 78% said staff had adequate knowledge of the subject and I found the presentation easy to understand, 11% said they were not sure
- 83% said they had a chance to get my voice heard and add to the discussions, 17% said they were not sure

About Commissioning Intentions:

About Engagement Strategy:
The following questions were asked of participants, discussions were supported by table facilitators.

How can we - Listen to the People of Merton?

- Use Healthwatch as an access point for listening
- Use other local resources such as existing groups and organisations
- Run more listens events and health days
- Gather information using
  - Annual survey
  - Telephone contact
  - Focus groups
  - Use touch screen
  - Online tools
  - Offer alternatives to online

How can we - Hear carers' views and support them?

- Improve communication with Voluntary Council Sector
- Use existing mechanisms i.e. Carers Merton, Cross Roads, respite services
- Carers to be identified by GPs, keep register of carers – flu jab/annual health check, flag up health needs on assessments
- Training and awareness on carers' issues for Healthcare professionals
- Better promotion of carers' entitlements and services
- Young carers – online campaign/social media/competitions through Carers Merton

Who are 'seldom heard groups'?

- Polish and Eastern Europeans
- Groups that find it harder to communicate, e.g.
    - Dementia/MH/learning
    - People who don't have internet access
    - Older people or people on very low income
    - Younger people, e.g. school nursing, counsellors
    - Homeless
    - Housing Associations
    - Ethnic and faith groups
    - Frail, isolated, housebound, living alone
    - Care homes/sheltered residents
    - Travellers
    - Children & young people
    - Carers
    - Young professionals
    - Sensory & physical impairment
    - Learning difficulties
    - English not first or any language

How do we - Engage with seldom heard groups?

- Work closely with existing voluntary or support workers/groups with a voice for these groups i.e. residence associations, housing associations, tenant participation groups, Merton Priory homes, Merton neighbourhood partnership meeting run Merton Priory homes, including children & young people
- Partnership/joint appointment with voluntary and support groups
- Information sharing and knowledge of voluntary groups – directory – linking to web site searchable
-
- How do we - Mobilise the patients in our GP practices?
- Make Patient Participation Groups work

- Practices to advertise opportunities
- Discuss strategy for good agendas/train chairs/consider grouping practices
- Use the "wait" in GP practices, invest in waiting room technology
- Target specific messages at certain times
- Range of media i.e. internet, text, newsletters, social media, press, council offices, community (services)

How do we - Add value to existing structures and systems?

- The CCG needs to listen well to each element of the structure and systems
- As a result of this, they then need to foster collaboration, not competition
- They will then facilitate the right information for seamless care for patients
- Effective information sharing across agencies not just public sector (with consent)
- Clear access and signposting through the systems for all (professionals, services users, families)
- Information and advice for patients

About Patient Participation Groups:
31 participants attended 2 one hour workshops. During the workshop, participants were asked the following questions relating to setting up, and strengthening patient participation groups.

What support would PPGs / PPG members want now and in the future?

- Support/guidance on recruiting members that are representative of the practice population
- PPG Members given training on, and support with
    - Clarification of roles
    - How to hear patients
    - Confidence building
    - Delivering presentations
    - Talking in public
    - Writing questionnaires and surveys
    - Producing newsletters and promotion materials

How can PPGs support their GP Practice now and in the future?

- Feedback on patients experience to Practice Managers – act as face of the patient
- Help with patient surveys and questionnaires
- Promote the PPG within the practice and at local events
- Hold a contact day
- Health promotion day on specific conditions i.e. diabetes, COPD
- Sign post local services
    - Within the Practice i.e. flu jabs, health MOTs
    - Local Pharmacy
    - Out of hours
    - Walk-in Centres
    - Community Services

Other thoughts and feelings from the workshops

- PPGs should have a budget to do specific pieces of work
- Need support from Practice staff to develop PPGs
- Would like GP practices understanding the benefits they don't have the time to support them. don't know what to do with them and don't see them as a positive resource

About Patient Experience:
Two fictional scenarios were acted out in front of the audience, and through coaching and feedback the participants supported the actors to have more constructive and meaningful interactions. The scenes were based around:

- A refugee attempting to newly register at a GP practice.
- A patient with past alcohol and drug addiction going for an ante-natal appointment.

Key Themes:

- Equalities awareness training should be undertaken by all health professionals, clinical and managerial.
- Support in the community - we must be better informed about what services are available in the voluntary and community sector and signpost appropriately.
- Prejudice - everyone has them, but how these are handled and kept in check when dealing with each other is very important.
- Thinking about what different people need, and altering your approach to fit and suit individual needs.

- Terminology - staying away from medical terms and acronyms and using simple English to enable better communication, especially if it is not someone's first language, they are hard of hearing etc.

We Did

Commissioning Intentions

Message from Adam Doyle: 'I found the event a really helpful experience and am hugely appreciative of the number of people who gave their time to tell us about how the services we commission could be improved. From the feedback given, we have revised our commissioning intentions to include:

- Carers and young carers will be more involved in how we design and shape our services
- When planning and reviewing services, we will look at physical and mental health together
- We have incorporated services for younger older adults
- We need to stretch ourselves further in relation to children with complex needs

Feedback from the Engage Merton event has allowed us to enhance the finished product. Documents can be found at www.mertonccg.nhs.uk

Communications and Engagement

MCCG draft Engagement and Communication Strategy builds on the original Patient Engagement and Communication Strategy agreed by the shadow MCCG Governing Body in November 2012.

The draft Strategy outlines how MCCG communicates and engages with its many audiences or stakeholders, sets out our objectives, guiding principles and key areas of communication and engagement activities we need to focus on to be an effective and responsive organisation. The Implementation Plan outlines the action required to achieve the objectives set out in the Strategy.

Both documents take into account the experience during the first six months of MCCG and draw on feedback from the 'Engage Merton' event and other stakeholder events. Further comments on the draft documents will be accepted up to 31st December. Documents can be found at www.mertonccg.nhs.uk

Conclusion

Merton CCG will continue to use the finding from this event to inform and influence local services. Findings will be shared with internal and external colleagues and made available on our website www.mertonccg.nhs.uk

Merton CCG would like to extend their gratitude and say thank you to everyone who took part in this engagement activity. We hope you will join us in 2014 for the next Engage Merton event.

Appendix 2

Urgent Care QIPP Scheme 2014- 2016
The Urgent Care QIPP Scheme aims to redesign pathways within the Merton area in order to improve the quality and efficiency of urgent care systems.
The two main areas seek to proactively manage vulnerable patients and develop reactive pathways to crises in order to avoid unnecessary hospital admissions and keep patients well in the community.
This will be delivered over the next 2 years in a staged approach, with several work streams combining towards this common aim:

Expansion of CPAT - This builds on the existing CPAT pilot, expanding skills, competencies and remit of the existing MDT team. They currently provide rapid holistic assessments of patients over 18 deemed to be at risk of a hospital admission. The aim is to extend their working hours, introduce medical input and increase support in nursing homes.

Work with St George's Hospital (SGH) :
SGH delivers majority of patient activity for Merton area and areas of inefficiency identified which are to be addressed:

Management of Admissions and Timely planning of transfers of care/discharges – Clarify pathways to identify if alternatives exist and stream line discharge planning.

ED/Community Interface @SGH –Redesign STAR Team, Interface Geriatrician and New OPARS (HARI) model - Propose a redesign of the STAR team to incorporate Medical (in the form of a consultant Interface Geriatrician) and Social Care input to support prevention of unnecessary admission and offer rapid holistic assessments to patients who present unwell to the ED.

Interface Geriatrician working across the ED and into the community within the new HARI (Holistic Assessment and Rapid Investigation) service. This service aims to deliver a community-based rapid holistic assessment including diagnostics via an MDT. Team to include Social care, Nursing, Therapy, Memory Assessment as well as the Consultant Geriatrician, and would have close links with the Voluntary Sector. The Service will be located at the Nelson redevelopment from 2015 (with an interim form from October 2014) and will aim to liaise closely with CPAT and other Community and Primary Care teams.

Review of Intermediate Care Beds - Review of existing Intermediate Care Systems, including beds jointly commissioned currently with Sutton CCG. Aim to redesign Intermediate care model to ensure efficiency and seamless merging with other Urgent Care services and models of care.

Locality Based Multi-Disciplinary Teams (Merton wide)- Aim to improve integrated working to facilitate proactive planning for patients and ensuring rapid access to reablement /rehab and social care to support CPAT / STAR/ HARI in preventing unnecessary admissions. Development of Key workers to co-ordinate care for patients at risk of hospital admission.

Appendix 3

Merton Integrated Care Project

Project Board – Terms of Reference

1. Introduction

The Merton Integrated Care Project will develop integrated care across health and social care in Merton, focusing on older people, with the specific outcomes to achieve:

- Reduction in non elective admissions (or a reduction in the rate of growth in admissions) to the three Acute Trusts serving Merton
- Reduction in lengths of stay in these three hospitals, subject to the financials being made to work so that funds can be used for community alternatives
- Reduction in admissions to residential care or nursing homes
- Increase in patient and carer satisfaction

The project is a partnership including:

- Merton Clinical Commissioning Group
- Merton Council
- Sutton and Merton Community Services (part of The Royal Marsden NHS Foundation Trust)
- St George's Healthcare NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust
- Voluntary and community organisations, with involvement of Merton Voluntary Service Council
- Patients, service users and carers, with involvement of Healthwatch Merton

2. Authority

The Merton Integrated Care Project Board takes its authority from the Merton Health and Wellbeing Board, and reports to it via the One Merton Group.

3. Responsibilities

3.1. Oversees the development and introduction of the “Merton Model” of integrated health and social care.

3.2. Ensures that the style of the project appropriately blends a learning, evolving, exploratory approach which builds on well-functioning aspects of the current system, with a structured project management approach to delivering agreed changes.

3.3. Ensures that the project continues actively to involve users and carers, staff, professionals and managers.

3.4. Supports the development, implementation and performance management of the Better Care Fund

3.5. Ensures that no organisation should be a major gainer or loser in financial terms from integration.

3.6. Ensures the development of a Project Plan with clear milestones and ambitious timescales

3.7. Monitors progress against the project plan, receiving highlight reports from the Project Director and the project groups.

3.8. Monitors progress of key elements of performance of integrated care, with a dashboard of measures, and initiate action amongst the partners where necessary.

3.9. Agrees the range of outcomes expected from each part of the plan assuring their quality.

3.10. Advises on and manages high level risks

3.11. Manages and resolves issues that are identified and escalated.

3.12. Maintains a focus on managing relationships to ensure effective delivery of improved outcomes for patients.

4. Membership

Simon Williams	Director of Community and Housing, Merton Council
Eleanor Brown	Chief Officer, Merton CCG
Dan Burningham	Director of Strategy, South West London & St. George’s Mental Health Trust
David Grantham	Director of Workforce and Organisational Development, Kingston Hospital Foundation Trust

Maggie Gairdner	Director, The Royal Marsden NHS Foundation Trust
Janet Samuel	Head of Clinical Programmes, Epsom & St. Helier Hospital NHS Trust
Paul Alford	Divisional Chair for Community Services, St. George's Healthcare NHS Trust
Trudi Kemp	Director of Strategy, St George's Healthcare NHS Trust

Attendees will attend in particular to the Project Director at the discretion of the Chair.

5. Administrative Support

Minutes	Administrative support to commissioners
Distribution & Dates	Jacqui Phelps, Executive Assistant, Merton Council

6. Quorum

One executive member from Merton Council, one executive from Merton Clinical Commissioning Group, and two provider trust executive members.

7. Frequency

Monthly

8. Governance

The Project Board will report to the Health and Wellbeing Board, via the One Merton Group and individual members to their respective organisations. Appendix 1 shows the governance arrangements.

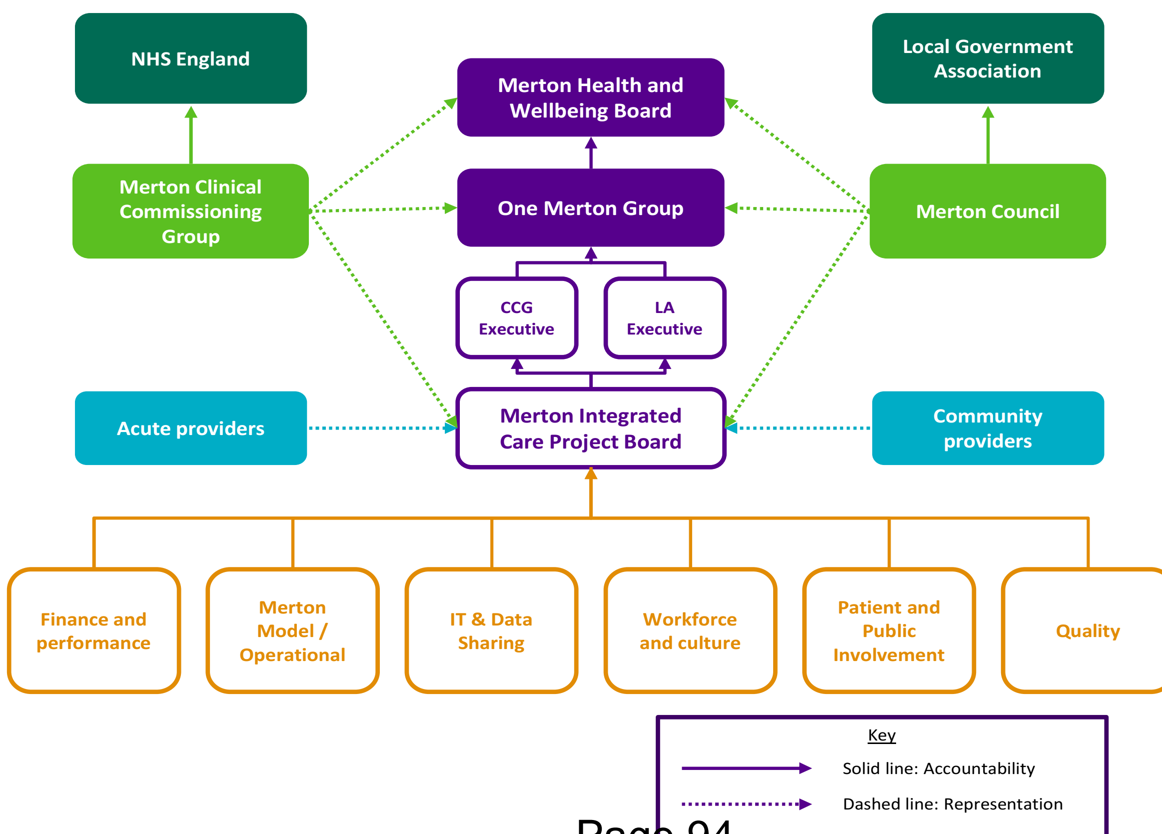
Minutes and action log from this Project Board will be circulated to the chairs of each project group.

9. Review

These terms of reference will be reviewed in October 2014.

February 2014

Appendix 1:



Appendix 4

7-Day Working, London Borough of Merton
Initial Thoughts – Early Draft

The Merton approach to 7-day working has been divided into two separate work streams, which are:

1. The Reactive stream, which is based around the current hospital discharge and Reablement Service to facilitate a rapid and timely response. The aim of the reactive stream is to prevent both social and medical admissions to hospital, attendance at A&E, and to facilitate an earlier discharge through the provision of intensive home care and night sits.
2. The proactive stream will focus on providing an enhanced social work service at St Helier's Hospital and St George's Hospital. The service will operate from hospital sites to Merton residents. It will prevent Merton residents unnecessarily being admitted onto an inpatient hospital ward, and will also enable them to be safely supported to return home with an appropriate package of care, avoiding reliance on institutional care (hospital or care home) wherever possible.

   The amount of social work presence in St Helier's and St Georges will be increased. If there are difficulties with planned discharges, the social worker will do everything possible to resolve these so that discharge is not prevented or delayed.

3. **The Reactive Stream**
   To meet the aims and objectives of the 7-day working programme and NHS England the in-house Service needs to be fully restructured to ensure the right staff, with the right skills is in the right place at the right time. This restructure will include internal Carers, Senior Carers, Social Workers, Assistant Care Managers, Occupational Therapists, Assistant Occupational Therapists and back office staff such as Admin and Care Organisers. The service will be restructured into three geographical patches to comply with the three new health localities and enhance integration opportunities.

   To ensure the 7-day working meets the needs of the customers, it is essential that the interdependencies are recognised and addressed. For the London Borough of Merton there are interdependencies at both ends of the process.

3.1 Interdependencies
Pre-referral – Merton are dependent on health colleagues working 7-days per week to make the referrals into the service. This includes GP's, Community nurses and therapists, Hospital Discharge Coordinators and Consultants. If these groups are not working, referrals on the weekends and out of peak hours will not be possible.

3.2 Post-referral – Following the interventions of the Merton Hospital Discharge and Reablement Service, any case requiring on-going long term support is transferred via the in-house Brokerage Service to an independent sector agency domiciliary

care provider. Again for 7-day working to be achieved there must be a weekend and out of hours Brokerage Service and independent sector agencies will need to extend their hours for taking referrals and setting up care as both services currently work the core 9-5 Monday to Friday hours.

3.3 Additional Resources required

Out of Hours Brokerage Officers to source and set up care packages
Occupational Therapists to implement reablement programmes and techniques and/or provide equipment, minor adaptations and Telecare prior to service packages and /or admissions to residential/nursing or hospital beds.
Out of hours admin support to update the data base on a real time basis.
Additional carers to provide short term intensive home care and night sits
Mobile Response Officer to provide back up and immediate installation of telecare monitoring system

3.4 Additional Training requirements

- All senior Carers to be trained to 'Trusted Assessor' Status
- All carers to receive training in 'Reablement' processes and techniques
- All carers to receive training in basic nursing observations and pressure care awareness.

3.5 Processes

All processes to be reviewed to:

- Eradicate any duplication/overlap internally or with health colleagues.
- Facilitate better use of the independent sector capacity and skills
- Facilitate better use of the third sector specialisms

3.6 Metrics

i. Number of referrals for prevention of attendance, including night sit provision
ii. Number of referrals for prevention of attendance, excluding night sit provision
iii. Numbers of referrals for prevention of admission, including night sit provision.
iv. Numbers of referrals for prevention of admission, excluding night sit provision
v. Number of referrals for prevention of re-admission including night sit provision
vi. Number of referrals for prevention of re-admission excluding night sit provision
vii. Number of referrals for earlier planned discharge, including night sit provision
viii. Number of referrals for restarts, including night sit provision
ix. Number of referrals rejected by the service broken down into the following categories

- Inappropriate referral (wrong borough, insufficient info, medically unfit, under 18)
- Lack of service capacity

x. Number of referrals withdrawn by referrer broken down into the following categories:
   - Medically unstable
   - Family/patient choice
   - Medical support/equipment not in place

xi. No of patients going on to admission following the service

xii. Patients stating their service/experience as good (PREM)

3.7 Proposed costs of additional resource

Post	FT	Unit cost (approx.)	Total cost (approx.)
3 x Occupational Therapists	3	42,000	126,000
2 x Brokerage officers	2	31,000	62,000
2 x Amin Support	2	25,000	50,000
10 x Carers	10 x .5 = 5 FTE	24,000	120,000
1 x Mobile Response Officer	1	40,000	40,000
Total			£398,000

4. The Proactive Stream

4.1 The service will operate as follows;

- **Monday – Friday, 8am – 5pm,** full referral, assessment and supported discharge service for all inpatient wards, assessment wards and accident and emergency units
- **Monday – Friday, 5pm – 8pm**, new referrals will be accepted from assessment wards and accident and emergency units to prevent admissions onto inpatient wards by assessing customer need and risk, setting up immediate support, providing practical help, counselling, information and advice, and signposting. The role of the social worker will also be to resolve any difficulties with planned discharges from inpatient wards, to enable customers to leave hospital.
- **Saturday and Sunday, 9am – 5pm**, same as Monday – Friday, 5pm – 8pm

4.2 Dependencies

A range of other health and social care services and provision will need to be available during the extended hours to enable social workers to effect safe and appropriate hospital discharge and prevention of hospital admission. These include;

- MILES (Reablement, Crisis, Hospital Discharge)
- Community Nurses (monitoring of health conditions)

- Residential/Nursing Homes (respite, interim and emergency admissions) MASCOT (telecare provision for enhanced monitoring, safety and risk management)
- Virtual Beds (for 24 hour care within the home)
- Respite/Reablement Flat (for assessment purposes and to avoid care home admission and promote confidence and independence)
- Occupational Therapy (for assessment and equipment)
- Pharmacy (for provision of medication)
- Hospital Consultants (to agree discharge)
- G.P availability (to facilitate GP home visits where necessary)
- Brokerage (to identify suitable and cost effective care providers)
- Funding (for food, electricity, heating, telephone connection, intensive domestic cleaning, clothing, basic home repairs eg broken windows, new locks etc)

4.3 Outcomes

Clinical – customers will not be admitted to an inpatient hospital ward unless medically necessary, enabling customers to have their needs met in the least intrusive manner, and as close to their familiar home environment as possible. This will relieve pressures on acute services, increase health professionals access to social care services, and improve customer experience.

- **Operational –** joint working between health and social care staff with enhanced hours presence will enable a more productive response to customers, who will be given the right care and support at the most effective time. The project will reduce the spikes in activity caused currently by Monday to Friday working. All of this will support the 4 hour A&E target, other local initiatives to implement seven day working, and support a reduction in the average length of stay for patients

4.4 Costings

Costings have been worked out assuming that locum social workers will be used at a basic rate of £26 per hour. Evening working and Saturday working commands an enhanced rate of 1.5 times the basic rate (£39 per hour), and Sunday working commands an enhanced rate of 1.75 times the basic rate (£45.50).

Costings have also been worked out on the assumption that existing hospital social work staff will cover the hour between 8am and 9am.

Therefore the weekly cost for providing a social worker (2 social workers) at St George's Hospital and St Helier's Hospital from 5pm – 8pm Monday to Friday, and on a Saturday and Sunday from 9am – 5pm, is **£2,743**.

The cost of providing this service 52 weeks per year is **£142,636**.

5. Work Stream Leads

5.1 The Reactive Workstream – Sarah Wells, Service Manager
5.2 The Proactive Workstream – Jenny Rees, Service Manager

NHS
Merton
Clinical Commissioning Group

Appendix 5

How to use the ACG risk stratification tool

Document Version: **1.2**

Date: **10th September 2013**

Review: **1st May 2014**

This guidance is designed to help you make the most of the risk stratification ACG tool currently being rolled out in Merton. It is also aimed at creating some consistency to help synergise everyone's efforts across Merton CCG (community services, acute care, GPs, social services and mental health).

Please note this guide is a work in progress and we are still learning about the best ways in which the tool could benefit Merton practices. It is due to be posted on the Merton CCG Intranet (when it is set up) and therefore can be updated with new learning in the future.

The CCG is very keen for this whole process to be clinically driven. We are aware that all practices are different and the approach needs to be adapted to reflect this.

We would value feedback on developing this guidance and the sharing of any learning that has emerged.

Divya Verma
Darzi Fellow

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Introduction

WHY RISK STRATIFICATION?

- **It is evidence based as being the best way of predicting events compared to other 'case finding' approaches including clinical opinion[1]**
- **To improve patient care - it can be used to identify specific cohorts of patients to target clinical care such as those patients who are 'under the radar' (i.e. not actively managed or known to the GP Practice) or those that may benefit from more proactive support**
- **To improve resource utilisation by reviewing patients predicted to be 'at risk' of high resource use and identifying ways in which this can be reduced**

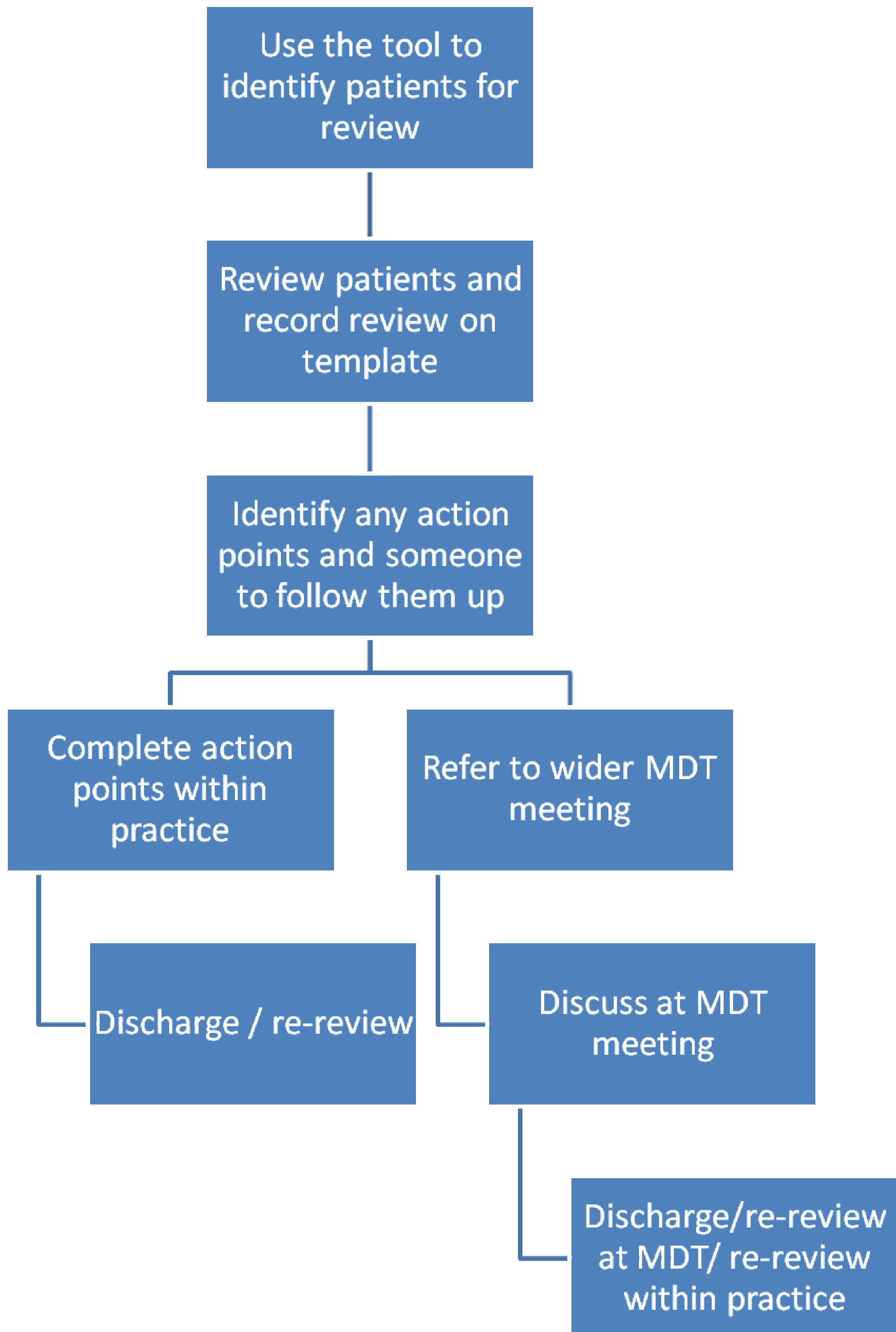
HOW DOES THE ACG RISK STRATIFICATION TOOL WORK?

- **It uses primary care data (READ codes from the GP patient record) and secondary care data (patient SUS data) and feeds it into an algorithm produced by Johns Hopkins University**
- **The algorithm uses the patient's diagnoses and predicted disease patterns to produce scores for the patient. These include scores of current resource use, future resource use, and specific pharmacy use of a patient relative to the practice population**

[1] Nuffield Trust (2011) Choosing a predictive risk model: a guide for commissioners in England. Available at

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/choosing_predictive_risk_model_guide_for_commissioners_nov11.pdf

The risk stratification process



The risk stratification process (step by step guide)

1. **Identify a practice lead for risk stratification and case management.**

2. **Use the ACG risk profiling tool to identify patients to review using the steps provided on page 7.**

3. **Sort the list by predicted relative cost weight with the highest value at the top.**

4. **Review the top 10% of this list (with a cap of 40) using the template (to be provided).**

5. **For each patient reviewed ensure:**
   - **They are coded with the READ code 3896 'Assessment of needs – review'**
   - **All action points are recorded (including referral to MDT meeting)**
   - **A follow up review date is recorded.**

6. **Discuss any patients identified as suitable for multi-disciplinary review at the MDT meeting. These should be held as a minimum on a quarterly basis. Ensure each patient:**
   - **Is coded with READ code 7L1W1 'Assessment by multi -disciplinary team'**
   - **Is allocated a lead professional**
   - **Has a personalised care plan.**

   For more information regarding MDTs and the role of the lead professional refer to the paper entitled 'Integrated Care in Merton' August 2013.

7. **Each quarter re-run the risk profiling tool as described in step 2 to identify the patients that are in the top 10% (cap at 40) in this quarter. Order the list starting with the highest predicted relative cost weight.**

8. **Identify anyone on this list who has not already been reviewed. This could be done by searching for anyone who does not have the READ code 3896 or by comparing practice numbers/patient names.**

9. **Review and discuss identified patients using the process described in steps 4 to 6.**

10. **Ensure there is a system to identify previous patients who need re-reviewing and action points have been completed from the previous review process.**

11. **Complete the DES monitoring form every quarter. A search can be performed on the READ codes above.**

Identifying patients

The first step to reviewing patients is to filter the practice population using certain parameters stated in the DES:

a) Patients with 2 or more of the specified long term conditions (asthma, COPD, ischaemic heart disease, heart failure, diabetes)

b) Patients with dementia

Below is a step by step guide on how to do this:

No.	Action
1	Log onto tool
2	Open the case management report
3	Filter in the tool by chronic conditions. Only select the boxes: 'asthma', 'congestive heart failure', 'chronic obstructive pulmonary disease,' 'diabetes', 'ischaemic heart disease.' Press view report
4	Click on the floppy disc icon on the toolbar and export the data to excel
	Scroll across till you can see a spread of 11 chronic conditions Delete the 6 columns which are not the specified conditions above e.g. delete arthritis, chronic renal failure etc. You should be left with 5 columns titled asthma, congestive heart failure, COPD, diabetes and ischaemic heart disease Do not delete hospital activity or any other data
5	Use the 3 new columns on the right hand side at the end of the table (AN, AO and AP) and head them: "ICD Count", "BTH count" and "Total Diagnosis count" respectively. You will need to expand the columns at the top to be able to enter these headings
6	Enter the formula =COUNTIF(W13:AA13,"ICD") into cell AN13 ('ICD Count' column) for the first patient
7	Enter the formula =COUNTIF(W13:AA13,"BTH") into cell AO13 ('BTH Count' column) for the first patient
8	Enter the formula =AN13+AO13 into cell AP13 ('Total Diagnosis Count' column) for the first patient
9	Drag down the formula through each column by selecting the cell where you have entered the data and hovering over the bottom right corner. There will be a black cross which appears which you can then drag
10	Select all rows with data and sort the spreadsheet 'Total Diagnosis Count' column by decreasing values. Please remember to highlight the entire table before sorting on this

	column. You can use the sort and filter option under the heading data and choose 'custom sort' to do this
11	Delete any rows where the count in this column is less than 2
12	Then go back to the tool and search for patients with dementia and delirium under the EDC heading Neur11. Remember to clear any previous filters before running this search
13	Export these patients to excel
14	Delete the 6 columns which are not the specified conditions above e.g. delete arthritis, chronic renal failure etc. You should be left with 5 columns titled asthma, congestive heart failure, COPD, diabetes and ischaemic heart disease Do not delete hospital activity or any other data
15	Select the patients, copy, and paste into the list of patients with 2 or more specified chronic conditions under the last entry. Remember to paste in the very first column (A)
16	Sort by 'predicted relative cost weight' to ensure patients with the highest risk are at the top
17	Save your list to a secure filing area in your practice and label: '2 or more chronic conditions or dementia ddmmyy'

Helpful tips:

- **The data is refreshed monthly on the third Thursday of every month so it is best to generate new lists after this date**
- **Take your top 40 as a starting point and copy this into a new excel spreadsheet /hide the remaining patients**
- **It is often useful to take a few more patients than just the top 10% as there may be patients you do not wish to review (e.g. deceased/previously discussed at GSF meeting) and this enables you to move down to the next person on the list**
- **Some practices have found it helpful to place an 'at risk' marker on the records of these patients so that they are aware that this patient is predicted to have a high predicted cost weight during consultations**

Reviewing risk stratified patients

WHY:

- **A chance to identify and raise awareness of individual risk factors which may 'tip' the patient into crisis**
- **An opportunity to try and intervene in a proactive manner and prevent their conditions worsening and/or emergency hospital admission. These will often be small interventions to try and reduce the predictive risk**
- **To assess whether they would be appropriate to be discussed in a MDT meeting**

HOW:

- **Review the data and record any actions completed as well as those to be completed on a computerised practice system template**
- **Some of the data sources available for review are:**
    - **List of patients produced for the DES (CONSIDER: predicted relative risk, difference in cost weight, diagnoses, hospital dominant count, inpatient emergency admissions)**
    - **Secondary/community care correspondence (CONSIDER: medications, current conditions and their status, causes of A&E admission)**
    - **Patient select and patient viewer section of ACG tool – accessed by clicking the NHS number of the patient (CONSIDER: hospital utilisation)**

- **The template provides a structured way to record the review process. Templates are being designed for EMIS Web, EMIS LV, EMIS PCS and Vision**

Below is a draft of this template and the options available to READ code. The points in purple are some points which may be useful to consider whilst reviewing patients.

Chronic Disease Management

Compare the medical record against ACG coding and secondary care correspondence. Is the ICD coding correct in the records?

Medical records coding reviewed (EMISQRE17 - Review of patient medical records)

....
...

Codes to be added

H33 - Asthma
H3 - Chronic obstructive pulmonary disease
C10F - Type 2 diabetes mellitus
C10E - Type 1 diabetes mellitus
... and 13 more
____

....
...

PLEASE NOTE: Codes will be added to the medical record but NOT to the Problem list; please add codes manually.

....
...

Review of correspondence

Appropriate actions from correspondence taken (9NDG - Letter actioned by GP)

....
...

Actions taken:

9b0n - Telephone call to a patient
9NC3 - Letter sent to patient
413 - Laboratory test requested
5112 - Radiology requested
9N7-2- Patient asked to come in

....
...

Review of Service Use

Is there anything that can be done to prevent these occurring again e.g. prophylactic antibiotics, referral to specialist services, education about their condition?

Is patient accessing health services inappropriately?

9NO - Inappropriate use of out of hours service

EMISNQIN65 - Inappropriate use of walk-in centre

9Nr - Inappropriate use of accident and emergency service

....

..

Medication

Has medication been reviewed for suitability, side effects and compliance?

8B3V - Medication review done

8B3U – Medication review due

....

...

Prevention, Self-Care and Risk Identification

Consider referral for education of their conditions e.g. EPP, diabetes structured patient education, pulmonary rehab, heart failure, memory clinics

Has patient had all appropriate immunisations?

Yes - 68N1 - Up to date with immunisations

No - 68NL - Immunisation due

....

...

Is the patient at risk of falls?

Yes - 14OC - At risk of falls

No - 14OW - Low risk of falls

....

...

Is the patient a carer?

Yes - 918G - Is a carer

No - 918r - Not a carer

....

...

Does the patient have a carer?

Yes - 918F - Has a carer
No - 918V - Does not have a carer

....
...

Does the patient have mental health needs?
6A6 – Mental Health Review

Is the patient housebound?

13CA - Housebound

Care Plan

Personal care plan completed (GP contract - KPI) (8CMD - Personal care plan completed)

....
...

Personal care plan offered (9NS5 - Personal care plan offered)

....
...

Assessment of needs - review (DES) (3896 - Assessment of needs - review)
This could be where the action points are noted

....
...

Patient identified for discussion at MDT meeting (8HlQ - Referral for multidisciplinary review)

(Some practices have also coded patients considered 'at risk' of hospital admission using 13Zu – at risk of hospital admission)

....
...

Actions from review of records

Therapy Referrals Recommended

- ❑ 8H77 – Refer to Physiotherapist
- ❑ 8H7X – Refer to Podiatry
- ❑ 8H7J – Refer to occupational therapy
- ❑ 8HTP – Referral to musculoskeletal clinic
- ❑ 8H7G Refer to speech therapist
- ❑ 8H7u – Referral to pulmonary rehabilitation
- ❑ 8Hj0 – Referral to diabetes structured education programme
- ❑ 8H7b – Refer to day hospital
- ❑ 8HH5 – Refer to domiciliary physiotherapy
- ❑ 8Hk3 – Refer to community respiratory team

Nursing Referrals Recommended

- ❑ 8H7w - Referral to continence nurse
- ❑ 8Hk3 - Refer to community respiratory team
- ❑ 8H71 – Refer to practice nurse
- ❑ 8H7e – Referral to nurse practitioner
- ❑ 8H72 – Refer to district nurse
- ❑ 8H72 – Referral to heart failure nurse
- ❑ 8HHJ – Referral to respiratory nurse specialist
- ❑ 8HHD – Referral to tissue viability nurse specialist

Other Referrals Recommended

- ❑ 8H7p – Referral to community alcohol team
- ❑ EMISNQRE57 – Refer to case manager
- ❑ 8H78 – Refer to counsellor
- ❑ 8H76 – Refer to dietician
- ❑ 8H7A – Refer to mental health worker
- ❑ 8H7H – Refer to optician
- ❑ 8H4D – Referral to psycho-geriatrician
- ❑ 8Hc0 – Referral to community mental health team
- ❑ 8HT2 – Referral to hearing aid clinic
- ❑ 8H75 – Refer to social worker

Follow-up of MDT meeting

Named clinician
....
.

Follow-up Date (9c0H - Follow up)

………
.

Helpful tips:

Administration

- **It may be helpful to freeze the headings on the spreadsheet whilst reviewing patients.**
- **You can print the list off before-hand but the headings are not duplicated onto every page so it can be difficult to know what the columns refer.**

The process

- **Whilst conducting the review it may be useful to have two windows of the patient record open – one to review the notes and the other to complete the template**
- **Some GPs have found it helpful to start this process by reviewing previous action points to ensure they have been completed and discussing any patients from previous discussions whose follow up review is due.**
- **There has been some positive feedback on the benefits of having two or more clinicians present for the review process to be able to challenge each other**
- **It is important the practice seeks patient consent to proceed with any intervention/service advised following the review**

The data

- **The important columns to look at are difference in cost weight, predicted cost weight and hospital dominant count as these are future indicators. Try not to get too distracted by cost which is historic**
- **If the difference in current and predicted risk is negative this suggests the risk is decreasing and these may not be the best patients to review**
- **There may be duplication in some of the patients being identified for review and those being discussed within GSF/EOL meetings. It may be more useful to select another patient from the list if these patients have been reviewed comprehensively already**
- **Patients with cancer or on dialysis may already be well managed within secondary care and there may be little more that can be done.**

NB: If there are any issues being raised regarding the quality of the tool please could you feed these back to David Wilcox and cc Annette Bunka (contact details on page 18)

Multi-disciplinary team (MDT) meetings

The MDT meeting will be practice based (initially at least) with a core team of GP, practice nurse, social worker and named clinician from Community Services.

- **Merton Adult Social Services – there are three senior social workers who are currently supporting this (one for each locality) please see Appendix 3 for details. Additional staff to support this work are being selected and trained.**
- **Community Services – there are community sisters allocated to cover all practices (please see Appendix 4 for details)**
- **The MDT meetings should occur on a minimum quarterly basis.**
- **A lead professional/key worker needs to be nominated – training is currently being developed to support this. For more information see the paper 'Integrated Care in Merton' August 2013.**

Helpful tips:

- **It has been suggested that it is useful to have some time prior to the first meeting to get to know the team members, the services they provide and clarify expectations of both sides from the meetings.**
- **One way of engaging all parties involved could be to ask everyone to submit patients they would like to discuss in advance and these can be added to the existing list which would already have been circulated**
- **The MDT could be added onto the end of an existing MDT meeting such as the CMC/GSF meetings**

- **The MDT could be widened to include mental health, palliative care, third sector, specific community team nurses e.g. heart failure nurse.**

Information Governance

IG arrangements are currently changing around risk stratification due to the new guidance which has been released by NHS England.

It is important to be aware that GP Practices have a legal responsibility to make patients aware that their data is being used for the purpose of risk stratification.

There is a generic leaflet and poster which has been created by SL CSU for patient awareness. This should have been provided to practices with the training session or can be obtained by contacting David Wilcox or Wendy Gault (see page 18)

Sources that can be used to increase awareness include:

- **Posters**
- **Leaflets**
- **Website**
- **Patient participation groups**

These should also be made available in other languages as appropriate for your practice population

Future Development Plans

- **A macro to allow the patient list to be viewed with patient names**

- **A Merton CCG template to record actions and outcomes from reviewing patients as part of the risk stratification DES. This template is currently being developed and ratified for EMIS Web, EMIS PCS, EMIS LV and Vision**

- **New data sharing contracts to allow the CCG to access practice and CCG level data without patient identifiers in order to help better understand the disease profile in Merton CCG**

- **Developing consistent care plans across the CCG with a potential of using the data from the template to mail merge into care plans for the patient**

Contacts

- **ANNETTE BUNKA (Merton CCG) – annette.bunka@mertonccg.nhs.uk**

Contact regarding DES enquiries and overall programme of integration

- **WENDY GAULT (CSU) – wendy.gault@nhs.net**

Contact regarding queries on training and the ACG tool

- **DAVID WILCOX (CSU) – david.wilcox@swlondon.nhs.uk**

Contact regarding queries on training and the ACG tool (and preparing the list of patients for the DES)

- **DR CARRIE CHILL (PRIMARY CARE SUPPORT) – caroline@carolinechill.co.uk**

Contact regarding queries on the contents of the template

- **JEREMY ROBERTSON – jeremy.robertson@smcs.nhs.uk**

Contact regarding community services attendance in MDT

Glossary

Adjusted Clinical Groups

Adjusted Clinical Groups are used to categorise patients who have a similar pattern of morbidity and resource consumption over the course of a given year. Diagnostic data from primary and secondary care, and primary care prescribing data is used to assign patients to ACGs.

Aggregated Diagnosis Groups

Aggregated Diagnosis Groups (ADGs) are used to categorise diseases and conditions. They represent clusters of ICD codes that are grouped into a single ADG based on the following five clinical criteria:

- Duration of the condition (acute, recurrent, or chronic): How long will healthcare resources be required for the management of this condition?
- Severity of the condition (e.g., minor and stable versus major and unstable): How intensely must healthcare resources be applied to manage the condition?
- Diagnostic certainty (symptoms versus documented disease): Will a diagnostic evaluation be needed or will services for treatment be the primary focus?
- Aetiology of the condition (infectious, injury, or other): What types of healthcare services will likely be used?
- Specialty care involvement (e.g., medical, surgical, obstetric, haematology): To what degree will specialty care services be required?

A patient may be in more than one ADG

Expanded Diagnosis Clusters

Expanded Diagnosis Clusters (EDCs) are groupings of diagnosis codes which are used to easily identify people with specific diseases or

symptoms. There may be many ICD codes for a particular diagnosis, so they are mapped to a single EDC to reduce the impact on your analysis of differences in ICD coding styles

EDCs are also grouped into Major Expanded Diagnosis Clusters (MEDCs). For example, there are six allergy EDC codes which are grouped under a single 'Allergy' MEDC code

Current cost weight

The relative cost weight based on the ACG assigned to the individual, relative to an average of 1.0 for the whole population. This is sometimes referred to informally as ‘current risk’

Predicted cost weight

The estimated relative total costs for the following 12 months. This is based on how an individual’s disease burden is likely to change and is compared to a population average of 1.0. This is sometimes referred to informally as ‘Predicted Relative Risk’

Hospital Dominant Count

A count of Aggregated Diagnosis Groups containing trigger diagnoses indicating a high probability (typically greater than 50%) of future admission

Frailty Flag

This flag exists if the individual has a diagnosis related to any of the following: malnutrition, dementia, impaired vision, decubitus ulcer, incontinence, loss of weight, obesity, barriers to access of care, mobility impairment, fallers

GP Activity

Count of all GP ‘encounters’ recorded in the practice system

Appendix 1 - Lists to assist with PMS KPI targets

In the PMS contract the admission reduction KPI requires practices to review and produce care plans for all patients who are at risk. It specifies these as:

1. **2 or more emergency admissions in the last 12 months**
2. **2 or more of the following chronic conditions: asthma, COPD, chronic heart failure, ischaemic heart disease, diabetes**
3. **Other patients considered at risk e.g. those identified by a risk profiling tool**

It is important to have systems in place to identify and review these patients

1. Creation of a list of patients with 2 or more emergency admissions in the last 12 months

No.	Action
1	Log onto tool
2	Open the case management report
3	Filter in the tool by care utilisation. Only select the box 'Inpatient Emergency Activity > 0'. Press view report
4	Sort in the tool by decreasing number of emergency admissions
5	Click on the floppy disc icon on the toolbar and export the data to excel
6	Delete all rows towards the bottom where there are less than 2 emergency admissions
7	Save your list to a secure filing area in your practice and label: '2 or more emergency admissions ddmmyy'

2. Creation of a list of patients with 2 or more specified chronic conditions in the last 12 months

No.	Action
1	Log onto tool
2	Open the case management report
3	Filter in the tool by chronic conditions. Only select the boxes: 'asthma', 'congestive heart failure', 'chronic obstructive pulmonary disease,' 'diabetes', 'ischaemic heart disease.' Press view report
4	Click on the floppy disc icon on the toolbar and export the data to excel
	Scroll across till you can see a spread of 11 chronic conditions Delete the 6 columns which are not the specified conditions above e.g. delete arthritis, chronic renal failure etc. You should be left with 5 columns titled asthma, congestive heart failure, COPD, diabetes and ischaemic heart disease Do not delete hospital activity or any other data
5	Use the 3 new columns on the right hand side at the end of the table (AN, AO and AP) and head them: "ICD Count", "BTH count" and "Total Diagnosis count" respectively. You may need to expand the columns at the top to be able to enter these headings
6	Enter the formula =COUNTIF(W13:AA13,"ICD") into cell AN13 ('ICD Count' column) for the first patient
7	Enter the formula =COUNTIF(W13:AA13,"BTH") into cell AO13 ('BTH Count' column) for the first patient
8	Enter the formula =AN13+AO13 into cell AP13 ('Total Diagnosis Count' column) for the first patient
9	Drag down the formula through each column by selecting the cell where you have entered the data and hovering over the bottom right corner. There will be a black cross which appears which you can then drag
10	Sort the spreadsheet 'Total Diagnosis Count' column by decreasing values. Note, you must highlight the entire table before sorting on this column. You can use the sort and filter option under the heading data and choose 'custom sort' to do this
11	Delete any rows where the count in this column is less than 2
12	Further sort by 'predicted relative cost weight' to ensure patients with the highest risk are at the top
13	Save your list to a secure filing area in your practice and label: '2 or more chronic conditions ddmmyy'

Appendix 2 – What else can you look at:

- **Patients most likely to go into hospital** – sort by hospital dominant count (i.e. number of conditions that make them >50% likely to go into hospital) as well as predicted relative cost weight
- **Patients at risk of greatest change in their scores** – sort by difference in cost weight
- **Patients who have low GP attendance but are at highest risk** – filter by GP Activity = 0 (under care utilisation) then order by predicted cost weight
- **Patients with high predicted future pharmacy costs** – sort by predicted relative pharmacy cost weight
- **Patients with particular disease profiles** (to ensure QOF targets are being met) – filter by chronic condition or if you want to be more specific EDC
- **Highest A&E admissions** – filter by inpatient emergency admissions>0
- **Frail and elderly (possibly for reablement)** – filter patients with frailty flag
- **Patients with a chronic disease but no contact** – select the tile 'patients with chronic disease and no activity'. Sort by predicted cost weight. Do the top few need any extra interventions?

- **Appendix 3 – Social Services Teams**

East Merton
Senior Social Worker
(Health Liaison)
Gifty Asare- Badu
Telephone: 020 8545 4431
Email:
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Appendix 4 Community Services Contacts

Surgery	Community Sister	Team Mobile	Team email	Nurse Manager	Nurse Manager Contact
Alexandra Road	Sheryl Moore-Quavar	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Cannon Hill Lane	Vacant (covered by Antonia Brown)	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Central Medical Centre	Antonia Brown	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Church Lane	Catherine Gourlay	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Cricket Green Medical Practice	Melissa Civale	077 7573 2457	nhsswl.smcsMitchamTeam@nhs.net	Lisa Venables	07881 831 389
Figges Marsh Surgery	Melissa Civale	077 7573 2457	nhsswl.smcsMitchamTeam@nhs.net	Lisa Venables	07881 831 389
Francis Grove	Sheryl Moore-Quavar	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Graham Road Surgery	Melissa Civale	077 7573 2457	nhsswl.smcsMitchamTeam@nhs.net	Lisa Venables	07881 831 389
Grand Drive	Vacant (covered by Catherine Gourlay)	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
James O'Riordan	Antonia Brown	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Lampton Road	Vacant (covered by Sheryl Moore-Quavar)	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Lavender Fields / Colliers Wood Surgery	Angella Barrett	077 7068 4838	nhsswl.smcsMitchamTeam@nhs.net	Lisa Venables	07881 831 389

Merton Medical	Catherine Gourlay	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Mitcham Medical Centre	Angella Barrett	077 7068 4838	nhsswl.smcsMitchamTeam@nhs.net	Lisa Venables	07881 831 389
Morden Hall	Catherine Gourlay	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Princes Road	Sheryl Moore-Quavar	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Riverhouse Medical	Sheryl Moore-Quavar	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Rowans Surgery	Ash Kassaye	079 6131 7073	nhsswl.smcsMitchamTeam@nhs.net	Lisa Venables	07881 831 389
Stonecot	Antonia Brown	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Tamworth House Surgery	Ash Kassaye	079 6131 7073	nhsswl.smcsMitchamTeam@nhs.net	Lisa Venables	07881 831 389
Vineyard Hill	Sheryl Moore-Quavar	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Wandle Road	Antonia Brown	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069
Wideway Medical Surgery	Ash Kassaye	079 6131 7073	nhsswl.smcsMitchamTeam@nhs.net	Lisa Venables	07881 831 389
Wilson Walk in	Melissa Civale	077 7573 2457	nhsswl.smcsMitchamTeam@nhs.net	Lisa Venables	07881 831 389
Wimbledon Village	Sheryl Moore-Quavar	07714 427 043	nhsswl.smcsWimbledonTeam@nhs.net	Jeremy Robertson	020 8687 4760 0777 085 0069

Appendix 5 – Risk stratification DES

Enhanced Service Specification - Risk Profiling and Care Management Scheme -2013/14

The minimum requirements for the Merton CCG Enhanced Service Scheme entered into with GP practices are that:

1. **The GP practice carries out, on at least a quarterly basis, risk profiling using the risk profiling tool agreed by Merton CCG (which for 2013/14 is the Sollis/ACG tool) DES REQUIREMENT A**

2. **The GP practice use the risk profiling tool on a minimum quarterly basis to identify two cohorts of patients:**
   a. **Patients with 2 or more of the specified long term conditions (asthma, COPD, ischaemic heart disease, heart failure, diabetes)**
   b. **Patients with dementia**

3. **The above cohorts are combined to create one list of patients**

4. **The patients identified by these searches are sorted by predicted relative cost weight[1] (used as a proxy for emergency admission risk) which is calculated by the tool**

5. **The practice selects the top 10% of this sorted list (with a cap at 40 patients) for initial assessment within the practice, on at least a quarterly basis.**

6. **The initial assessment consists of a review of the patient using the criteria attached in Appendix A on a computerised practice system template. The initial assessment should be READ coded 3896 'Assessment of needs – review' in the patient record**

7. **Patients from the initial assessment considered suitable for active case management are identified for discussion at a Multi-Disciplinary Team (MDT) meeting DES REQUIREMENT B**

8. **The practice needs to redo steps 2-5 above and review the list of the top 10% (or the top 40 patients) at least every quarter and undertakes an initial assessment on any patients who are new to that list**

9. **The patients identified for case management are discussed within an appropriate MDT meeting on at least a quarterly basis, in order to develop a personalised care plan. This care plan should be designed to improve quality of care and reduce individual risk of emergency hospital admission, using an integrated approach. Patients are reviewed as required. The discussion at the MDT should be READ coded 7L1W1 'Assessment by multi disciplinary team' in the patient record DES REQUIREMENT D**

10. **Within the multi-disciplinary team, a lead professional needs to be nominated who is responsible for each patient identified for case management, including: DES REQUIREMENT E**

- **Undertaking a review with the patient**
- **Undertaking a care planning discussion with the patient (and carer if appropriate)**
- **Ensuring delivery of the personalised care plan agreed in the MDT**
- **Agreeing the frequency for reviewing the care plan with the patient**

11. **The practice also needs to agree an overall nominated lead for risk stratification and case management DES REQUIREMENT E.**

[1] The estimated relative total costs for the following 12 months. This is based on how an individual's disease burden is likely to change and is compared to a practice population average of 1.0

Risk Profiling and Care Management Scheme – Quarterly return

i. The GP Practice has carried out risk profiling at least once this quarter using the risk profiling tool agreed by CCG.	Please indicate: YES or NO
ii. State the number of patients that meet the agreed criteria: (as identified in Steps 2-4 by your risk profiling tool).	Please state number:
iii. State the number of patients (from the list above) who have had an initial assessment using the agreed criteria.	Please state number:
iv. State the number of patients (from the list above) who have been reviewed by a multi -disciplinary team.	Please state number:
v. The practice to confirm it has carried out regular MDT meetings (at least quarterly) which have developed a shared and integrated approach to the case management for patients identified in iv above.	Please indicate: YES or NO. Please list dates of MDT meeting:
vi. The MDT to agree a nominated lead professional who is responsible for each of the patients identified for case management whose role includes undertaking a review and care planning discussion with the patient at a frequency agreed with the patient and delivering the care plan .	Please summarise the number of patients newly allocated to specific professional groups by the MDT. GP- Practice Nurse- District Nurse - Therapist (please specify) - Social Care- Other (please specify) -
vii. The practice to agree an overall nominated lead for risk stratification and case management.	Please state overall lead professional in the practice for this work:

For post payment verification the practice should retain:

- **Sign in sheets to MDT meetings**

Appendix A- Initial Assessment Template – options to appear as dropdown options or spaces on a computerised template. This template will have a READ code which can be used by GPs to run searches if required. If any of the answers are 'no' please action/record action points to be carried out

Chronic Disease Management

- Are all diagnoses coded correctly (Y/N)

Recent correspondence (e.g. secondary care/community services letters) and service use

- Have recommendations been completed (Y/N)
- Is patient accessing right services at right time e.g. A & E attendance (Y/N)
- Is education required informing of alternatives (Y/N)
- Are any investigations outstanding or required (Y/N)
- Action points from above questions: ………………………………………………

Medication

- Is medication appropriate – consider polypharmacy, prophylactic medication (Y/N)
- Is the medication review in date – consider use of community pharmacist (Y/N)
- Is compliance an issue (Y/N)
- Action points from above questions…………………………………………..

Prevention and self care

- Has patient had all appropriate immunisations
- Has patient and carer been referred/signposted for education and help for their conditions – consider EPP, diabetic, pulmonary rehab, heart failure, memory clinic services, third sector (Y/N)
- Is there a support mechanism in place for crises e.g. telephone number (Y/N)
- Have you considered risk of falls, screening for depression/dementia, social care assessment (Y/N)
- Does the patient have a carer – are they known to the practice, are they READ coded (Y/N)
- Is the patient a carer and had a carer assessment
- Action points from above questions……………………………………………………………….

Care Plan

- Completed care plan in place – key conditions, medications, interventions, clinicians, contingency planning, agreed goals, review date (Y/N)
- Shared with patient (Y/N)
- Action points from above questions ………………………………………………………………

Follow up

- Is patient appropriate for case management in MDT – add to MDT list (Y/N)
- Date of follow up (set reminder) …………………
- Named clinician…………………………………………........

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