Committee: Health and Wellbeing Board

Date: 25 November 2014

Wards: All

Subject: HWB Priority 3 – Update on Progress

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Lead member: Howard Freeman, Chair, Merton CCG

Forward Plan reference number: N/A

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Recommendations:

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

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

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

1.2 The HWB previously received an update report on this Priority Area in January 2014 where progress on plans and development plans were set out. In the intervening period, the CCG has agreed its two-year Operating Plan (2014-16) and submitted its Better Care Fund Plan, under which documents a significant number of the initiatives outlined in this Priority Area are being actively managed. Progress with schemes under the Better Care Fund are reported under cover of a separate HWB paper and managed by the Merton Integration Board and the One Merton Group.

1.3 Progress in delivering outputs set out in the Operating Plan is managed through the CCG's Executive Management Team and, ultimately, the Governing Body. Consequently, this report provides a summary of outputs that support the HWB Priority Area but will also be reported elsewhere.

1.4 This priority has been broken down into 6 key areas

- Improve the health related quality of life and level of control for people with long term conditions
- Enable people with dementia and their carers have access to good quality early diagnosis and the support to live well with dementia.
- Ensure people with mental health issues have access to timely assessment, diagnosis, treatment and long term support for their mental and physical wellbeing.

- Deliver timely access to good quality diagnosis, treatment and care in the most appropriate location.
- Increase the preferred place of care and death for those who need end of life care services.
- Enable people to stay in their own home as long as possible.

1.5 The report sets out progress and plans under each of these headings.

2. INTRODUCTION

2.1 The CCG's aim is to deliver high quality, patient-centered services and this will be against a backdrop of transition. Merton will play a key role in assisting to shape the local health economy, in order to deliver a clinically led and patient focused delivery programme.

2.2 Our mission is to improve the health outcomes of our population, by addressing the diverse needs of people, and improving patient experience. This will be done in a way that is clinically and financially sustainable.

2.3 Our vision is to deliver the right care at the right time and place with the right outcomes.

2.4 With the implementation of its Operating Plan for 2014/16, Merton CCG has committed to a number of strategic commissioning initiatives and continues to develop clinical cases for change in the following areas:

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 Services

2.5 Each of these initiatives is supported by detailed aims, budgets and objectives and some are already beginning to deliver outputs to meet the CCG's aim and visions for Merton.

2.6 Additionally, the impact of many of these schemes is being managed in an integrated way alongside the Better Care Fund (BCF) Plan, progress on which is reported separately on this agenda.

3. OUTCOME 3.1

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

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

  The Merton Integration Programme continues to focus on delivering a new model of care that will enable as many people as possible to manage their own condition outside an Acute hospital environment. A broad range of schemes based around both reactive and proactive services is being developed in localities and as 'whole-Merton' services.

  Support to achieve this includes jointly developed care planning, where patients and their carers understand what actions they need to undertake to keep themselves well and where their condition deteriorates, what actions they can take.

  Integrated locality teams and surgery-based multi-disciplinary teams have been developed to drive this work and additional staff will be recruited to support this work, including dementia nurses to help support patients with dementia and their carers in the community as well as closer links to the voluntary sector and the Age Well Programme detailed below.

  The indicator/success measures are being developed through the Integration Programme and the Better Care Fund Plan and include:

  - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.
  - Number of new placements to Permanent Care Homes 65+ (C72) (monitoring of number of people).
  - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.
  - Proportion of older people (65 and over) who were offered a Reablement or Intermediate Care Service during the period Oct. to Dec.
  - Number of older people (65 and over) who were offered a Reablement or Intermediate care service - (clients Reablement services started per month).
  - Delayed transfers of care from hospital per 100,000 population (average per month).
  - Number of delayed transfers of care from hospital.
  - Social care-related quality of life (User Survey) Enhancing quality of life for people with care and support.

  The Expert Patient Programme, designed to promote and build people's confidence and self-management skills, empowering them to take control of their health and improve their quality of life has been expanded in Merton, with 3 programmes delivered so far in 2014/15 and a further 5 programmes planned for the remainder of the year.

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

  A funded scheme within the Better Care Fund Plan aims to improve access to support for carers. The value of the scheme is £551,000 and it 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.

  Additionally, the Ageing Well Programme that is now part of the Better Care Fund Plan focuses on support services for carers provided by Carers Support Merton such as:

  - Neighbourhood peer support groups/networks;
  - Self-financed activities for carers as respite;
  - Carry on caring workshops; Emotional Support and Coaching.

  Currently metrics are being developed to be in place by April 2014 to measure success.

  One of the Expert Patient Programmes that ran this year was specifically designed for carers to help build their confidence and coping skills, empowering them to support their caring role and improve the quality of life of both the patient and the carer.

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

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

  The Integration Project Team also worked with HealthWatch to undertake a joining up health and social care event in September, where we gained valuable feedback about to inform how patients and carers think services should and could work together better. The main themes on the day looked at; Dementia, End of Life Care, Carers, Crisis, Keeping Well at Home and Discharge from hospital.

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

All GP practices in Merton's now have access to the risk profiling tool and have received training in its use. In 2013/14, 23 of our 25 practices submitted a return to confirm the practice had undertaken a review of patients with two or more long term conditions or dementia and where appropriate support these patients through multidisciplinary team working.

With the BCF Plan submission process focusing intensively on avoiding non-elective admissions, a piece of work is currently being planned to assess the effectiveness of the risk-management process for the highest risk patients. The process will examine how to make the assessment process more consistent and to improve the overall outputs across all practices in Merton.

- **Monitor emergency admissions and measure and compare emergency admissions especially for key long term conditions.**

  The CCG monitors performance against a range of key indicators including overall emergency admissions. Unpublished data indicates that we achieved a 4.2% reduction in avoidable unplanned admissions in 2013/14 compared to 2012/13. We are continuing to reduce admissions and, at month 5 in 2014/15, we are below the target trajectory for avoidable unplanned admissions.

  We have also implemented a health coaching pilot for COPD patients. The aim of the one year pilot is to support patients who have high levels of unplanned admissions to manage their condition as well as reduce unplanned admissions. The Health Coaching Service is a telephone based service which it is hoped will improve care by supporting patients through direct access to dedicated clinical Health Coaches. Health Coaching aims to build on the patient's knowledge of COPD to facilitate an understanding of how healthy behaviours impact on the disease and can improve their quality of life whilst living with the condition. Patients on the Health Coaching pilot will be encouraged and supported to set achievable goals towards behaviour change which, when met, will build their confidence in their own ability to manage their conditions.

  The CCG continues to monitor performance against a range of key indicators including overall emergency admissions and the focus of the BCF Plan reporting on the reduction in non-elective admissions means that the preventative agenda is embedded in all that the overall health economy in Merton sets out to achieve.

  The Ageing Well Programme was launched in April 2013, and an important part of this programme is the provision of support services for carers. Carers Support Merton is one of the Ageing Well organisations and provides services such as peer support groups, 'Carry on Caring' workshops and coaching.

4. OUTCOME 3.2

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

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

  A range of initiatives with the goal of increasing Merton's dementia diagnosis rate are being undertaken.

  Well attended dementia education events for primary care took place at the Merton Dementia Hub during November 2014. These included sessions which explored the benefits of early diagnosis from different perspectives (patient, family, medical, social care and public health) and the variety of support services that are available in the borough.

  Searches for primary care clinical systems have been built which can support practices to identify patients who have a high or reasonable likelihood of having dementia but who do not have a formal diagnosis recorded. The current rate is at 51% with and expected trajectory by the end of the financial year of 67%.

  Work is underway to introduce a skilled Community Nurse with additional dementia health training into each of the three localities. The nurses will have an extremely valuable role in improving the health and wellbeing of individuals living with dementia and their carers, and they will be a valuable asset for primary care. These nurses will also have a role in overcoming some of the barriers that may be encountered in the process of an individual receiving a diagnosis.

  The ambition is for memory clinics to run from the new Nelson Local Care Centre in order to facilitate greater access to local dementia services and work is underway to achieve this.

  The CCG's main acute providers (St George's, St Helier and Kingston hospitals) have a range of areas of focus which relate to dementia and there is emphasis on the identification of potential dementia patients, their assessment and the appropriate onward referral.

  Efforts are underway through the Merton Dementia Action Alliance and other avenues in order to work towards Merton being a Dementia Friendly borough and increasing awareness around the condition.

  It is recognised that further work is required to understand the reasons behind low presentation of ethnic groups with dementia to ensure equity of diagnosis and access to services.

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

  There are various training and education opportunities from which care home staff can benefit and Dementia Friends sessions are being promoted across the borough. A Care Home Forum has recently been established in Merton with the aim of promoting continuous improvement and facilitating shared learning. The forum also supports the effective usage of healthcare

services and the development of valuable relationships between the homes and a range of statutory and non-statutory organisations. Plans are underway to deliver a session relating to dementia care at one of the upcoming forums.

One key objective is to reduce across all care homes the use of anti-psychotics for people with dementia who exhibit challenging behaviour. A pharmacist will review medications of people in nursing and residential homes, which will include those with dementia. Where anti-psychotic drugs are administered, and it is appropriate to do so, recommendations relating to alternative management strategies or pathways will be made, for example drawing upon the expertise of the challenging behaviour team.

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

  Staff from Carers Support Merton and the Alzheimer's Society are present at memory assessment clinics run by South West London and St George's Mental Health NHS Trust. This enables the needs of carers to be identified at the initial stages when an individual is diagnosed with dementia. Carers Support Merton and the Alzheimer's Society offer an array of services across the borough which support carers, and they are aware of other available services and so can signpost carers to appropriate services bearing in mind their needs and wishes.

  The Alzheimer's Society delivers many of its services from the Merton Dementia Hub which is located in Mitcham. This was created through refurbishing the former Cumberland Day Centre using DH dementia-friendly environment funding. A significant number of people with dementia and carers benefit from the services available and several of these, including tailored training courses, are specifically designed to meet the needs of carers.

5. OUTCOME 3.3

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

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

  The Merton Mental Health Needs Assessment was signed off by the Health and Well-Being Board in September 2014.

  As part of its findings the Assessment made a number of recommendations for health and social care commissioners to ensure that those with mental ill health have better access to services as well as continuing support for both their mental and physical wellbeing.

  Whilst some of these recommendations (like re-procuring the current IAPT services with robust engagement of service users/carers and a revised

service specification, as well as commissioning the complex anxiety and depression service for patients for whom IAPT is not suitable) are already being implemented, others will be a subject of discussion with the Mental Health Workstream Delivery Group, prioritised with other schemes and developed into additional work packages.

The joint commissioning arrangements in respect of learning disabilities are being reviewed to ensure that in the move from the PCT to CCG clinical governance arrangements in respect of the Community Learning Disability team are robust and a series of performance measures is being developed in relation to the delivery of health services to people with learning disabilities.

Work is underway to ensure that there is clarity around commissioning arrangements for people with learning disabilities requiring a placement entailing high levels of support which are not available in the locality, in the light of the Winterbourne View report and subsequent action plans. The aim is to achieve a situation where people needing high levels of support do not need to be placed a long way from their own home area and can receive the care they need in a setting which is, as far as possible within a community setting.

Work is also underway to identify a pathway into appropriate in-patient services when required for people with learning disability and mental health needs. This affects a very small number of people on an infrequent basis but without a clear pathway can lead to delays in people receiving the appropriate care.

The Learning Disability Self Assessment, which reviews a number of measures in relation to local services, due to be submitted to NHSE in February 2015, is currently underway and an action plan will be developed from that self assessment. It is already highlighting that information from primary care about the health status of people with learning disabilities could be improved to enable improved service planning. People with learning disabilities are known to be at higher risk of developing health problems in later life but information on their take up screening and preventative health measures is limited.

6. OUTCOME 3.4

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

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

The Nelson LCC is on track to be open by March 2015, where the Holistic Assessment and Rapid Investigation (HARI) service will further enhance the current Older People's Assessment and Rehabilitation Service, including more medical input through an Interface Geriatrician and the introduction of an urgent pathway as a potential alternative to A&E, where an individual needs urgent assessment but not acute admission.

In respect of the development of services in East Merton, the initial public engagement on this was through a stand at the Health Hub at the Mitcham Carnival in June. As a result, none members of the public indicated that they would like to be involved in further engagement events.

As part of the site assessment process, a patient and public engagement event was attended by 40 people on 2 October. The event set out aspects of the proposed development and set out the intention to involve members of the public at all stages of the project, from the design of the East Merton facility to how it will operate when it opens its doors.

The economic business case is being reviewed by the CCG's Governing Body in November 2014.

7. OUTCOME 3.5

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

The Community Prevention of Admission Team (CPAT) has been in operation since October 2013 and the service has seen 408 referrals from Merton patients (up to the end of August 2014). This service delivers an urgent response to prevent an unnecessary admission to hospital and where possible supports patients in their usual place of residence.

Work is also taking place to support nursing and residential care homes to provide more proactive support and make use of services like CPAT, where an admission to hospital can be avoided.

An in-reach nursing service has been commissioned for Merton patients at St George's, where nurses with extensive knowledge of what is available in the community can help identify and support patients in their discharge arrangements from hospital back into the community.

LBM is currently undertaking a review of the reablement service. This is set to be completed by end of February 2015 and will inform the further work on this outcome area.

Further investment has been identified to increase the number of intermediate care beds in Merton and work to secure them is underway.

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

- Enabling people to live for longer in their own homes and delaying or reducing spend on Council funded social care.

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

The services funded by the Ageing Well Programme are:

- Age UK Merton – 'Life After Stroke'; continence awareness and support service.
- Carers Support Merton - Neighbourhood peer support groups/networks; activities for carers as respite; 'Carry on Caring' workshops; emotional support; coaching.
- Merton & Morden Guild of Social Service - 'Fit for Life' exercise programme; falls prevention programme; opportunities for volunteering.
- Merton Community Transport - Volunteer community car service.
- Merton Mencap – 'Evolutions' support service for non-FACs eligible people with autism; activities club; carers community advice service.
- Merton Vision - Buddying programme; emotional support and counselling; training to use equipment.
- Volunteer Centre Merton - Supported Volunteering Programme for mental health service users and people with learning, physical or sensory disabilities.
- Wimbledon Guild of Social Welfare - Community coaching sessions; menu of services; informal drop-in café

The Ageing Well programme has been incorporated into the BCF Plan and work is underway to evaluate the programme as a whole and its services effectively from quality and productivity perspectives.

8. OUTCOME 3.6

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

- **Raise awareness of options for care and place of death and dying across our population**

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

  The CCG recently supported a successful bid to the South London Membership Council for Innovation and Excellence in Health Care which enabled St Raphael's Hospice to deliver training to improve the quality of care for people who are thought to be in the last year of life. This course is for staff who work in care homes, social services professionals and those who work for agencies which provide community care, and includes areas such as physical assessment, communication skills, caring for people with dementia, advanced care planning and spiritual awareness.

  Various engagement events have taken place recently which have acted to raise awareness about the choices that are available for those who are approaching the end of life. An event entitled 'Joining Up Health and Social Care' was co-ordinated by Healthwatch and took place on 11th September 2014; at this event End of Life Care was one of the six main themes explored. An engagement 'marketplace' formed the second half of the 'Engage Merton' which took place on 16th October and was led by the CCG; at this marketplace there was a stand for End of Life Care and attendees were given the opportunity to ask questions and provide feedback. Further, two dedicated engagement events regarding End of Life Care took place on 6th November 2014.

  A number of proposals have been put forward which relate to communication, awareness raising and information dissemination; these will be considered and the suggestions deemed to have the most potential will be taken forward.

- **Raise awareness of Co-ordinate My Care register and increase the number of people on the register**

  Coordinate My Care (CMC) is an electronic urgent care record enabling details of a person's illness and their wishes to be shared in order to improve the coordination of care and allow people's choices to be known to emergency and out-of-hours services. CMC is being used in all 25 Merton GP practices, hospitals, hospices and community services.

The most recent CMC report (October 2014) shows that 1484 patients are registered on CMC. The most recent dataset showing utilisation across London revealed that Merton CCG ranks fourth out of the 32 London CCGs in terms of the proportion (37%) of the population estimated to be in the last year of life who have a CMC record.

An End of Life Care Local Enhanced Service has been running since 2012/13 and sixteen practices are currently signed up to deliver the service. One component of the service promotes raising awareness of CMC and the development of CMC records for patients. Work is underway to revise the service specification so that it encourages better use of the functions that are available, for example the opportunity for the development of robust cross-organisational care plans which can be updated throughout the patient's journey.

The new Community End of Life Nursing Service Specification includes the requirement for the team to monitor and support the use of CMC in the Nursing Homes. As a result, increasing numbers of patients are offered a CMC record and have been registered on CMC. Members of the team also attend End of Life Care MDT meetings in general practice and they support discussions about the management of patients who have CMC records.

Through the recent engagement events and opportunities, the valuable role of CMC has been conveyed and useful discussions have taken place about the tool and how it can be used.

9. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

9.1 None specific for this report

10 LEGAL AND STATUTORY IMPLICATIONS

10.1. None specific for this report.

11 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

11.1. None specific for this report

12 CRIME AND DISORDER IMPLICATIONS

12.1. None specific for this report

13 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

13.1. None specific for this report

14 APPENDICES

14.1. None.

15 BACKGROUND PAPERS

15.1. Merton Operating Plan 2014/16

15.2. Commissioning Strategic Plan 2014/16

15.3. Merton Health & Wellbeing Strategy 2014/15