The Joint Strategy for Health and Social Care in Sutton

Enabling people to maintain their independence, health and wellbeing within their community

NHS Sutton CCG
London Borough of Sutton

June 2014
Version 9

Version	Date	Author	Change Description
V1	*20th Jan 14*	*Tanya Trimnell*	*Following on from version 13 (10th Jan) of the OOH strategy, this version has been developed with a New format, new headings and additional content added*
V2	*21st Jan 14*	*Tanya Trimnell*	*BL – Footnotes added and content*
V3	*23rd Jan 2014*	*Tanya Trimnell*	*JU and KS content changes*
V4	*24th Jan 2014*	*Tanya Trimnell*	*Format, contents and page number page updates*
V5	*28th Jan 2014*	*Tanya Trimnell*	*Sue R's content changes (up-to page 36 and including changes on the 'Next steps to deliver the strategy)'.*
V6	*6th /10th/11th Feb 2014*	*Tanya Trimnell*	*Includes comments from AC*
V7	*5th & 27th March 2014*	*Tanya Trimnell*	*Includes comments on section 11 from AC*
V8	*1st April 2014*	*Tanya Trimnell*	*Delivery plan referenced in section 11*
V9	*19th May 2014*	*Susan Roostan*	*June dates added, final amendments ahead of OSCC and CCG governing body approval and HWBB approval.*

KEY HEALTH FACTS FOR SUTTON for 2012/2013

All Sutton Residents	**192,000 population**
Number of A&E attendances	70,174
Cost of A&E attendances	£7,054,139
Number of unplanned hospital admissions	16,160
Cost of unplanned hospital admissions	£34,380,022

There was an increase of 14% in unplanned hospital admissions spend in 2012/2013 when compared to 2011/2012.
The cost of unplanned hospital admissions for this financial year 2013/2014 is expected to be £39million (an increase of 14%).

Sutton residents aged 75+

Number of residents 75+	14,100*
Number of unplanned hospital admissions	5,656 (35%)**
Cost of unplanned hospital admissions	£15,471,009 (45%)**

There has been an increase of 6% in unplanned hospital admissions for residents aged 75+ in 2012/2013 when comparing to 2011/2012.

In 2013/2014 it is expected there will be 4,615 unplanned admissions for residents aged 75+.

KEY SOCIAL CARE FACTS FOR SUTTON for 2012/2013
London Borough of Sutton Adult Social Services:

Number of adults supported in the community	1820
Number of Sutton adults supported in care homes	340

Under 65years - 665 are in the community and 174 are in care homes;
Over 65years - 1155 in the community and 165 in care homes

Number of Supported Self-Assessments completed 2,500
Number of Care Homes in Sutton - 45 homes for people 18-65 (500 beds) and 40 homes for those over 65 (1080 beds)
Net cost of adult social services packages and placements £35m

*Approximately 8% of the population of Sutton - POPPI data
** Of total spend/activity for all ages

CONTENTS

1. EXECUTIVE SUMMARY

This strategy sets out the joint vision of both the Sutton Clinical Commissioning Group (SCCG) and the London Borough of Sutton (LB Sutton) for the integration of health and social care services for residents of Sutton. Health and social care integration is about combining services locally to improve lives and make public funds go further.

Although with progress in recent years of building on existing networks and integrated services, pressures are recognised across our hospitals, our General Practitioner (GP) surgeries, our community healthcare teams and our social services. As our populations grow and people live longer, the challenge of balancing available resources and local needs continue to grow. Our vision is to transform the quality and experience of care, across all elements of commissioning and provision, on behalf of our communities.

Building on the Joint Health and Wellbeing Strategy (JHWS), experience of self-directed support, personal budgets, integrated services and pilots, and other strategic documents such as urgent care strategies and Mental Health strategies, Sutton CCG and LB Sutton aim to develop and commission person-centred co-ordinated care[1]. Ensuring the right care is delivered to our communities in the right place and at the right time; care that is delivered in partnership, to the highest possible standards.

To sustain a healthy future this strategy builds on the needs of residents;

- Supporting people to maintain their independence – by providing more support in communities and by communities to help people to effectively manage their own health and wellbeing;
- Prevention– help people remain healthy and living in their own homes in their communities, avoiding unnecessary admissions to hospitals and care homes;
- Improving quality of care – following an episode of ill health or crisis, with the delivery of the right services, in the right place at the right time.

This strategy will ensure social care and health services can enable Sutton's residents to live a full and active life, live independently and play an active part in the community.
Our strategy therefore is to develop an integrated pathway in the following areas;

- Keeping people healthy and independent in the community. *Universal and Preventative Services*.

[1] Sutton Joint Health and Wellbeing Strategy - https://www.sutton.gov.uk/CHttpHandler.ashx?id=18919&p=0

- Local access to specialised health and social care services - *Targeted Primary and Community Care Services*.
- Supporting people when they require hospital and residential services. - *Acute care and Care Home services*.

The key principles in this strategy (anticipating those in the new Care Bill – due to come into effect 2015/16) are[2]:

- To commission high quality integrated health and social care services for the population of Sutton through joint working, ensuring people's physical, mental and social well being needs are met;

- To ensure Sutton residents are at the heart of decision making, working in partnership with individuals, representative groups, families and carers to deliver high quality accessible services that tackle inequalities and respond to personal needs;

- To maintain an efficient and financially sustainable local health and social care system by improving primary care and community services and working closely with secondary care to deliver integrated services;

- To support the development and delivery of an integrated commissioning framework that supports both a single, pooled budget for health and social care services and aligns separate budgets to agreed delivery priorities across the local health and social services spectrum;

[2] The Care Bill - http://services.parliament.uk/bills/2013-14/care.html

- To prevent, postpone and minimise people's needs for formal care and support with a social care and health system built around the over-riding principle of promoting people's independence and wellbeing;

- For people to be in control of their own care and support by maximising self-care and community capacity;

- To reduce the need for secondary care admissions (hospitals and care homes);

- To find ways to improve how the health and social care needs of young people with special educational needs are met as they transition from Children's services to Adult life.

Personal budgets and person-centred care are central to achieving these objectives both in social services and those with Long Term Conditions (LTCs), especially those receiving Continuing Healthcare[3]. Equally important is the advice and information or advocacy that needs to be available to ensure that residents can make the right choices for themselves with the right tools and support.

Currently, both the health and social care sectors are focused on the acute end of the spectrum with too much of the available resources spent on institutional forms of care – within residential and nursing care and within hospitals. This strategy is focused on how to achieve the objective of investing in services, offered in community settings and helping to keep people where they want to be – in their own homes.

The community and voluntary sector has an important role to play in Sutton with continued collaboration to meet the objectives in this and related health and social care strategies.

This document brings together the strategic intent and operational delivery of the existing Joint Health and Well-being Strategy and forms the basis of the Better Care Fund plan (BCF)[4].

[3] Continuing Healthcare - a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital who have complex ongoing healthcare needs.

[4] Better Care Fund - https://www.gov.uk/government/publications/better-care-fund

2. BACKGROUND

Sutton CCG and LB Sutton are committed to working together and with provider partners to ensure that residents have their health and wellbeing needs met in the right way, at the right time, and in the right place. It is the intention of both health and social care to reduce the pressures across our hospitals and ensure that hospitals are only used when absolutely necessary.

Left unaddressed, fragmentation between GPs and clinical specialists, physical and mental health providers, the range of social providers and health and social care commissioners will hinder the delivery of the high quality coordinated care that residents and government policies increasingly require and expect. The integration of health and social care services delivered outside of hospital offers the realistic goal of improved outcomes for people, alongside the greater efficiencies required to meet the financial challenge and improved workforce satisfaction.

Care for people is necessarily provided by different organisations in a range of settings by many professional groups. Residents' experiences are too often adversely affected by movement between services or progression along a pathway that can often be fragmented and delayed as a result of cultural, procedural and organisational boundaries.

Personalisation and care centred on the individual are core values for social services and for the National Health Service (NHS). Integrated care is a key component in the delivery of the principles set out in this strategy and will form the basis for the BCF.

2.1 Integrated care

Our approach brings us into line with the national focus on integrated care. In May 2013 the government published "Integrated Care and Support, Our Shared Commitment" sending a clear message to local authorities and the NHS that integrated care is a critical issue and a key component of meeting the system's challenges[5].

All localities must develop plans for integration unique to the requirements of their local area from 2015 and integrated care must be the norm by 2018.

The June 2013 spending round included the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care. The funding is

[5] "Integrated Care and Support, Our Shared Commitment" - https://www.gov.uk/government/publications/integrated-care

described as *"a single pooled budget for health and social care to work more closely together in local areas, based on an agreed plan between the NHS and local authorities".* The monies, originally referred to as the Health and Social Care Integration Transformation Fund (ITF), (now the Better Care Fund - BCF), come into full effect in 2015-16 however local authorities and CCGs are charged with building momentum in 2014-15[6].

Draft joint plans were jointly written and signed off by LB Sutton, the Sutton CCG and the Health and Wellbeing Board (HWB) and submitted to NHS England. Following NHS England feedback, the submission was finalised and sent to NHS England on the 4th April 2014.

The explicit purpose of the BCF is to compliment and further develop this and other joint strategic plans. The aim is to provide the right care, in the right place, and the right time including a significant expansion of care in community settings. There are 10 measures of success that will be monitored to meet key BCF performance outcomes.

2.2 Key national and local policy

Over the past decade consistent Government policy has been to encourage care outside of the hospitals and care homes, by developing health and social care services within the community. This was included in the Health and Social Care Act 2012 and is being further developed in the Children and Families', and the Care Bills[7,8]. Also recently, NHS England launched a new publication called "A Call to Action" to stimulate a public debate about the unique challenges facing health and social care in London[9].

The benefits of providing healthcare outside of hospital wherever possible are wide ranging but it is largely accepted that they may include:

- Improvements in the quality of clinical care by avoiding the risk of going into hospital;
- Reduction of the burden on acute hospitals and shortened waiting times, for example if outpatient appointments or diagnostic tests are undertaken in community settings;
- Following on from this, it can help to deliver the 18-week targets for planned care, and the 4 hour waiting time in Accident & Emergency services (A&E);
- Ability to meet the growing demands of patients to get more local access to services;

[6] BCF Planning - http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
[7] Health and Social Care Act 2012 - http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[8] Children and Families Bill - http://services.parliament.uk/bills/2012-13/childrenandfamilies.html
[9] Call to Action - http://www.england.nhs.uk/2013/07/11/call-to-action/

- Reduction in costs by providing care in cheaper settings;
- Improved outcomes and access to planned care;
- Facilitation of new ways of working and allows a remodelling of the workforce;
- Exploitation of a wide range of new clinical and technological developments;
- More independent lives for people and the prevention of illness (including mental health);
- Reduce the issues of poor quality and risk from infection, abuse or poor care in hospitals.

The benefits of delivering healthcare and social support to those with Long Term Conditions (LTCs) needs in the community as opposed to care homes are similar to that in healthcare. These include:

- Choice and independence, high quality outcomes for residents;
- The reduction of risks from institutional abuse (see Winterbourne View report[10]);
- Greater opportunity for family and community networks and capacity to be developed to meet health and social needs;
- Greater access to end of life care at home by patients dying in their own home by choice;
- Enabling those with dementia to live at home with sustainable support for their carers;
- Enable those children and young people with long term conditions or disabilities to have greater choice and control through integrated assessments, personal budgets that cross health, social care and education support;
- Promote better access to appropriate support for the carers of those most at risk of loss of independence or admission to specialised secondary care.

2.3 The Financial Challenge

Current models of care need to change fundamentally if they are to be fit for the future, and preserve the values that underpin a universal health service, free at the point of use, and reduce the cost to residents of social and personal care support. It is imperative that health and social care organisations work together to deliver a sustainable care system in Sutton in the face of the most challenging financial environment in decades. The financial pressures facing public services for the

[10] Winterbourne View report - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213216/easy-read-of-final-report.pdf

foreseeable future make it crucial that initiatives to deliver care in innovative, integrated, coordinated and cost effective ways are pursued as a matter of urgency.

LB Sutton's medium term financial plan, currently looking forward to 2016/17, estimates the level of funding that for 2014/15 and 2015/16 will be significantly reduced following a 25% reduction in 2010/13. The current planning assumption is that there will be a funding gap of £26million by 2016/17, representing about 15% of the LB Sutton net budget, and a possible increase in the gap to £40million in 2017/18. In the context of this financial challenge, it is expected that commissioning efficiencies from health and social care integration will play a crucial part in managing the ongoing demographic pressures as well as the impact of the new Care Bill requirements and meeting JHWS objectives.

The Sutton CCG in April 2014 produced 5 year financial plans comprising detailed operating plans for the first two years. National financial planning assumptions and guidance were released in December 2013 support the planning process for the Sutton CCG. Of particular importance is the two year Sutton CCG resource allocation announced in December 2013.

The current planning assumption is the level of financial savings required through the Quality, Innovation, Productivity and Prevention Programme (QIPP) will be of a similar nature to the current financial year that is £7 m or 4% in real terms[11].

2.4 Performance

The need to focus on integrated working and integration funds is clear and in particular planning for the Better Care Fund to both meet government requirements and local demand.

The key measures of success for integration which this strategy supports are:

- Protecting Social Care Services
- 7 day services to support discharge
- Data sharing
- Joint assessment and accountable lead professional
- Impact of changes in the acute sector
- Local outcome measurement
- Patient outcome measurement
- Avoidance of emergency admissions to hospital
- To reduce delayed transfer of care (DTOC)

[11] QIPP - https://www.evidence.nhs.uk/qipp

- Improved reablement and rehabilitation outcomes
- Avoidance of care home admissions.

The monitoring of performance for the purposes of the Better Care Fund will be integrated with the overall joint commissioning governance carried out by the One Sutton Commissioning Collaborative on behalf of the Sutton Health and Wellbeing Board.

3. DEMANDS AND CHALLENGES TO SERVICES

3.1 Health Services Demand

For the year ending April 2013, Sutton CCG spent £18.7million on non-elective admissions at Sutton's two main acute providers (Epsom St Helier (ESH) and St George's Healthcare NHS Trust) for registered patients over the age of 65 years. £14.2million of this was on patients over 75 and £7.2million on patients over 85 years of age). Included in this figure is spend of over £1.1million for excess bed days over and above the, often lengthy, trim points for many of the diagnosed conditions. With an increasing ageing population under current models of care, this is only going to increase and therefore we are looking to deliver transformational change to the way in which care is provided to residents over 65 years of age.

A&E demand

Sutton's A&E demand (which is mostly served from St. Helier Hospital) has remained stable over the last 3 years, with a slight change in the age profile of those requiring urgent care (Fig 1). However, through planned attendance avoidance schemes by the hospital and through this strategy including shifting from A&E to Urgent Care Centres (UCCs), A&E attendances are expected to decrease.

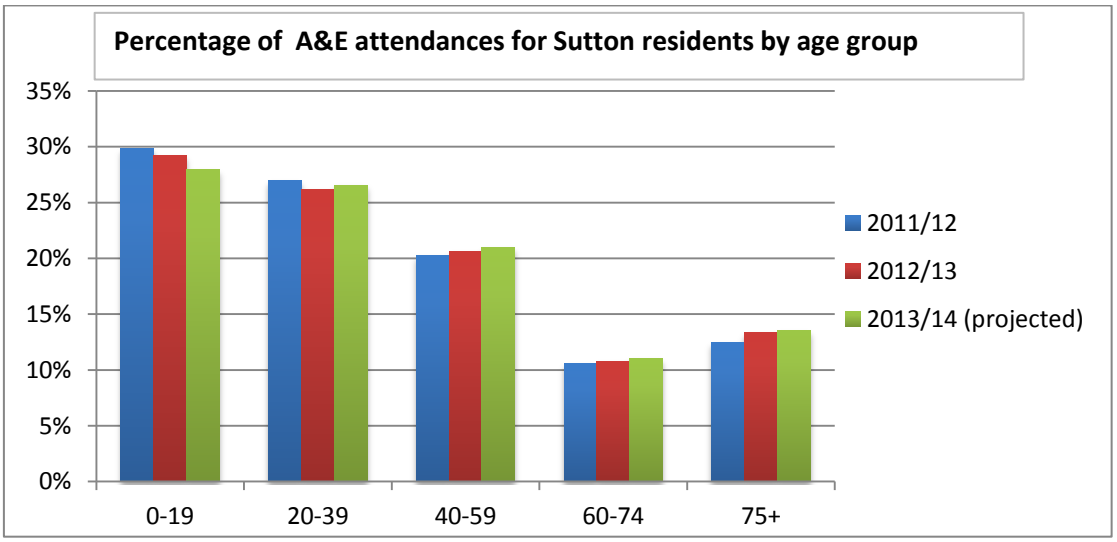


Figure 1: Percentage of A&E attendances for Sutton residents by age group

Unplanned hospital admissions

The number of unplanned hospital admissions in Sutton increased by 3% between 2011-2013, and spend increased by 14% over the same period. These increases largely attributable to the 75+ age group, which had a disproportionate increase in admissions of 9% and a spend increase of 20% (Fig 2, Fig 3).

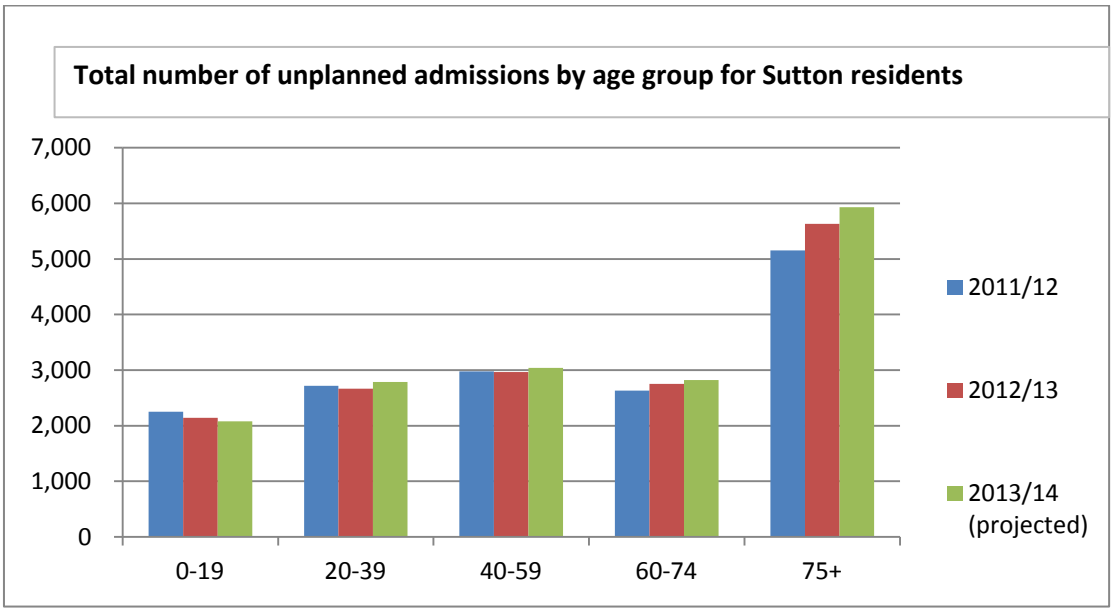


Figure 2: Total number of unplanned admissions by age group for Sutton residents

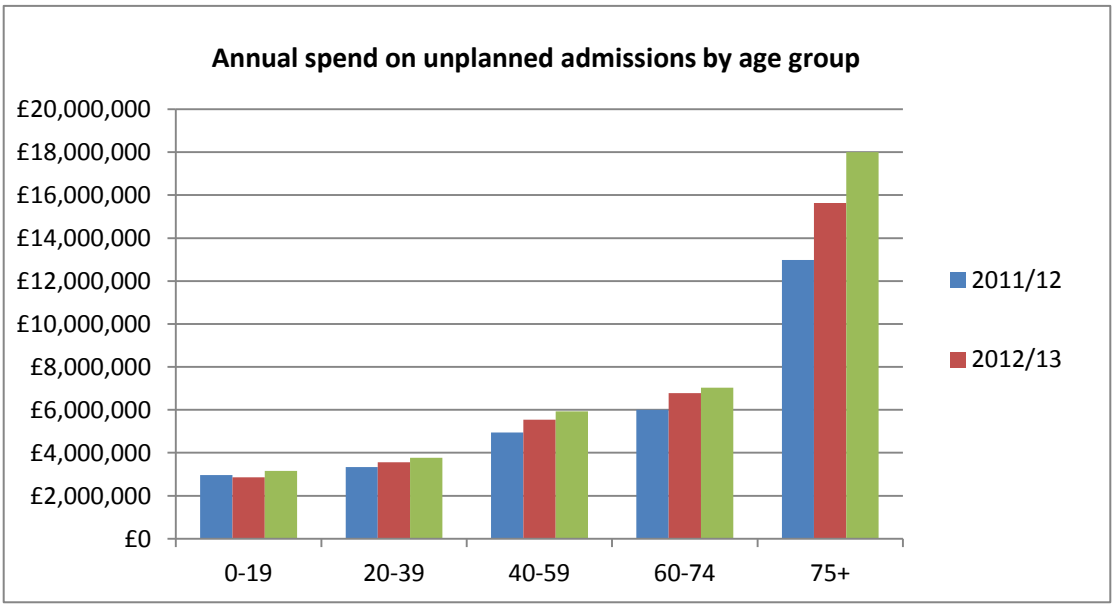


Figure 3: Annual spend on unplanned admissions by age group

Hospital services from residential and nursing homes

Analysis of the use of ambulance conveyance and acute services amongst residential and nursing homes identified a list of 20 care homes who demonstrated a particularly high level of usage at a cost of over £3.8 million in 2013/2014.

The majority of these ambulance calls were during hours when alternative services were available. This suggests that providing assistance to these homes on order to facilitate them to support individuals to remain at the home during escalation of their condition or towards end of life as appropriate would be beneficial, delivering benefits to the individual patients themselves and the system as a whole (Fig 4).

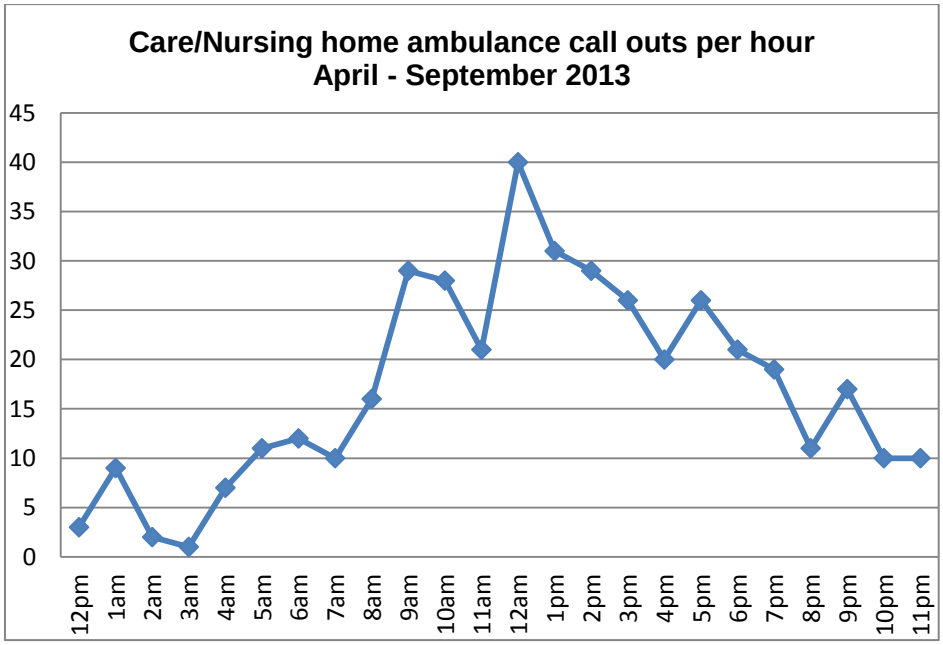


Figure 4: Residential/nursing home ambulance call outs per hour April-September 2013

A further analysis of acute sector demand is set out in *Appendix 2*

3.2 Social Care Services Demands

For the financial year 2012/13 LB Sutton Adult Social Services spent £18.4 million on care home placements, £8.5 million on domiciliary care and direct payments, and £8.3 million on supported living. These figures include a total of £12.1 million expenditure (30% of total Social Services) on people over the age of 65 years. Service users have been offered more choice and control through their personal budgets to assist them to remain at home where possible. During 2012/13 the Council also spent £1.5 million on reablement services to support people after a stay

in hospital, or to help prevent admission or readmission to hospital. Reablement expenditure was £950k in 2013/14 this funded by Sutton CCG.

Social services have a duty to provide an assessment of need under the NHS and Community Care Act 1990, to anyone who appears to be in need of community care services, and a duty to provide and arrange appropriate care and support for people[12].(who meet the eligibility criteria – moderate-high, substantial and critical). The current 'means test' threshold for public funding means that an estimated 60% of social care in Sutton is not arranged or funded by LB Sutton. Currently on average in a year there are 2400 new assessment of need, 2000 reviews for existing clients and 400 Carers' assessments.

Older people currently make up 73% of adults with eligible social care needs in Sutton. Demand is increasing as the population ages, and is set to increase significantly with the introduction of the Care Bill in 2015 which will lead to an assessment, and a 'Care Account' and/or a support plan to be provided by the Council even if they continue to arrange and pay for their own care. An indication of overall Older People's needs in Sutton is the Attendance Allowance claimants in Sutton number some 3,800 over 65s, compared to a client base of approximately 2,300 known to Social Services.

In Sutton, the Adults Social Work service is organised into intake and long term teams with all new work coming into the Community Social Work, Hospital or Short Term Assessment and Reablement Teams (START). Ongoing Social Services support is reviewed and supported by the Mental Health, Disability and Review teams.

Hospital discharges demand

Acute Hospital discharges require social services to assess and plan care within a tight timescale, often within 48 hours. Activity usually peaks over winter but in 2013/2014 there has been an unprecedented increase in demand all year long. Social Services have increased the number of staff working in the hospital and START (see below) to meet the volume and improved joint working with NHS partners..See the chart below for formal Social Service assessments.

[12]NHS & Community Care Act 1990 - http://www.careandthelaw.org.uk/eng/b_section8

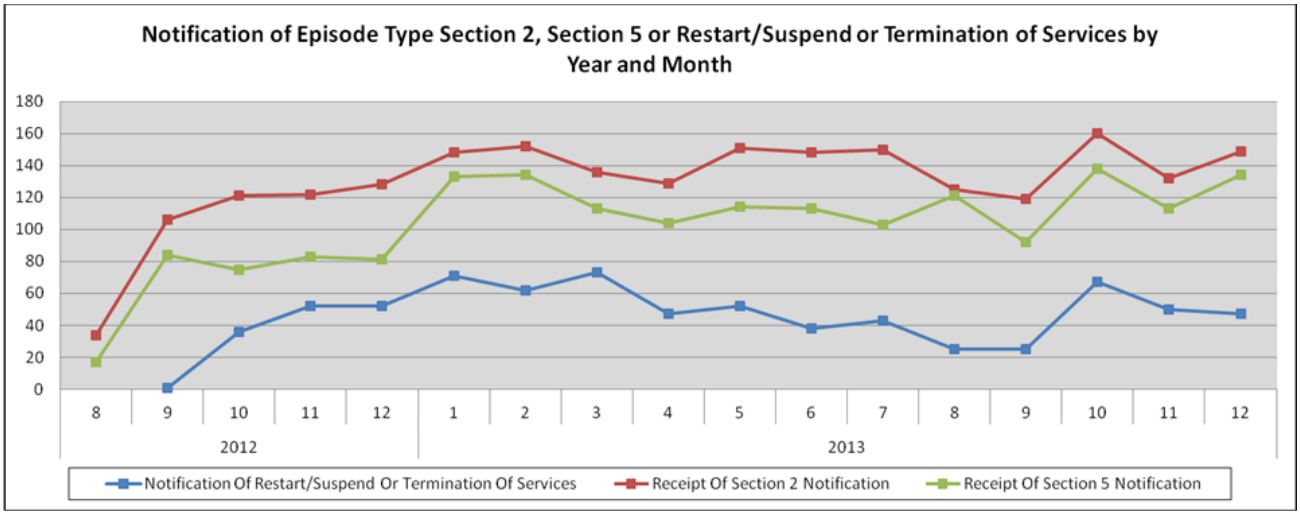


Figure 5: Social Service assessments from hospital.

Reablement demand

START reablement is a specialist homecare team which works with people on discharge from hospital or to prevent admission to hospital and long term care[13]. Approximately 60% of people who complete their reablement have no ongoing care needs and this is comparable with best practice nationally. The team was expanded significantly in 2013 with funding from Sutton CCG. This has provided an additional average 400 hours per week of care capacity and allows the team to provide social work, occupational therapy and physiotherapy input. The team receives 100-120 new referrals a month and liaises closely with community healthcare services to ensure a single rehabilitation response is made to GPs and the hospitals without onward referrals.

As the demand on the acute hospital from over 75s increases, so does demand on START. The service is additionally challenged because of emerging capacity and workforce challenges in the long term homecare market in Sutton. Commissioners continue to address supply problems in homecare that cause delays transfer of care (DTOC).

Historically Sutton has performed well on Social services delays, with one patient delay per month on average, this has increased to around 3 per month in the last quarter of 2013/2014. However as a whole system there are too many delayed transfers of care in the Epsom St Helier Hospital. This strategy seeks to address the full range of solutions to achieve efficient hospital discharges.

[13] Sutton START Service - https://www.sutton.gov.uk/index.aspx?articleid=12806

There is a range of community healthcare services provided by Sutton Merton Community Services (SMCS) to help meet this demand. For more information on these services please see *page 52*.

Occupational Therapy (OT) demand

The council's occupational therapy service carries out the following functions:

- The functional assessment of ability and need and the commissioning of equipment and adaptations (disabled facilities grants – DFG) to meet needs for adults and children;
- Manual handling assessment and the commissioning of equipment to meet needs for adults and children;
- Sensory impairment assessment and support, including the commissioning of equipment, conducted by specialist vision and hearing rehabilitation officers for adults and children;
- Functional assessment for concessionary awards including blue badges, disabled freedom passes and taxi cards for adults;
- Assessment for Telecare for adults.

The occupational therapy service faces increasing demand and increasing complexity of demand as more people live for longer with long term conditions and disabilities, and the need to safely discharge people from hospital. Currently LB Sutton and Sutton CCG jointly contribute £708,000 per year to the equipment budget which is under pressure.

Adult safeguarding demand

Adult safeguarding activity continues to increase within the London Borough of Sutton as the awareness of the need to report adult safeguarding concerns increases. For example, in 2005, 50 safeguarding cases were reported. In 2011/12, 919 alerts were raised and in 2012/13 1148 alerts were made. Current figures for 2012/14 suggest over 1200 alerts for the year, with between 70 and 140 being received per month. This has had a significant impact on social work capacity to make enquiries into and investigate between three and six safeguarding adults alerts per working day. The number of alerts from St Helier Hospital has steadily increased and the safeguarding leads at LB Sutton and at St Helier Hospital work closely together. In addition, heightened awareness of the requirements of the Mental Capacity Act (2005) across hospitals and care and nursing homes is leading to an

increase in the number of requests for Best Interests Assessments, which are carried out by specially trained social workers[14].

4. Health and Social Care Commissioning/Market Development

Within the health and social care sector nationally, there tends to be an over-investment in formal and institutional forms of care such as residential and nursing care. While these services meet people's needs, there has traditionally been an over-reliance upon them which is counter to the objective of helping to keep people independent within their own homes.

This strategy is aimed at reducing admissions to care homes in line with the Sutton Joint Health and Wellbeing Strategy (JHWS). LB Sutton has been very successful in limiting the use of residential care, against the national and London-wide trend. The demographic and financial pressures facing the UK will pose a major challenge for the future, especially for residents fully funding their care needs (self-funders).

LB Sutton's 'Transforming Lives' programme has been focused on enabling people to have the choice and control over the care and support they need including the ability to determine how their services are delivered and by whom[15]. A key principle in this strategy is the expansion of the range of options available to people needing care and support in the community.

Greater choice and control by Sutton residents significantly changes the commissioning and contracting model which local authorities need to use in order to interact successfully with the care market. Sutton has been successful in making Personal Budgets the universal offer to all eligible for social services support in the community in the last 18 months, with a corresponding high (20%) level of direct payments. Further work in this strategy is aimed at extending choice and control to those with personal health budgets linked to social service personal budgets. .

While it is still early in the life of the Personal Care Framework[16], the most significant challenge facing the Sutton health and social care economy in achieving all its objectives concerns the capacity of the local home care market to meet all of Sutton's

[14] Mental Capacity Act 2005 - http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/menincap/mca-act-easyread.pdf
[15] Transforming Lives – LB Sutton's programme to launch self directed support and personal budgets.
[16] In February 2013 the Council successfully established the Personal Care Framework (PCF) as a core part of the response to personalise and shape the home care market for eligible service users, including personal budget holders - http://sutton.moderngov.co.uk/documents/s24623/121120%20Personal%20Care%20Framework%20-%20Award%20v1%205%20docx.pdf

needs including traditional home care services, the supply of personal assistants, as well as meeting more complex care needs.

A range of elements need to be available to Sutton residents to help keep them independent:

- Information and advice to help guide people to making the right choice in selecting services that meet their specific needs;

- A wide range of housing options including a good supply of affordable housing (for rent and leasehold) and specialist, supported housing for people with social care needs (including housing with care);

- A variety of preventative services for older people, people with physical and sensory disabilities, people with learning disabilities and people with mental health needs;

- Effective support to carers to help support and maintain people to continue with their vital caring role as well as maintain a good quality of life for themselves;

- Quality assurance to ensure that social care services offer good quality and cost-effective care and support to Sutton residents;

- Overall, strong partnerships between health, social care and housing services to deliver a seamless service across the spectrum of need that can be found within Sutton;

- Telecare and related assisted technology support to residents with long term conditions.

5. HOW HEALTH AND SOCIAL CARE SERVICES WILL WORK TOGETHER

Health and social care integration is about both joint commissioning and combining services locally to improve lives and make public funds go further. By 2015/2016 LB Sutton and Sutton CCG will have a pooled budget to jointly commission services to support residents to remain living healthy lives in their community, building upon existing joint plans..

Patients and their carers tell us that they fall between the gaps in health and social care services. Family, community and voluntary services often fill the gap.

In the future, our residents will experience well-coordinated and integrated health and social care based on evidence-based pathways, case management and personalised care planning of which carers, community and voluntary services will be a part.

Identified patients with the most complex needs will receive specialist proactive care from integrated multi-disciplinary teams arranged by locality. These teams will share patient information and use their combined expertise to deliver the best care possible enabling maximum independence.

Other patients with long term conditions and whose health and wellbeing is at risk of rapid deterioration will have access to reablement support to help them stay healthy and reduce their risk of hospital admission.

Patients at the end of their lives will receive a coordinated End of Life Care (EoLC) that meets their needs. We will ensure that their preferences for end of life care and place of death are respected and information sharing is improved with the use of 'Coordinate my Care' (CMC)[17].

To support an integrated way of working, LB Sutton and the Sutton CCG are investigating options for joint commissioning including how information for an individual being supported by health and social care can be shared across teams to support joint assessments, improve care services, and reduce duplication of assessments and information gathering.

The implementation of this strategy is outlined in the 'Delivery of the Strategy' section on page 61 and following further consultation on this strategy a detailed action plan will be formulated by 4th April 2014.

[17] Coordinate my Care - http://www.coordinatemycare.co.uk/

6. OUR VISION OF HOW CARE WILL BE DIFFERENT

Currently, many of our residents are being admitted to hospital when well-coordinated community services could care for them effectively in their own homes. Our aim is to develop co-ordinated services so more residents can be supported at home and in their community instead of having to go into hospital or residential care.

We aim to work proactively in Sutton to make a difference by:

- Building capacity in the community to work collaboratively through integrated services to reduce admissions to hospitals and care homes;
- Expanding the capacity of the reablement and rehabilitation services to support residents in the community;
- Realigning the capacity of the acute sector (Epsom and St Helier University Hospitals NHS Trust) to match changing demands and community capacity;
- Developing cross sector working that targets intervention and support to those most at risk of admissions to hospital and care homes;
- Maximising residents' capacity to self-care – by supporting communities and individuals to look after their own health and wellbeing.

This strategy is about re-shaping health, social care and wellbeing services for the borough so that people are supported to remain well for longer in their own homes, rather than becoming unwell and requiring hospital and residential care support.

Sutton CCG and LB Sutton aim to develop and commission person-centred co-ordinated care, ensuring the right care is delivered to our communities in the right place and at the right time. Our strategy is to develop an integrated pathway in the following areas;

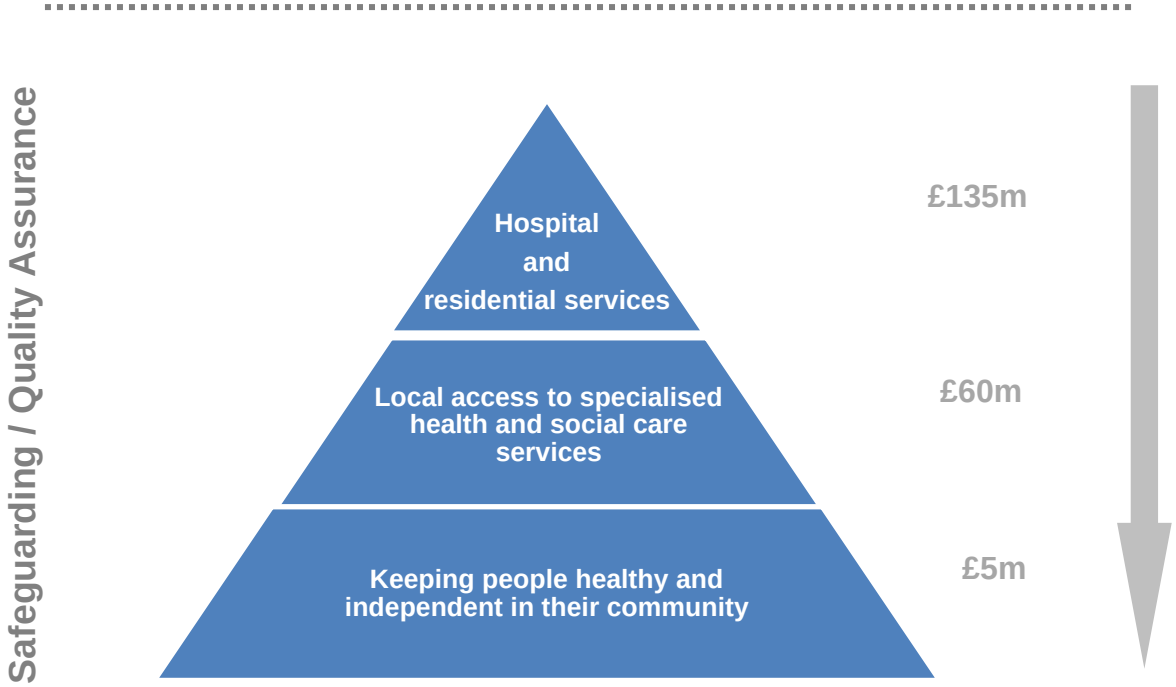
- **a. Keeping people healthy and independent in the community.** *Universal and Preventative Services*;
- **b. Local access to specialised health and social care services** - *Targeted Primary and Community Care Services*;
- **c. Supporting people when they require hospital and residential services.** - *Acute care and Care Home services*.

The following sections of this strategy detail these three key areas.

a. **Keeping people healthy and independent in their community** – this section describes the universal and preventative services available to all Sutton residents to help people maintain their own health and wellbeing and be self- supporting as far as possible.

b. **Local access to specialised health and social care services** – this section details services available to support residents that require specialist support in their community – to help people remain healthy and living in their own homes, avoiding unnecessary admissions to hospitals and care homes.
c. **Hospital and residential services** – this section details services available to residents following an episode of ill health.

The diagram below illustrates where the focus of service delivery needs to be; to support residents to maintain their health and wellbeing within their community; to access preventative health and social care support at the earliest opportunity; to progressively prevent escalation from preventative services to primary and community care services and to further prevent escalation from primary and community services to acute and care home services. The diagram also highlights how current spend is allocated.



£ Figures are approximate spend for LBS and SCCG in Sutton for 2013/2014.

Progress is underway, but meeting the ongoing challenge requires an ongoing programme of work. The following sections of the strategy outline the interconnected initiatives at varying stages of development and delivery that together will move Sutton's health and social care economy towards our key priorities.

Strategic and commissioning intentions have been summarised in Appendix 1.

7. KEEPING PEOPLE HEALTHY AND INDEPENDENT IN THEIR COMMUNITY

To help people remain healthy and independent in their community there are universal and preventative services available to all Sutton residents to help people to maintain their own health and wellbeing and be self-supporting as far as possible. Examples include: libraries, leisure centres, community and social centres, entertainment, employment, public parks and a wide range of public facilities.

The family and community networks that people belong to are important in providing resources and to sustain a quality of life in the community. The prevention of isolation and mutual support such networks afford are aspects of universal, preventative, public health, and community social work services.

Community resources are those frequently available through charities, voluntary and community organisations, special interest and peer support networks and groups, and neighbourhoods. LB Sutton, the NHS (through the Sutton CCG), police and other statutory services fund or subsidise these organisations to ensure they are free, or at least easily accessible to complement any other income they may generate.

At a community level the aim is to shift to a position where as many people as possible are enabled to stay healthy and actively involved in their communities for longer, and delaying or avoiding the need for reactive statutory services. It means people and their communities playing a bigger role in supporting themselves and others, building on personal strengths and in particular the unrealised potential of the vast majority of their informal networks: families, friends and carers. People form social systems which can provide for a range of needs – this could be within households, communities, localities and neighbourhoods – creating networks of

mutual obligation, care, concern and interest, contributing to tackling issues around loneliness and isolation.

LB Sutton fund several voluntary sector organisations as part of the Prevention Prospectus to prevent isolation by developing family and community networks. These include the Volunteer Centre's befriending, EcoLocal's community garden, and Sutton Mental Health Foundations' 'Connect Learn and Support'. LB Sutton is also working with residents to achieve this as part of the Community Wellbeing Programme. Sutton CCG also fund voluntary sector organisations to provide services to the local community.

The provision of information and advice is the first level of support people in the community should access to enable them to support themselves to meet live healthy lives and stay independent in their community. This 'self-help' information will range from healthy eating and living active life styles to activities/groups to attend in the local area and volunteering opportunities.

The is also a need for more specialist health and social care information which will explain issues relating to housing, benefits and how the social care and health systems work as well as the types of specialist/targeted support that is available to meet a person's needs.

The provision of information and advice in the borough is extensive including the council's website, information leaflets, and council staff (social workers, library staff, etc.) help circulate council information. Sutton Centre for Independent Living and Learning (SCILL), The Stroke Association, Sutton Citizen Advice Bureaux (CAB), and others were also commissioned to provide information and advice services.

Improvements in this area will be developed as part of an information and advice strategy being developed in the spring of 2014.

7.1 Keeping people healthy, preventing ill-health and reducing health inequalities.

The population of Sutton is growing. There were 191,123 people living in Sutton at the time of the 2011 census, and this is projected to rise to around 222,000 by 2021. The age profile is increasing also - by 2021 the number of over 65 year olds is predicted to increase by 19%. During 2013/2014 we expect there will be 14,100 residents over the age of 75[18].

[18] 2011 Census data for Sutton - https://www.sutton.gov.uk/index.aspx?articleid=18161

In addition to our increasing and ageing population our local communities are becoming more diverse and multicultural.

Generally, people living in Sutton are healthy; there is good life expectancy (exceeding the national and regional average) for both men and women. Although the borough has fewer people dying from conditions that could be avoided[19] compared to national and regional rates, there are health inequalities in Sutton. In Sutton in the areas of deprivation (focused mainly but not exclusively in the Northern wards, Sutton Central, St. Helier, with a significant area in Belmont), life expectancy is at the lower end of the borough range which is from 74.5 years to 82.6 years for men and from 79.1 to 87 years for women[20].

Circulatory disease (including stroke) and cancer[21] are still the major killers in Sutton - these diseases (along with diabetes) are among the main causes of long term illness and disability. Hospital admissions and re-admissions for diabetes, chronic obstructive pulmonary disease (COPD, lung disease) and heart disease have been on the rise since 2005 although there are wide variations between areas and between men and women.

Key risk factors include smoking, obesity and alcohol and therefore many of these conditions are potentially preventable.

- The levels of risky drinking are significantly higher in Sutton than both the regional and national levels. Although these are only estimates, the figures are supported by the increases seen in hospital admissions for alcohol related harm which are above national and regional increases.

The ways we will work to prevent these diseases (set out in later sections) include:

- Stop smoking services;
- Health checks to detect early risk factors such as high cholesterol, high blood pressure, and overweight/obesity, at an early stage;
- Identifying people with hazardous or harmful alcohol intake and offering them advice or referral into specialist services.

For detailed information about the health and wellbeing of the population in Sutton please go to: http://www.suttonjsna.org.uk

[19] such as circulatory or heart disease or cancer in people aged under 75 years which are often caused by smoking, excessive alcohol intake or by being seriously overweight
[20] 2011 Census Sutton Health - https://www.sutton.gov.uk/CHttpHandler.ashx?id=21538&p=0
[21] Commissioning of cancer screening is the responsibility of NHS England as of April 2013

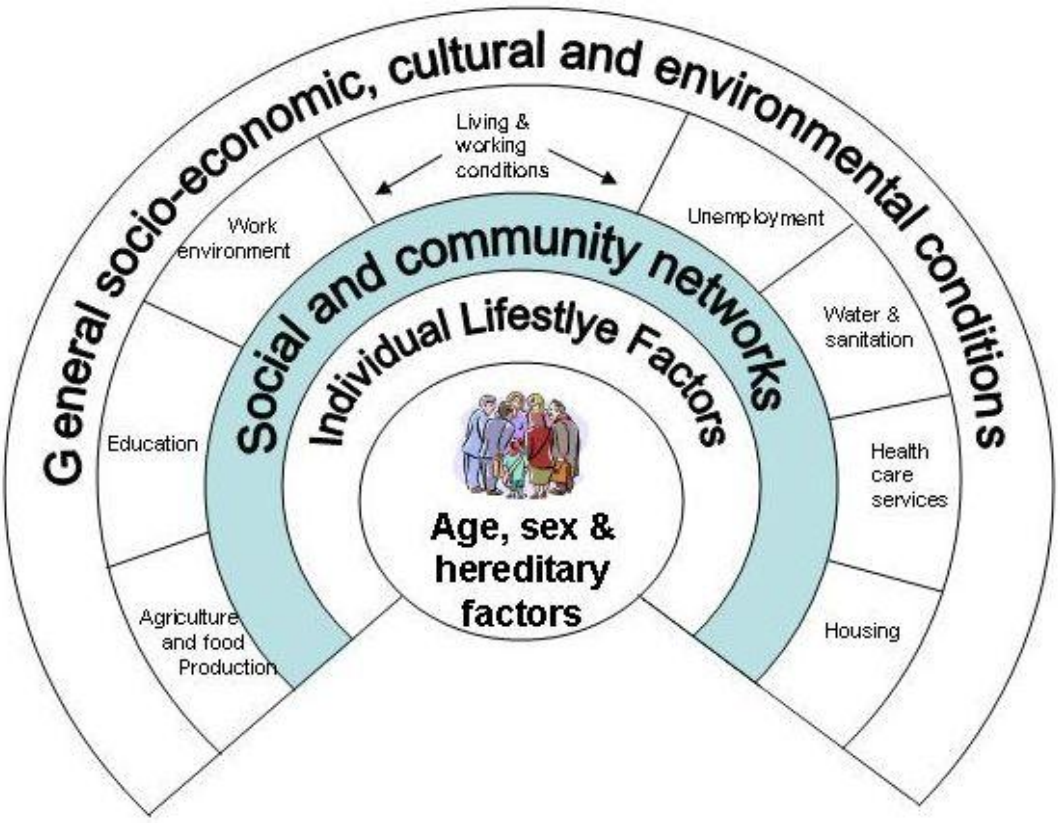


Figure 6 - Social Model of Health – Dahlgren & Whitehead[22]

[22] Dahlgren & Whitehead - http://www.nwci.ie/download/pdf/determinants_health_diagram.pdf

8. LOCAL ACCESS TO SPECIALISED HEALTH AND SOCIAL CARE SERVICES

To help people remain healthy and living in their own homes, avoiding unnecessary admissions to hospitals and care homes, services are available to support residents that require specialist support in their community.

Over the past decade a consistent health and social care policy has been to encourage a greater range and volume of care to be delivered outside the walls of the traditional district general hospital and care homes. This was consolidated in the Health and Social Care Act 2012 and policy towards integration since.

The key objectives for supporting people within their community are:

- Improvements in the quality of clinical care by avoiding the risk of going into hospital and reducing readmissions;
- Reduction of the burden on acute hospitals and shortened waiting times as parts of the care pathway, such as outpatient appointments, diagnostic tests, are undertaken in community settings;
- Maximising the access to and impact of reablement and rehabilitative services;
- Ability to meet the growing demands of residents to get more local access to services for health and social care through self-directed and personalised support in the community;
- Reduction in costs by providing care in settings available in the community;
- Facilitation of new ways of working and allows a remodelling of different disciplines and agencies working together;
- Exploitation of a wide range of new clinical and technological developments;

- More independent lives for people the reduction of impact of illness and disability;
- Enabling EoLC by choice in the community.

This part of the strategy will focus on the areas across the system that can be delivered using care services and as such interventions that do not require attendance or admission to hospital. Using services already available in the community such as primary care services including community pharmacists, social services, or third sector services residents can be supported to stay well and at home.

The strategy highlights activity and service areas that are currently commissioned to support these pathways but also identifies areas for future development and possible integration opportunities to enhance pathways.

8.1 Dementia support

Sutton CCG and the LB Sutton commission services to support residents living with dementia;

The Alzheimer's Society runs some services part funded by Sutton CCG including the:

Dementia Support Service - The service provides specialist support for families and carers of those diagnosed with dementia. It aims to prevent unnecessary hospital admissions and promote independence and receipt of care in the person's own home. The service provides information and raises awareness, promotes good practice in dementia care and helps patients engage socially through peer support groups. Patient can self-refer to the service which runs from various sites across Sutton Monday to Friday from 9am to 5pm and at weekends and evenings to meet the needs of service users. Any patients with other medical conditions are excluded from the service. For 2012/13 the service had 429 members diagnosed with dementia and 460 members who act as carers.

Information Service dementia - A dementia information hub with up to date information including a library (printed and online), information available by phone, email and letter, face to face information from trained staff, awareness campaigns (e.g. dementia awareness week) and interaction from others diagnosed with dementia, their families and carers. The service has a membership of 1,004 who receive regular support and information.

Peer Support Service dementia - The peer support service runs groups in the community offering support to those diagnosed with dementia, their family and carers. These include Tuesday Club, Young Inspirations, Memory Lane Cafe, Daytime Support Group, Evening Support Group and Singing for the Brain (only Tuesday club is funded by the Sutton CCG).

LB Sutton has implemented a range of measures aimed at improving quality of life for people living with dementia, including:

Dementia Community Support Service - In 2012/13 LB Sutton piloted a dementia community support service with the provider Avenues Group, which matched trained dementia support workers with those living with the condition. Through relationship based care, typically delivered in minimum 3 hour episodes, those involved in the pilot programme were enabled to access the community and participate in meaningful activities on their choice, as a personalised alternative to institutional care in day centres. Following an evaluation of the pilot the Avenues service has been made available to any citizen with dementia where the need for such a service has been identified in social work assessment. Other LB Sutton approved providers are also commissioned to provide this type of personalised support.

Admiral Nursing Service - LB Sutton is launching a new Admiral Nursing Service from January 2014. Admiral nurses are specialist nurses for carers of people living with dementia. Their role is to provide counselling, education, emotional support and practical advice to carers, which helps improve quality of life and reduce unplanned admissions to hospital and will delay or avoid admissions to residential care. The admiral nurse will work closely with GP clusters and the Sutton Carers Centre (SCC) to identify patients and families where the caring situation is at risk of breakdown and provide a bespoke individual intervention aimed at relieving the crisis, offering continuing longer term support once the immediate crisis is resolved.

Assistive Technology - LB Sutton has expanded the range of assistive technology solutions available to support people living with dementia to remain safely at home. This includes 'Just Checking' which is a discrete monitoring system which provides professionals or family members with a means to recognise how the person with dementia is functioning when home alone[23]. The Just Checking system provides valuable information about the person's daily routine and movements which help to tailor care appropriately and identify and manage risk, often avoiding unnecessary admissions to care, but also evidencing the need for admission in some cases.

[23] Just Checking - https://www.sutton.gov.uk/index.aspx?articleid=8714

Dementia Diagnosis

Currently there are estimated to be 2,000 residents in Sutton living with dementia, with only 700 of these having a dementia diagnosis. Of these at least 150 with a primary need of dementia are currently supported by social services. The number of people living with dementia is expected to increase by 18% to 2,360 by 2021 increasing the demand and pressure on both health and social care services.

To develop and improve care for people living with dementia; the GP networking initiative aims to integrate health and social care services' information sharing between GPs and LB Sutton. Information sharing will enhance awareness of residents diagnosed and living with dementia that may require support, and also inform future commissioning and forecasting of requirements.

8.2 Supporting people at risk of hospital admission

Reablement-Hospital Avoidance with well-organised Community Care

LB Sutton has expanded its highly regarded home care reablement service with a significant investment of resources transferred from the Sutton CCG, this has enabled the team to increase provision form 600 hours to up-to 1,000 hours a week. From July 2013 the START service has been provided free for up to 6 weeks (dependent on need) to people who are at risk of admission to hospital or residential/nursing care or who require support on discharge from hospital.

The team provides a multidisciplinary assessment with input from social work, occupational therapy and physiotherapy. In addition the team provides specialist assessment over 24 hours for people living with dementia which will monitor, identify and address needs and risks in line with the principles of person centred dementia care. The START team also offers end of life care at home, support and advice to other care providers, and an emergency out of hours response to vulnerable adults in Sutton working from 7am to 11pm, 365 days a year.

After the first quarter it built up to provide an average of 800 hours per week support to over 130 residents at a time. Over 40% of people supported through the reablement service required no support after and the remainder are enabled to access homecare or personal assistant support for longer term needs.

The Learning Disabilities Health Team

LB Sutton provides a specialist adult learning disabilities health service, funded by Sutton CCG via a Section 256, comprising nursing, psychology, occupational therapy, physiotherapy, speech and language therapy and creative therapies. The team provides specialist health services to both individual clients and to other health and social care professionals and services including GPs, St Helier Hospital, Sutton and Merton Community Services, residential care homes and supported living services[24]. Adults with learning disabilities are recognised to face especial challenges in maintaining their own health and to have an increased likelihood of complex health problems. The team supports GPs to carry out annual health checks on their learning disabled patients and to create health action plans, which show and monitor how health needs will be met. The team also facilitates healthy lifestyles by providing advice and support on healthy eating and by with working with leisure service providers to set up and run exercise classes for adults with learning disabilities This work of the team helps to prevent hospital admission by improving the health of adults with learning disabilities in the community.

The team also supports St Helier Hospital to ensure that it is meeting the needs of adults with learning disabilities via a hospital liaison service that checks that basic needs are being met and maintains connections with community services and families whilst an adult with learning disabilities in hospital.

8.3 Caring for people with Long Term Conditions

Managing patients with LTCs is one of the key enablers for the Quality, Innovation, Prevention and Productivity (QIPP) Programme. The best practice model of care for LTCs is based on three cornerstones: risk stratification; establishment of neighbourhood care teams and improved self-care. The King's Fund has reported that this model of care improves clinical outcomes and significantly reduces unscheduled hospital admissions[25].

A priority is to effectively manage more patients with LTCs in the community working collaboratively with key partners and avoid utilisation of unscheduled secondary care. It is anticipated that this will achieve improved patient outcome and economic gains for the local health economy.

[24] Sutton & Merton Community Services - http://www.smcs.nhs.uk/
[25] The King's Fund - http://www.kingsfund.org.uk/publications/improving-quality-care-general-practice

Active Case Management

Active Case Management is aimed at those people with complex health and social care needs. Creating patient-centred care that is more co-ordinated across care settings and over time, particularly for patients with long-term chronic and medically complex conditions who may find it difficult to 'navigate' fragmented health and social care systems.

The co-ordination of care through an identified responsible professional or key worker whose primary role is to ensure the performance of the core tasks of new government policy case management. The core tasks involve case finding and screening, assessment, care planning and monitoring and review.

The Locality Hub multi-disciplinary team (MDT) will be a key driver to the health and social care system integration. This service will need to be developed in partnership between LB Sutton and the Sutton CCG with the overall aim to deliver proactive care in the community supporting patients with complex health and social care needs.

It involves identification of high risk of admission patients, selection of patients, engagement and involvement of patients and developing and agreeing the care plan with the MDT. The target population will include those who are registered with a GP in London Borough of Sutton, aged 75+ and suffer from two or more long term conditions, and/or high admission rates to hospital.

The outcome may include:

- Patients enabled to manage their own health conditions.
- Over time, a reduction in emergency admissions and bed-days, and placement in care homes, for the population they cover;
- Identification of the appropriate clinical and social care inputs required to improve the health and well-being of the people being presented to the MDT;
- Provision of better co-ordinated care across community and acute NHS settings, social care and other relevant care ;
- Identification of clear timescales for all actions required for individuals, including review dates and triggers and dates for re-presentation at the MDT;
- Identification of the most appropriate key worker/case manager to co-ordinate the care for the individual ;
- Improved relationships and co-ordination between local health, social and third sector organisations.

Risk stratification of patients with long term conditions

Risk stratification and predictive modelling has been identified as a key tool in facilitating the support of patients in primary and community care and reducing pressure and reliance on acute care. The tool recently commissioned by the Sutton CCG is available and fully operational in all 27 GP practices.

The risk stratification tool will enable our 27 GP practices to risk stratify their registered population by levels of risk to:

- Identify patients at high risk of emergency admission;
- Understand current healthcare needs;
- Predict future health trends;
- Identify opportunities for improving patient care;
- Develop new ways of working with key partners.

8.4 Supporting Carers

The economic benefit of registered carers in Sutton alone is estimated to be £296m a year; however carers are twice as likely to suffer from poor health as those without caring responsibilities[26]. At present it is estimated that £878,200 a year is spent on services that specify respite as their primary purpose, including residential and community based service provision. LB Sutton has also invested a further £1m in adult social services through the voluntary sector to support carers in general.

The carers support and respite project aims to scope the current total investment in services for carers, gaps in services as described by local carers, through needs assessments and intelligence from GP practices and elsewhere and to forecast future demand for respite and support services for carers. The project links into the Care Bill 2013/14 which aims to recognise carers in law in the same way as those they care for and thus brings with it a likely increase in demand for services.

Having scoped current services and identified gaps the project would develop joint commissioning plans for community and family support to increase choice and develop the market to respond to needs which it currently does not do. The project has a £90,000 budget to be spent on a project support officer and project manager (full and part time respectively) over a 12 month period.

Councils carried out a Carers Survey during October and November 2012 following guidance from the Department of Health by surveying carers who LB Sutton had

[26] Economic Value of Carers - http://www.carersuk.org/

assessed or reviewed in the last year. Some of the key results in Sutton include: 57% of carers surveyed were very satisfied, 54% found it easy to access information and advice, and the quality of life score was 7.4 out of 12. These scores were relatively low compared to other London boroughs[27].

LB Sutton responded to these findings through continuing and developing many streams of work that are dedicated to supporting Sutton's carers, including:

- Hosting joint training sessions between LB Sutton and SCC for social workers in order to better communicate with carers, with the aim of increasing the number of carers assessed/reviewed by LB Sutton;
- In 2013, an Adult Social Services & Health (ASSHe) Task & Finish group analysed respite care in Sutton and made suggestions on how to shape the market to provide better respite[28];
- Identifying carers balancing their caring roles and maintaining their desired quality of life, which may include employment, as an outcome for the Adult Social Services, Housing & Health (ASSHH) Directorate;
- Contracts with the SCC to provide a variety of services like activities and breaks, training, support groups, family skills work; or on a one-to-one 'casework' basis such as information, advice, advocacy, and emotional support; as well as mental health services and services for young carers;
- In 2012/13, providing over 13,500 hours of domiciliary respite care and over 450 weeks of residential respite care; more than 400 carers assessments; and spending more than £45k on carers personal budgets[29];
- Commissioning the SCC and Alzheimer's Society (among others) to provide high quality information to carers on what support is available to them.

[27] http://www.hscic.gov.uk/catalogue/PUB10963
[28] ASSHe Respite Report - http://sutton.moderngov.co.uk/ieListDocuments.aspx?CId=449&MId=3407&Ver=4
[29] Sutton Local Account 2012/13

8.5 Improving the health of residents by preventing falls

Community Falls Prevention Team

Commissioned by Sutton Public Health and Merton Public Health, post transition 1st April 2013

Provided by Sutton and Merton Community Services (SMCS), the overall aim of the service is to improve the health of the older person by preventing falls, fractures and unnecessary admission to hospital. The service is delivered as a therapy based intervention either as group exercises in a community setting or in a client's home. The service delivers:

- Staying steady exercise classes;
- Home response team to carry out multifactorial falls assessment;
- OTAGO type home exercise programme.

The service works in conjunction with the local older people community services also provided by SMCS i.e. the Community Rehabilitation Team, Community Neurotherapy Team, and Older People Assessment and Rehabilitation Service (OPARS).
Areas of development are:

- Fracture Liaison Service (FLS);
- Appropriate Care Pathway (ACP) with the London Ambulance Service (LAS);
- Falls screening for case finding by local authority staff and the voluntary sector;
- Support of the Telehealth/Telecare project.

Recommendations for future development are:

- *Further investigate an exercise continuum so that participants can move from the NHS led programme into a 'step down' community class;*
- *Undertake stakeholder engagement with a wider audience;*
- *Discuss at CQRG (CQRG) potential to set up a falls focus/strategy group i.e. design an osteoporosis pathway, in conjunction with clinical commissioners;*
- *Health Needs Assessment including unmet need where patients require rehabilitation and are identified via the Home Response service;*
- *Model capacity and demand for both 'staying steady' and Home Response including seasonal variations;*
- *Support the service to undertake an Equality Impact assessment;*

- *Develop falls screening for case finding by local authority staff and the voluntary sector.*

8.6 Access to local specialist services to help people remain healthy in their community

Assistive technology

Integrated Community Equipment Service (ICES) and Telecare

As more people are supported to live at home, and with more people being discharged promptly after hospital stays, the demands for equipment are rapidly increasing. Equipment can help improve or maintain people's independence in everyday living activities and help facilitate nursing care at home.

The retail environment has been developed to ensure a broad range of equipment is both visual and accessible for people with physical or sensory disabilities; equipment may be large like a hoist, or a perching stool or a small device such as a jar opener, amplifier or liquid level indicator.

To maximise efficiencies and to prepare for the demand on services Sutton Integrated Community Equipment Services (ICES) joined a shared service in partnership with Croydon Council[30]. Croydon are already operating successfully as an Integrated Procurement Hub offering the benefits of shared procurement to other local authorities and Health partnerships.

- Personalisation of services = increased demand;
- Services need to be as efficient and modern as possible now and in the future;
- An ageing population will further increase demand on services as needs become more complex;
- Prevention of hospital attendance and admission;
- Reduced length of stay and facilitation of early discharge;
- Increased number of people enabled to remain at home.

[30] Sutton ICES - https://www.sutton.gov.uk/index.aspx?articleid=12377

ICES is jointly funded by Sutton CCG and LB Sutton to provide equipment to the residents of Sutton.

Telecare is a term used to describe both community alarms and a range of sensors that can be set up to raise an automatic alert to the monitoring centre if, for example, the person has a fall, leaves the property or if a linked smoke alarm is activated[31].

Sheltered Housing properties have a built-in emergency alarm system, enabling residents to summon emergency assistance if and when required.

LB Sutton supply Telecare services as part of an individual support plan following a Supported Self-Assessment. Alternatively anyone can purchase the service privately from a community alarm provider.

Depending on the provider, this service may be supported by a team of local responders, who provide a 24/7 personal response service for people who do not have a local keyholder.

Health checks

The NHS Health Check programme is a public health programme in England for people aged 40 – 74 years which aims to keep people well for longer by detecting early risk factors for cardiovascular disease, such as high blood pressure, high cholesterol, smoking and obesity[32]. It is a risk assessment and management programme to prevent or delay the onset of diabetes, heart and kidney disease, and stroke so that clients can be referred to programmes such as weight management and stop smoking.

Since 1st April 2013 1883 eligible people in Sutton have been invited and 1137 have completed their NHS Health Check

A Learning Disability annual health check is a requirement for all known residents with a learning disability: In 2012 approximately 50% of those known to have a learning disability had a health check[33]. There is support to primary care to carry this out and ensure those that require hospital visits or treatment are appropriately cared for, from the Learning Disabilities Community Health Team which was assessed by the Care Quality Commission (CQC) in 2013 as being a model of best practice.

[31] Telecare - https://www.sutton.gov.uk/index.aspx?articleid=10685
[32] NHS Health Check Programme - http://www.healthcheck.nhs.uk/
[33] Learning Disability Annual Check - http://www.nhs.uk/Livewell/Childrenwithalearningdisability/Pages/AnnualHealthChecks.aspx

Older People's Assessment and Rehabilitation Service (OPARS)

The service is run from Wilson Hospital and Cheam Priory Day Centre with assessments at the Wilson site on Mondays and Wednesdays and rehabilitation services run from the Cheam site on Tuesdays, Thursdays and Fridays. Referral criteria for the service are that the patient is:

- Over 65;
- A Sutton or Merton resident;
- Requires therapeutic intervention from more than one health professional;
- Has the mental capacity to participate in group and individual based rehabilitation;
- Referred through the SMCS website.

Full assessments of therapy/nursing assessments and falls screenings are available and need to be linked to the LTCs work outlined for Active Management.

Model of care for Diabetes

The prevalence of diabetes in Sutton, both types one and two, is lower (5.4%) than the national average (5.8%) (2011/12). With a range from 3 to 7% by practice. However, it is likely that there is a proportion of the population in Sutton with diabetes but who remain undiagnosed as seen when looking at the recorded prevalence of diabetes against the modelled expected prevalence. This comparison gives a ratio of 0.51 which, although lower than both national (0.58) and regional (0.62) averages still suggests a statistically significant number of patients remain undiagnosed.

The mortality rates from diabetes are also likely to be misleading as cause of death is often recorded as being due to complications arising from diabetes, such as cardiovascular problems, stroke etc, rather than from the disease itself.

Compared to other areas in South West London the clinical standards in primary care for diabetes locally indicate that measurement of blood pressure and cholesterol is comparable, although improvements in blood glucose levels of people with diabetes could have significant impact on outcomes including hospital admissions. The programme will continue to identify more people at risk of both heart disease and also of diabetes.

Following on from a 2012/13 Sutton and Merton PCT project, the Sutton CCG has agreed to continue with the implementation of the Healthcare for London Model of Care for Diabetes[34]. The model is based on four tiers of care delivered across three settings; primary, community and hospital. Focus for 2013/14 is on Tier 3 services that is, those delivered in primary care and community settings.

The work will focus on the prescribing of oral hypoglycaemics, insulins and blood glucose testing strips in order to decrease inappropriate use of the acute sector (hospital) by moving patients from secondary to community based care, in line with the National Institute for Clinical Excellence (NICE) guidance and resulting in increased cost effectiveness[35].

The aim is to improve the management, education and treatment of those diagnosed with diabetes through the following:

- Working with secondary care colleagues to develop more appropriate prescribing of intermediate/long acting insulin analogues to ensure adherence to NICE guidance and increase cost effectiveness
- Continuing to commission and provide workshops for clinicians where best practice can be shared and discussed
- Embedding the Tier 3 Diabetes services at the Jubilee Health Centre to ensure appropriate education for patients

We expect to see a reduction in outpatient appointments of 505 people for 2013/14. This represents only a half year outturn as the community diabetologist is not yet in post. The Jubilee Health Centre will also support this workstream with specialist diabetes consultant clinics which are scheduled to commence in September 2013 and which should reduce the number of outpatient appointments in the acute.

Respiratory community pathway

In 2011-12 respiratory related conditions, excluding cancer, across all age groups accounted for 7% of all emergency hospital admissions. COPD has been identified as the most commonly reported LTC in children, and the third most common in adults with a 1.3% prevalence in Sutton overall. Respiratory conditions have also been found to be the third major cause of death in under 75s in the 2013 JSNA[36].

[34] London Model of Care for Diabetes - http://www.londonprogrammes.nhs.uk/wp-content/uploads/2011/03/Diabetes-Guide.pdf
[35] NICE Guidance on Diabetes - http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7239
[36] JSNA Respiratory Diseases - http://www.suttonjsna.org.uk/causes-of-poor-health/respiratory-disease.aspx

In order to respond to our high levels of respiratory condition and improve our out of hospital care we will:

- Continue to embed the redesigned community clinical pathway to ensure optimal care of vulnerable, elderly patients (who generally live alone or in residential care). The pathway will particularly focus on optimising care post discharge by aligning medicines formularies between primary and secondary care to improve cost effectiveness, compliance, safety and quality;
- Optimise the support offered by community pharmacists through Medicines Use Reviews and other support services ;
- Focus on providing integrated services, including access to primary prevention services such as stop smoking and immunisation to reduce unplanned admissions and re-admissions;
- We will also explore the possibility of improving access to Pulmonary Rehabilitation, particularly for patients who have had an unplanned admission for COPD exacerbation.

Anticoagulation monitoring

Anticoagulation monitoring has been provided in primary care for a number of years with many practices providing a significant reduction in secondary care activity. However there is a wide variation in the numbers of patients remaining in secondary care across practices. We are looking to reduce this variation by increasing primary care provision by undertaking activity at the established Primary Care Hubs and participating practices.

Standardised and clinically effective anticoagulation management will be provided to primary care patients on warfarin or phenindione therapy. This is compliant with the standards set out by the British Committee for Standards in Haematology, the National Patient Safety Agency, the National Enhanced Service for anticoagulation monitoring and the Healthcare Commission at Primary Care Hubs and participating practices[37,38,39,40].
The aim of this initiative is to:

- Increase initiation of anticoagulation in the participating practices and primary care hubs;

[37] British Committee for Standards in Haematology - http://www.bcshguidelines.com/
[38] National Patient Safety Agency - http://www.npsa.nhs.uk/
[39] National Enhanced Service for Anti Coagulation Monitoring - http://www.wales.nhs.uk/sites3/Documents/480/anti-coag-mon-e.pdf
[40] Care Quality Commission - http://www.cqc.org.uk/

- Repatriate pts from the acute service to primary care for all anticoag follow ups (within inclusion data);
- Improve patient pathway by bringing service closer to home.

Electrocardiogram (ECG)

Begun in 2007, the ECG hub service aims to transfer a proportion of resting and 24 hour ECG tests taking place in secondary care to a community setting. The service takes place at two hubs – Old Court House Surgery and Shotfield Medical Practice, Jubilee health Centre.

It is anticipated that 100% of direct GP referred outpatient activity can take place through this service giving patients access to first rate ECG tests without having to repeatedly attend acute care appointments. The resting ECG is a walk in service but the 24 hour ECG will be by appointment.

Referrals are made by the GPs on to the "Cardiosoft" system, the ECG test is carried out by a trained Healthcare Assistants (HCA) and the results uploaded back on to the system for the referring GP to access. For the 24 hour ECG monitoring, the patient attends an appointment to have the equipment fitted and then returns the next day when the report is uploaded to the GP. Patients will return to their GP for the result of their tests. Where the result is not reported as "normal" it is sent to a Consultant physician who reviews the result and sends a report to the referring GP. The consultant will be available for 1 session per week to provide training and an expert opinion.

Urology

Specific pathways are currently being developed for the management of Lower Urinary Tract Symptoms (LUTS) it is anticipated that this will be delivered alongside the Urology Outpatients Service at Jubilee Health Centre.

'Walk In Walk Out' Hernia Repair Service

In 2011-12 there were 719 hernia repairs undertaken in the secondary sector, not including outpatient visits preoperatively (initial and post any required investigations), cancellations on the day of operation due to co-morbidities, use of HDU/ICU (HDU/ICU) and any postoperative visits. It is estimated that up to 643 of these appointments, or around 90%, could have been undertaken in a community based service. National trials of hernia repair services delivered in the community have

shown extremely high levels of patient satisfaction as well as low rates of complications of a minor nature (1%). It has also allowed patients with significant co-morbidities who are unable to undergo general anaesthetic to reap the benefits of hernia repair.

Sutton CCG has commissioned a 'Walk in Walk Out' hernia service at the Jubilee Health Centre with procedures commencing in January 2014. The service aims to improve the management of Hernias in primary care through a community based hernia repair service, supporting a reduction in overall secondary care referrals, shortening the care pathway and hence providing a more cost effective service.

Mental health services

South West London and St George's Mental Health NHS Trust operates the secondary and community health services, and LB Sutton the statutory social services for those with mental health needs.

The Mental Health Delivery Group is working on two integrated pathways: dementia and Adult mental Health to develop long term joint commissioning plans for Mental Health that will support the objectives in this strategy.

Current mental health services operating in Sutton include 'Sutton Reach', a programme offering housing support for a maximum of two years accessed via housing or social services, and 'Connect Learn and Support' which runs a drop in centre and community meeting places. Both of these services are well used in the borough and there is demand for additional services[41].

GPs will see and treat the vast majority of people with common mental health problems with 91% of contacts being seen in primary care including Improving Access to Psychological Therapies (IAPT) services (Joint Commissioning Strategy 2010 – 2015)[42]. Referrals will be made on where specialist intervention is required. Sutton CCG also commissions a specific self help group "No Panic" seeing people in relation to stress and anxiety management.

Improving Access to Psychological Therapies (IAPT)

Sutton CCG commission an IAPT service. This service is both a GP and Self Referral (67%/33%) for people with mild – severe depression and anxiety. The service is expected to see 13% of the overall prevalence rate for those conditions being 2,979

[41] Sutton Reach - http://www.thamesreach.org.uk/what-we-do/preventing-homelessness/sutton-reach/
[42] Joint Commissioning Strategy 2010-15 - http://www.sutton.gov.uk/CHttpHandler.ashx?id=7872&p=0

(total prevalence 22,914 people). The service will offer a range of treatments following assessment including, Cognitive Behaviour Therapy[43].

NHS 111 Service

Research with the public has made clear for some time that the public find it difficult to access NHS services when they develop unplanned, unexpected healthcare needs. Changes in the way that services are being delivered in particular the introduction of new services such as NHS Walk in Centres and UCCs have added to the complexity of the urgent care system. NHS reviews have found that patients want better information and more help to understand how to access care when they need it.

A comprehensive up to date directory of local services is a key part of the NHS 111 service and the data NHS 111 collects will be used to understand service demand and inform future commissioning decisions[44].

The 111 number is designed for use when:

- Someone needs medical help fact but it is not a 999 emergency;
- People don't know who to call for medical help or do not have a GP;
- Someone thinks that they need to go to A&E or another NHS urgent care service;
- People require information or reassurance about what to do next.

Call advisors use a clinical assessment system and ask questions to assess callers' needs and determine the most appropriate course of action including:

- Sending an ambulance;
- Providing information, advice and reassurance;
- Referral to a service with the appropriate skills and resources to support their needs;
- Provision of details of an alternative service where requirements fall outside of the scope of 111.

Since Sutton CCG successfully commissioned the 111 service from NHS Direct, NHS Direct has taken the decision to withdraw their services across the country as soon as an alternative supply can be identified and implemented. Harmoni is now the local provider of 111 services. The new 111 service for Sutton went live on the 12th November.

[43] Sutton & Merton IAPT - http://www.suttonmertoniapt.nhs.uk/
[44] NHS Direct/111 - http://www.nhsdirect.nhs.uk/

Out of Hours GP Service

The aim of the out of hours services is to provide urgent medical assessment, advice and medical care to patients registered with a Sutton GP, resident or temporarily resident, homeless or unregistered with a GP in the London Borough of Sutton. Patients can expect to access prompt, appropriate emergency advice and treatment that fully meets the National Quality Standards until they can access usual in-hours medical services[45]. The out of hours service provides a seamless service for urgent medical problems into mainstream primary care.

Jubilee Health Centre – increasing integrated care closer to home

There is a growing body of evidence that indicates that a volume of the work that is currently undertaken within an acute setting in district general hospitals such as St. Helier can successfully be carried out outside the walls of the acute hospital within communities.

As part of the overarching commitment to delivering more integrated care closer to home the £13million Jubilee Health Centre (JHC) opened in June 2012 with the intention of having a range of services migrated by the end of 2012. A full business case for the Jubilee Health Centre was drawn up in 2009 and outlined the following six key objectives for the centre:

- Improving patient outcomes;
- Providing more care locally;
- Tacking health inequalities;
- Meeting changing demographics and healthcare needs;
- Modernising estates;
- Using resources more efficiently.

These issues must also be addressed in order to ensure that the capacity within ESH is used only for those who require it. The services provided by the Jubilee Health Centre are reviewed each year as part of the contracting round. With effect from September 2013 the following services will be delivered by ESH within the Jubilee Heath Centre:

[45] National Quality Standards for Out of Hours Services – http://www.out-of-hours.info/downloads/quality_requirements.doc

Clinical Centres	Activity Volumes	Supporting Diagnostics	Activity Volumes
Diabetes Centre	16,000	Plain film X-ray	
Mobility Centre	34,020	Ultrasound	
Respiratory Centre	19,277	ECG	
Cardiology Centre	19,382	Phlebotomy	20,000
Women's Centre	20,526		
Family Centre	23,214		
Children's Centre	24,306		
Dermatology Centre	389		
Gastroenterology Centre			
Neurology	400		

We have drawn up a three and a half year plan in conjunction with ESH and NHS Property Services and agreed transition funding for ESH for 2013/14 to support these service delivery models and enable ESH services to relocate. We are therefore confident that the Jubilee Health Centre will continue to support our strategic priorities and help us to deliver our out of hospital strategy.

Future development for the Jubilee Health Centre

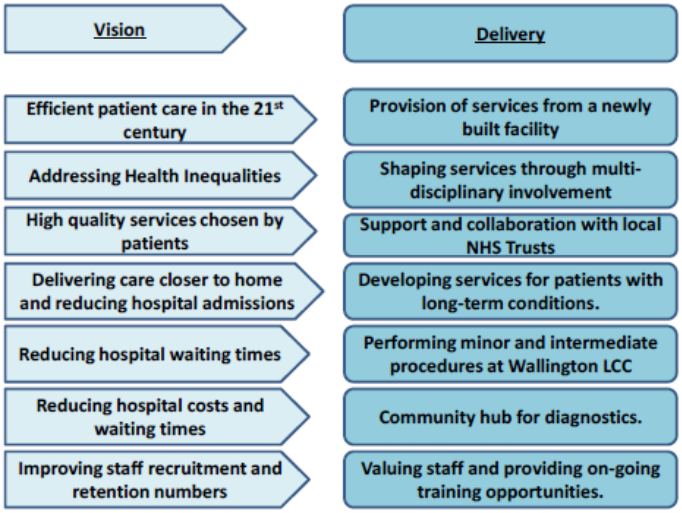
Having made the investment in the Jubilee Health Centre it is imperative that the health and social care community in Sutton make best use of the valuable resource that has been created.

In addition to transferring care from the acute into the community, the King's Fund report on improving the Quality of Care in General Practice indicates that a significant proportion of referrals made in general practice may not be clinically necessary[46].

The service has been commissioned to respond to the need to provide modern integrated care in facilities that are developed for the delivery of healthcare that can be safely delivered in the community.

The work supports the strategic priority of delivering more health care in primary and community settings and out of hospital. The vision for the health centre is illustrated in the table below:

[46] The King's Fund - http://www.kingsfund.org.uk/publications/improving-quality-care-general-practice


Vision
Delivery
Efficient patient care in the 21st century
Provision of services from a newly built facility
Addressing Health Inequalities
Shaping services through multi-disciplinary involvement
High quality services chosen by patients
Support and collaboration with local NHS Trusts
Delivering care closer to home and reducing hospital admissions
Developing services for patients with long-term conditions.
Reducing hospital waiting times
Performing minor and intermediate procedures at Wallington LCC
Reducing hospital costs and waiting times
Community hub for diagnostics.
Improving staff recruitment and retention numbers
Valuing staff and providing on-going training opportunities.

9. SUPPORTING PEOPLE WHEN THEY REQUIRE HOSPITAL AND RESIDENTIAL SERVICES

Following an episode of ill health or crisis, this strategy aims to deliver the right services, in the right place at the right time by delivering integrated pathways to ensure our residents are treated and cared for in the most appropriate way.

It is predicted that levels of acute (hospital) demand will continue to rise and as a consequence an increase in admission and attendances to the secondary care provision either via emergency departments or through planned interventions will increase to levels that are unaffordable and unsustainable across the whole system. Demand will swiftly outstrip the capacity available to manage the health and social care system in Sutton.

The strategy aims to address the growth in demand by offering services in the community and reducing the impact through a reduction in unplanned admissions, A&E attendances and outpatient appointments.

9.1 Urgent Care

Urgent care can mean many things and the section outlines the range of interventions and services that are in place to support local people accessing the right service at the right time. The interventions may require resource and support from both health and social care, the user of the service should have a seamless pathway where professionals communicate and transfer care seamlessly.

The focus for us is to ensure that services are available to people more consistently over a seven day period and to enhance communications to support signposting to the correct service. Over a longer period it is anticipated that through education and awareness raising for the local population a shift will occur in behaviour resulting in increased self-management and access of primary care services that reduce the use of urgent care to self-manage where possible.

This strategy and the associated Better Care Fund plan, are designed to help people in Sutton met their health and social care needs without emergency admissions to hospital or the loss of their independence. The interdependence of community health and social care services with that in hospitals is acknowledged in this strategy. The current position is unlikely to be sustainable and therefore requires alternative arrangement to be carefully developed in the medium term.

Raising Awareness of Local Urgent Care Services

Given the current national focus on A&E performance and appropriate use of urgent care services we are working to ensure patients are fully informed of the urgent care options available to them. Only by doing this will we see the benefits of the initiative we are developing realised. We will carry out the following activities:

- Publishing the local recovery and improvement plan for Sutton that has been jointly developed by primary community acute care, social services and Healthwatch[47];
- Working with patients identified as 'frequent users' of urgent care services and developing action plans to help this cohort access services more appropriately. This is actively being undertaken by practice teams and includes review of patients who are either frequent attendees, or attend for reasons more suited to consultation in primary care;
- Ensuring strong links to our LTC work on patient self-management;
- Working, through our locality groups, on improving access to general practice, particularly for those who have presented at urgent care and need to be re-directed back to their GP. This work will involve the provision of same day appointments and contact links between A&E streamers and general practice teams.

Sutton CCG will work with partners and with the communications department at the CSU (CSU) in order to reflect any nationally prioritised and run campaigns in local activity (Flu vaccination campaigns, promotion of 111 etc.).

[47] Sutton Healthwatch - http://www.healthwatchsutton.org.uk/

The 111 service may over time also provide functionality for primary care interface and access to appointments and it is recognised that preparing GPs for this new functionality will be a key aspect of the communications strategy for NHS 111. Part of this is the drive to have a Single Point of Access (SPOA) for information and advice ensuring synergy with NHS 111. We are keen to utilise social media as a channel of communication and to develop our web portal 'One Sutton' to incorporate information and advice, self-assessment as well as the ability to buy services and support online. Expansion of the urgent care at home pathway to seven days per week.

Urgent Care at Home Service – Care Homes

The Sutton CCG is commissioning an urgent care service to 20 residential, nursing and sheltered facilities. The service will provide an alternative to calling 999 and therefore reduce the numbers of resulting attendances and admissions. Nurse practitioners lead the service, and will work to liaise with the GP, pharmacy and other services to avoid preventable conveyances to hospital.

In order to respond to the cost of providing emergency acute service to residents of residential and nursing homes in the area, Sutton CCG took part in a pilot urgent care pathway which aimed to reduce the number of unnecessary attendances or admissions for older and disabled patients. The service has now been extended for a further 12 months to March 2014, covering 20 residential, nursing and sheltered facilities across Sutton. The service will do this by providing a mobile service, going into residential and nursing homes when required and ensuring that the patient is promptly assessed within 2 hours of referral and a treatment plan produced with eventual transfer to other community health services or discharged when appropriate. The service is provided by a multi-disciplinary team which will assess and initiate services in order to support patients in need of acute care. This approach makes best use of clinicians' time, ensures smooth handovers from nurse practitioners who lead the service to other health and social care professionals, including GPs and pharmacists, and encourages effective communication with home managers and care staff.

Currently the urgent care at home pathway is running between 9am and 6pm seven days a week.

This initiative is expected to avoid 500 A&E attendances per year. The team running the initiative expect to see between 100 and 120 patients each month across Sutton, on the basis of this, to see a resultant 15% reduction in admissions. This represents for Sutton an expected QIPP saving of £500,000. Additionally the service expects to see:

- An improved patient experience of urgent and emergency care;
- Increased support for patients in nursing and residential homes;
- Better co-ordinated EoLC;
- Increased use of community and social services.

9.2 Community Acute support

Community Prevention of Admission Team (CPAT)

Community Prevention of Admission Team (CPAT) supports the reduction of inappropriate emergency admissions to hospital by providing rapid assessment within 2-4 hours and support/intervention for 72 hours to enable the individual to remain out of hospital. This includes signposting to other health and social care services. CPAT is a team of highly skilled nurses and therapists who can provide comprehensive nursing interventions including nurse prescribing of medications along with ordering of equipment; undertaking complex moving and handling assessment and care planning. The CPAT scheme started in October 2013 with 65 referrals in the first month.

Community Rehabilitation Team (CRT)

There are a total of 33 beds jointly commissioned across Sutton and Merton at the following locations:

- Merton Woodlands Residential Home (13);
- Sutton Crossways Nursing Home (6);
- Sutton Abbey Care Home (9);
- Sutton Eversfield Residential Home (5).

The service is supported by the Sutton community team and accepts referrals from a number of other services and from GPs but does not accept self-referrals[48]

[48] SMCS CRT - http://www.smcs.nhs.uk/rehabilitation.asp

9.3 Inpatient Acute Care

In April 2013, the Complex Older People's Pathway (COPP) Project commenced, led by Sutton CCG supported by stakeholders which looked to initiate a scheme which aimed to commission an integrated service model for complex frail and older patients which encompasses primary, secondary, community health care providers, social services and the voluntary sector. The model is designed to support prevention of hospital admission, reduced readmissions and reduce length of stay as clinically appropriate, thus providing opportunity for significant savings and cost efficiencies.

In Hospital Care

The focus for In Hospital Care was to change the pathway within the acute trust, a 'one team' approach consisting of an integrated approach by health, social care and the voluntary sector, clinically led by a Trust consultant Geriatrician supported by a Service Navigator.

- One Team approach ensuring integration with social care and health providers across acute and community care;
- Patients identified and cohorted using pre identified criteria;
- Dedicated Geriatrician supporting patient cohort attending A&E and supporting community services;
- Admission to ward/service using agreed criteria via navigator/consultant Geriatrician/Team;
- Daily MDT meetings and review by Geriatrician;
- Enhanced OPALS/Therapy service to maximise patients and reduce length of stay. Intermediate care facility provides more appropriate care options.

Discharge to assess

A proactive approach to discharge planning will be developed to ensure that previous 'bottlenecks' in the system no longer occur and also to reduce the likelihood of readmission. Discharge needs to be an integrated approach across all participants in the patients care.

- In-reach/out-reach from community and social services improves continuity of care and discharge planning;
- Resource to follow up and monitor elderly respiratory discharges;
- Daily integrated MDT approach to discharge planning, including primary care, community care, social services and third sector;

- Discharge to hospital at home virtual ward services, facilitating shorter hospital stays where appropriate;
- Discharge to Community Rehab Beds and community rehab at home;
- Home from Hospital Service;
- Discharge passport.

9.4 Enabling patient independence and wellbeing

To support more patients back to a stable and supported self-managed environment, reablement and enhanced community- based therapy services are required. (Please see page 16 for a description of the LB Sutton reablement service – START)

To enable independence it is necessary to utilise existing links with the Voluntary Sector to ensure access to all appropriate services, care coordination to improve timely access and proactive integrated case management.

- Enhanced community-based therapy and reablement services to support more patients back to stable and supported self-management.
- Improved links with Voluntary Sector to ensure access to all appropriate services.
- Single assessment process to improve timely access to services which enable independence.
- Integration of social care in proactive case management enables early identification and response when needs change.

Hospital Social Work

The LB Sutton hospital social work team provides assessment and support planning to facilitate discharge and to support prevention of admission at A&E and AMU (AMU). Linking closely with the LB Sutton START team. The hospital LB Sutton social work team undertakes around 100 new assessments a month.

Home from Hospital Service (Age UK)

The Home from Hospital Service (including the Community Helpers Befriending Service)[49]. A one year pilot the service provides assessments and care packages for residents aged 65+, registered with a Sutton GP and with no family or friend support networks pre and post diagnosis in association with Age UK.

The Home from Hospital Service provides a rapid response low intensity support package for individuals with lower level practical needs and acts as a trigger for onward referral to other services. Located within the Rapid Response Team at St Helier Hospital the service also links in to ward staff, discharge co-ordinators, primary care, community services and social services to provide support for a maximum of four weeks. The aim of the service is to prevent hospital admissions or support safer discharges seven days a week with running hours between 11am and 7pm and an annual contract value of £99,320.

The Community Befriending Service operates Monday to Friday 9am to 5pm and provides emotional support for the same patient cohort and in particular for vulnerable patients with no family or friend support networks who are at risk of becoming isolated. The service offers face to face or telephone befriending and acts in part as an introduction to some of the social activities available in the community and as a confidence builder for lonely older people diagnosed with dementia. Its annual contract value is £82,500.

During its first year pilot to May 2014 the service received a total of 218 referrals, 195 of which were for different patients. Of these 155 patients received support from the service with positive feedback from patients as to their levels of independence at one, three and six months. Volunteers also reported feeling that the service was of great benefit and targeted patient groups which often 'fall through the gaps' as their needs don't qualify them for social care.

End of Life Care (EoLC)

This scheme aims to increase the number of people in Sutton achieving EoLC in their preferred place of care (PPC) through improved communication between services facilitated by the increase of implementation of Co-Ordinate my Care (CMC), the use of a Local Enhanced Service which included After Death Audits to promote learning, and ensuring implementation of best practice guidance[50].

[49] Sutton Home from Hospital & Community Befriending Service - http://www.ageuk.org.uk/sutton/our-services/home-from-hospital/
[50] Sutton End of Life Care - https://www.sutton.gov.uk/index.aspx?articleid=11698

It is expected that this will result in a reduction in the number of hospital admissions in the last year of life for EoLC patients where they wish to receive care at home or in a non acute setting.
The national target is 70% of EOLC patients whose PPC is not an acute setting is achieved; data up to and including October 2013 shows currently we are running at 73% for those patients with a CMC record and 39% for deaths overall.

Referral Management by GPs (referral facilitation schemes)

As part of the 2013/14 Practice Engagement scheme, practices have been asked to monitor their own in-house referral rates to secondary care by speciality. The aim is to reduce referral rates to standardised ‘norms’ across practices by varying degrees as clinically appropriate. The scheme has also introduced a new performance dashboard which provides practice level data on referrals alongside corresponding emergency admission levels and prescribing data by speciality.

This in turn informs our understanding of referrals to hospital and allows practices a more in depth analysis of their referral patterns in order to focus attention and resources more effectively. This will enable the sharing of good practice across GP practices and contribute to referral reduction where clinically appropriate.

Sutton CCG has implemented an escalation framework for practices which are performance ‘outliers’ to better manage GP referrals.

10. TESTING WAYS OF WORKING

During 2013/2014 NHS England transferred £100m nationally to adult social services. The aim of the transfer was for it to be used to support adult social care services which had a health benefit in each local authority. The funding was to support the development of more integrated health and social care working between Clinical Commissioning Groups and Local Authorities through existing adult social care services, new services, transformation programmes and to inform future commissioning. The integration allocation for 2013/14 for Sutton was £740k. Some of this funding was used to commission pilot projects from voluntary sector providers.

NHS England required local authorities to agree with health partners through their local Health and Wellbeing Boards how the funding was to be used. Please see the Committee report- NHS Funding Transfers for Adult Social Care Services 2013/14. (http://sutton.moderngov.co.uk/mgAi.aspx?ID=22170).

The health and social care funding supported the development of a number of initiatives in Sutton including:

Keeping people healthy and independent in the community

Food Poverty

To research the issues surrounding food poverty in Sutton - using a £30,000 budget this pilot has appointed a project officer on a temporary. The project officer will map existing resources, analyse need, tackle issues that emerge and deliver a plan to address any gaps that may emerge.

Caring Neighbour

This pilot will offer a community based service of practical support for patients aged 75+ with two or more long term conditions who are registered with a Sutton CCG GP. The service is aimed particularly at those with no family or friend support networks.

The service will cater for individuals with lower level needs resulting from diagnosed health needs, not requiring formal support from Health or Social Care including: shopping or assisting with shopping, cleaning, preparing light meals and will act as a trigger for onward referral to other services. In addition the pilot will offer a range of interventions including signposting to support services and regular reassurance calls which provide an emotional and befriending support to include well-being befriending

calls, one on one befriending relationships and once confidence is restored re-connection to community based social activities[51].
In addition to this, this pilot will raise awareness of how to keep warm and well in the winter. This will include:

- A publicity campaign, including pamphlets entitled 'Winter wrapped up' and 'Staying warm';
- Ten top tips for winter door drop distribution to 72,000 households;
- GP, health practitioner and pharmacy referrals of vulnerable patients for emergency 'keep warm' packs.

Local Access to specialised health and social care services

Community Choices Pilot for Mental Health Clients

The pilot introduces a quick response, short term support service for residents with mental health needs for up to six weeks offering intensive one-to-one support, information, sign posting and practical assistance from trained support staff[52]. Referrals will come from secondary mental health services managed by LB of Sutton and South West London & St George's.

The community choices pilot aims to reduce GP visits and Community Mental Health Team referrals for people who need a period of focused support to prevent escalation of mental health issues, support needs and promote recovery. It is estimated that over the course of the nine month pilot 50 people will be offered support from a budget of £60,000.

Peer Support Pilot

The Peer Support pilot delivers an additional 20 trained peer supporters in the community, to maintain and manage the recovery of people suffering from mental health issues. Peer supporters will have a personal understanding of these issues and be able to relate, directing them away from secondary care and supporting them to manage in their health within their own homes. Peer supporters are introduced via an identified group of GPs in Sutton. The budget of £40,000 will be used to identify

[51] Sutton Caring Neighbour Scheme - http://www.ageuk.org.uk/sutton/
[52] Sutton Community Choices - http://www.community-options.org.uk/wp-content/uploads/2014/01/Sutton_CSS04_114F.pdf

and train peer supporters, deliver peer support resources and develop outcome measurements.

Transition pilot (Children moving to adult life)

A transition pilot has been established to investigate new approaches to Transition work aimed at meeting the requirements of the upcoming Children and Families Bill 2013. A joint assessment process between representatives of the relevant agencies will be piloted with this group, The young people concerned all have special educational needs (SEN) and need to be eligible for Adult disability services. The budget of £30,000 is for the contribution for an LB Sutton full time Social Work Senior Practitioner in the Transition Unit.

Telehealth and Telecare

This pilot will introduce a joint Telehealth and Telecare solution monitoring general health and potential triggers of falls such as low body mass index (BMI), low weight and blood pressure, medication compliance to improve patient outcomes and help them to self-manage their care, putting the focus on early intervention and prevention as well as service modernisation to deliver care outside the hospital. By monitoring general health and reducing falls, there is an expectation considerable savings (in reduced hospital attendances and reduced number of fractured neck of femurs (hip fracture) resulting from a fall) may be achieved.

A cohort of 50 patients aged 65+ with either low blood pressure; who have previously fallen; suffered a fractured wrist as a result of a fall; or are diagnosed as osteoporotic and are at high risk of falling have been identified for inclusion in the pilot. They will be supplied with a package of Telehealth and Telecare for 36 months of the pilot. The service will run alongside the falls prevention service, fracture liaison service and LAS. It will operate with a £220,000 budget and (in addition to the target reduction of 12 admissions for the falls pathway in 2013/14 - based on an expected 158 admissions) it aims to avoid a further eight admissions with an expected saving of £100,000 in health costs and £144,000 in Social Care costs (residential care home costs and increased social care package).

Infrastructure changes

Data Sharing

In response to the Caldicott 2 review of information governance in health and social care (March 2013) and the BCF national condition of data sharing, Sutton CCG and LB Sutton are looking to explore the capacity and barriers to information sharing in the borough[53]. The pilot aims to develop the sector focus of securing consent for information sharing across integrated pathways involving organisations including the local authority, social services, public health, Sutton CCG and patient/stakeholder groups. Using a £50,000 budget the pilot will link in with the London Connects programme and is expected to improve patient experience through more integrated working and better access to real time patient information.

Further development

Further development for the integration of health and social care is being progressed through the Better Care Fund pooled budget proposals and a new operating model to be in place for 2015-2016. The pilots outlined above will be evaluated in 2014-2015 and subject to that, will be incorporated into the new operating model for health and social care. The aim will be joint commissioning, joint assessment of need and integrated access to health and social care services outlined in this strategy.

[53] The Government's Response to the Caldicott Review - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF

11. DELIVERY OF THE STRATEGY

This section describes what LB Sutton and Sutton CCG are going to do to deliver this strategy, with aims and steps that need to be taken being described within the following three key areas

- Keeping people healthy and independent in the community.
- Local access to specialised health and social care services.
- Supporting people when they require hospital and residential services.

It is recognised that this strategy builds on complementary plans and strategies that focus on supporting people to maintain their independence; help people remain healthy and living in their homes; and reduce preventable hospital and care home admissions. Whilst responsibility for these plans lies with statutory commissioners (the Council and the Clinical Commissioning Group), NHS Trust and social care providers will be part of the delivery. These plans include;

- The Joint Health and Wellbeing Strategy (including Delivery Plan)
- Better Care Fund – development of the integration of health and social care through pooled budgets
- Integrated Complex Older Persons Pathway (and Winter Pressures)
- The Joint Mental Health Strategy

The delivery of this strategy will be progressed through the Better Care Fund pooled budget and a delivery plan that combines the implementation of this strategy and the preparations for the Better Care Fund which will commence in April 2014. Where there is a link against a BCF national condition and performance measurement it has been listed against each step described.

BCF National Condition	
NC1	Protecting Social Care Services
NC2	7 day services to support discharge
NC3	Data sharing
NC4	Joint assessment and accountable lead professional
NC5	Impact of changes in the acute sector

BCF Metrics – Performance Measurement	
M1	Local outcome measurement
M2	Patient outcome measurement
M3	Avoidance of emergency admissions to hospital
M4	Reduction in delayed transfers of care
M5	Improved reablement/rehabilitation outcomes
M6	Avoidance of care home admissions

Keeping people healthy and independent in the community

This area links with the Joint Health and Wellbeing Strategy (JHWS) Priority 1 and 4.
Priority 1 – Improving and protecting health and wellbeing (early intervention and prevention).
Priority 4 – Supporting communities and individuals to look after their own health and wellbeing.

In addition to the priorities of the JHWS, the aims of this strategy are:

- At a community level, as many people as possible will be enabled to stay healthy and actively involved in their communities to improve and sustain their health and wellbeing. This will also help delay or prevent need for statutory health and social services. This strategy aims to maximise local residents' capacity to help each other in the community, and to access services available.

- To improve joint prevention measures through work across Public Health, Social Services and Health commissioning and seek reductions in health inequalities. This will include better joint commissioning by two new joint commissioners for Mental Health and Carers Support, and support through the voluntary sector and other community initiatives.

- To coordinate and improve access to the wide range of sources of information and advice, including through specific plans of the Council in line with new Care Bill requirements from 2015 (e.g Web portal, better liaison between health and social care teams and residents.)

Local access to specialised health and social care services

This area links with the Joint Health and Wellbeing Strategy (JHWS) Priority 2 and 3.
Priority 2/Outcome 1 – Improving the health and wellbeing of those who have a disease or disability – Supporting people with long term conditions to live healthier lives.
Priority 3 – Improving mental health and wellbeing

In addition, this area also links with the Integrated Complex Older Persons Pathway, which comprises of five stages in the patient's journey. Related to this area are the Enabling Optimum Independence and Well-being, Proactive Healthcare and Crisis Intervention stages.

In order to deliver this strategy, the priorities of the JHWS and the proposals to support the Care of Complex Older Persons, the next steps are:

- To offer both GP, out of hours GP, and hospital services a single point of access to reablement and community healthcare services to enable 7 day working, out of hours and weekend support. **NC1, NC2, M5.**

- To consolidate both Sutton CCG and Council expenditure on carers' support in integrated commissioning from 2015/16 to support more carers through personal budgets offering choice and control. **NC1**

- To expand the capacity of the reablement (START) and NHS community services to jointly support residents in the community, meet their health and social care needs thereby avoiding hospital and care home admissions. **M3, M6**.

- To expand the End of Life Care (ELOC) support to a wider range of patients and carers especially during 'out of hours' and weekends. E.g through an integrated night sitting service, and enhanced clinical support. **NC2, M3.**

- To continue to develop the Joint Assistive Technology Strategy and LB Sutton commissioned telecare service and related assisted technology to improve the choice and range of support to users and carers, preventing hospital and care home admissions and crises, including 7 day service. **NC2, M3, M6.**

- To develop joint health and social care assessments in the community and assign a lead professional for those with Long Term Conditions (LTCs), and those most at risk of admissions to hospital and care homes. Joint assessments will also be developed in hospitals to reduce delayed transfers of care (DTOC). **NC3**, **NC4, M4, M3, M6.**

- To further develop multi agency coordinated care and support in three localities, (matched to Sutton CCG GP localities) through the Active Case Management approach, combining the multi disciplinary and multi agency support needed by those most at risk of hospital or care home admissions with complex or long term conditions. Primary care including GPs, community healthcare and social services will form the core for these Localities, with voluntary sector input as appropriate. **NC3**, **NC4, M3, M6.**

- Using the Joint Strategic Needs Assessment (JSNA) and Risk Stratification at GP Practice level, identify those within the population that are most at risk of hospital and care home admissions. These patients will be highlighted as suitable for case management and will be discussed at multi-disciplinary team

meetings (MDTs). In addition, Sutton CCG is proposing to pilot a General practice Liaison Facilitator role – a role which will support practices in developing their MDTs to follow a consistent approach across Sutton.**NC5, M3, M6.**

- To develop a whole system approach to the pathway of support, including early diagnosis of dementia, for individuals and their carers living with dementia. This will include mental health specialists are included in joint assessments and locality developments outlined above (also see the Mental Health Joint Commissioning Strategy). **NC3**,**NC4, M3, M6.**

- To further develop new integrated joint health needs assessments for children and young people between 14 and 25 years of age between Education, Health, Children and Adult Social Services with a lead professional from the Transitions Unit or the Learning Disability Clinical Health Team. **NC3,NC4.**

- To build upon the success of supported living accommodation in Sutton and the ongoing programme of extra care and housing with care schemes for those living with dementia. **NC1, NC 3, NC4, M3, M6.**

- To use the Disabled Facilities Grant (DFG) and related equipment assessments to target support to those with long term conditions to avoid care home and hospital admissions. **NC1, NC 3, NC4, M3, M6.**

- For housing, equipment and adaptations - enable better and early access to information and advice through the joint assessments generated through the new integrated community services and Locality multi agency teams. **NC3, NC4.**

- To evaluate and review the results of the Health and Social Care Integration pilots, in order to commission those services that evidenced improved outcomes, preventing avoidable hospital and care home admissions and are value for money.

- For LB Sutton to further develop the provider market through the Personal Care Framework (PCF) to provide increased choice for people who need care and support to stay at home.

Supporting people when they require hospital and residential services

This area links with the Integrated Complex Older Persons Pathway, patient's journey stages In-Hospital Care and Discharge to Assess.

In addition to the Integrated Complex Older Persons Pathway proposals, the next steps to deliver this strategy are:

- To further develop and renew the work of LB Sutton Learning Disability Clinical Health Service for those jointly assessed 14 years old and above. This service also includes the specialist Learning Disability Clinical Health Nurse who supports those admitted to hospital to ensure they receive appropriate treatment, discharge planning and is safeguarded. **NC1, NC3, NC4, M3, M4.**

- To improve the liaison between the out of hours GP service, Community Health and Social Services, as well as the local hospital A&E/Urgent Care Centre to prevent admissions and support appropriate discharges. Liaison will be provided through two main routes – the 111 Directory of Services, and the Sutton and Merton Community Services (SMCS) Single Point of Access. The 111 team have access to the full range of services available in Sutton after hours and are able to signpost patients appropriately. The Single Point of Access operated by SMCS enables timely access to the Community Prevention of Admission Team, who in turn has close links to the Social Services START team. If patients do attend A&E, they are able to access these services through the Rapid response Team based in A&E. **NC2, NC3, M3, M4**

- To ensure better joint assessments, data sharing and enabling people to return home 7 days a week, the aim is to improve the effectiveness of Community Health and Social Care in-reach services in Accident & Emergency (A&E) and Urgent Care Centre (UCC).. **NC2, NC3, NC4, NC5, M3.**

- To reduce the burden on acute hospitals and shorten waiting times, for example by more outpatient appointments or diagnostic tests are undertaken in community settings, shared out-patient clinics and enhance clinical input to primary and community services. M3, M5, M6, NC5.

- To implement the Mental Health Joint Commissioning strategy through the redesign and development of community and primary mental health services. To prevent crisis admissions to acute mental health and improve patient outcomes that include less residential placements and enhanced work and

accommodation opportunities. (Please refer to the Mental Health Joint commissioning Strategy). **NC5, M3, M4.**

- To introduce a joint social services and health approach to implementing personal health budgets, as required from September 2014, combined with Social Service personal budgets and Continuing Health Care (CHC) that enhance better choice and control and outcomes for service users. **NC3, NC4.**

- The Sutton CCG 2 and 5 year plans will incorporate the Better Care Fund (BCF) and aligned Social Service medium term plans. Specifically a realignment of acute services to ensure provider Trusts sustainability and better patient outcomes, linked to the development of community health and social care capacity.

Implementation:

What we plan to do:
To support the implementation of this strategy a delivery plan has been developed. For full details please refer to 'The Joint Strategy for Health and Social Care in Sutton – Delivery plan'.

Key areas have been summarised below:

The implementation of the Better Care Fund (BCF), recognised as a national enabler for integrated care, will result in the creation of a joint pooled fund between Sutton CCG and LB Sutton. In Sutton, the minimum transfer from Sutton CCG to the BCF will amount to £614k in 2014/15, increasing to £14.657m in 2015/16. In keeping with our vision for coordinated and integrated services, we will ensure that these funds are used to maximum effect, which will both improve quality of care for residents of Sutton and avoid any cost pressures resulting from fragmented services.

We have therefore created a vision for out of hospital health and social care services in Sutton which reflect the joint ambitions for both Sutton CCG and LB Sutton, and assist in addressing care needs for Sutton residents more holistically. Through our integrated approach to commissioning services and working with our health, social care and third sector providers, appropriate care will be provided 7 days a week seamlessly without organisational and professional barriers.

By 2016, we will provide services that deliver high quality, integrated care to our residents through implementation of out of hospital initiatives which:

- support more patients to remain independent and receive care in their home or community
- minimise preventable hospital admissions, increasing timely access to community-based out-of-hours and urgent care where appropriate
- minimise residential placements, by supporting individuals to remain living in their own home
- provide effective reablement and rehabilitation services to support people in the community
- maximise self-care by supporting communities and individuals to look after their own health and wellbeing, especially for those with multiple LTCs
- transform the way in which care is provided characterised by a wide variety of organisations (including those in the voluntary sector) working collaboratively
- encourages independent community-based living which prevents social isolation and improves access to voluntary services which improve quality of life
- provides an experience of joined up services, where professionals from different teams and organisations work together well, with appropriate and timely communication, supported by shared records

To achieve a reduction in health and social care demands by 2016/17, we will:

- build capacity in the community to work collaboratively through integrated services to reduce non-elective admissions to acute settings and care homes;
- build capacity in the community to respond to escalating or urgent care needs of identified people at risk, such as older people or those with multiple or deteriorating long term conditions;
- expand the capacity of the reablement and rehabilitation services to support residents in the community, helping to reduce length of stay in acute settings and preventing readmissions by improved discharge planning;
- realign the acute sector (Epsom and St Helier University Hospitals NHS Trust) to match changing demands and community capacity;
- maximise people's capacity to self-care – by supporting communities and individuals to look after their own health and wellbeing;
- plan and develop a community workforce in collaboration with providers, which can deliver an expanded community service model, and transition professionals leaving acute settings into the community;

- provide stronger links with voluntary services and other community groups, preventing social isolation and dependency where appropriate.

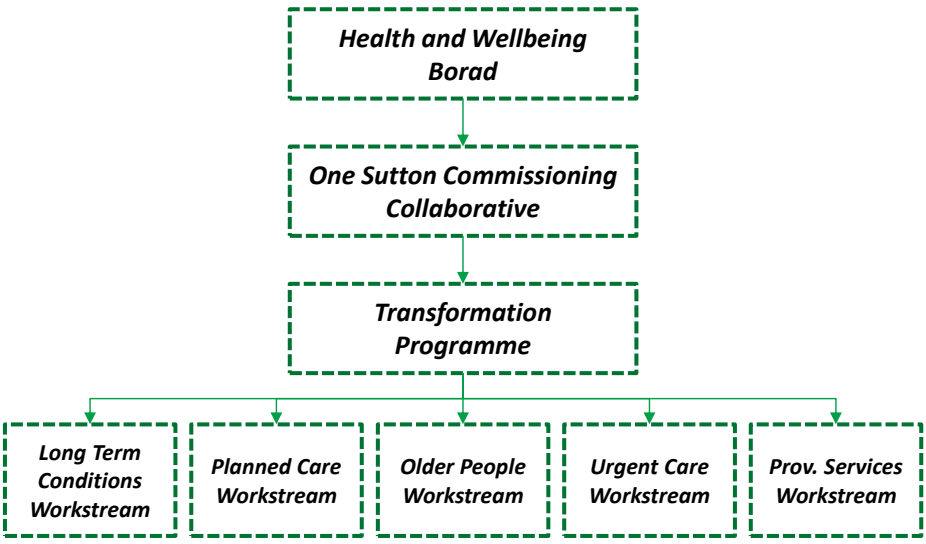
In order to deliver the vision set out above, we have developed delivery plans for each of the workstream areas outlining the key steps required in 2014/15 and 2015/16 in order to implement the individual schemes within each area. Commissioning managers from Sutton CCG and LB Sutton have outlined key milestones for in order implement new schemes and further evaluate and manage schemes over the next two years. The plans also outline the predicted outcomes that will be realised through execution of the schemes.

The workstreams are:

1) Long-Term Conditions
2) Planned Care
3) Older People
4) Providing Services Closer to Home
5) Urgent Care

Governance:

In order to deliver our aims and objectives reorganisation of our governance will be required. Moving forward the following governance structure has been proposed which will be live from June 14.



12. GLOSSARY

A&E	Accident & Emergency
ACP	Appropriate Care Pathway
AMU	Acute Medical Unit
ASSHe	Adult Social Services and Health
ASSHH	Adult Social Services, Housing and Health
BCF	Better Care Fund
BMI	Body Mass Index
CAB	Citizen Advice Bureaux
CAB	Sutton Citizen's Advice Bureaux
CCG	Clinical Commissioning Group
CHD	Chronic Heart Disease
CIP	Cost Improvement Plan
CIP	Cost Improvement Programme
CMC	Coordinate my Care
COPD	Chronic Obstructive Pulmonary Disease
(I)COPP	(Integrated) Complex Older People's Pathway
CPAT	Community Prevention of Admission Team
CQC	Care Quality Commission
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for quality and innovation across all NHS providers
CRT	Community Rehabilitation Team
CSU	Commissioning Support Unit
DOLS	Deprivation of Liberty
DTOC	Delayed Transfer of Care
DVT	Deep Vein Thrombosis
ECG	Electrocardiogram
EOL	End of Life
EoLC	End of Life Care
ESH	Epsom St. Helier
FACS	Fair Access to Care Services
FLS	Fracture Liaison Service
FPS	Falls Prevention Service
GP	General Practitioner
GPSI	General Practitioner with a Special Interest
HCA	Healthcare Assistant
HDU	High Dependency Unit
HWB	Health and Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICES	Integrated Community Equipment Service
ICU	Intensive Care Unit
ITF	Integrated Transformation Fund

JHC	Jubilee Health Centre
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joints Strategic Needs Assessment
LAS	London Ambulance Service
LB SUTTON	London Borough of Sutton
LTC	Long Term Condition
LUTS	Lower Urinary Tract Symptoms
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Clinical Excellence
OOH	Out of Hospital
OPALS	Older People's Liaison Service
OPARS	Older People's Assessment and Rehabilitation Service
OSB	One Sutton Board
OSCC	One Sutton Commissioning Collaborative
OT	Occupational Therapy
OTAGO	Otego Exercise Programme
PCT	Primary Care Trust
POPPI	Projecting Older People Population Information
PPC	Preferred Place of Care
QIPP	Quality, Innovation, Prevention and Productivity
SASB	Sutton Safeguarding Adults Board
SCCG	Sutton Clinical Commissioning Group
SCILL	Sutton Centre for Independent Living and Learning
SEN	Special Educational Needs
SMCS	Sutton and Merton Community Services
SPOA	Single Point of Access
START	Short Term Assessment and Reablement Team
SWL	Southwest London
UCCs	Urgent Care Centres

13. APPENDICES

Appendix 1: Health-Related Strategies

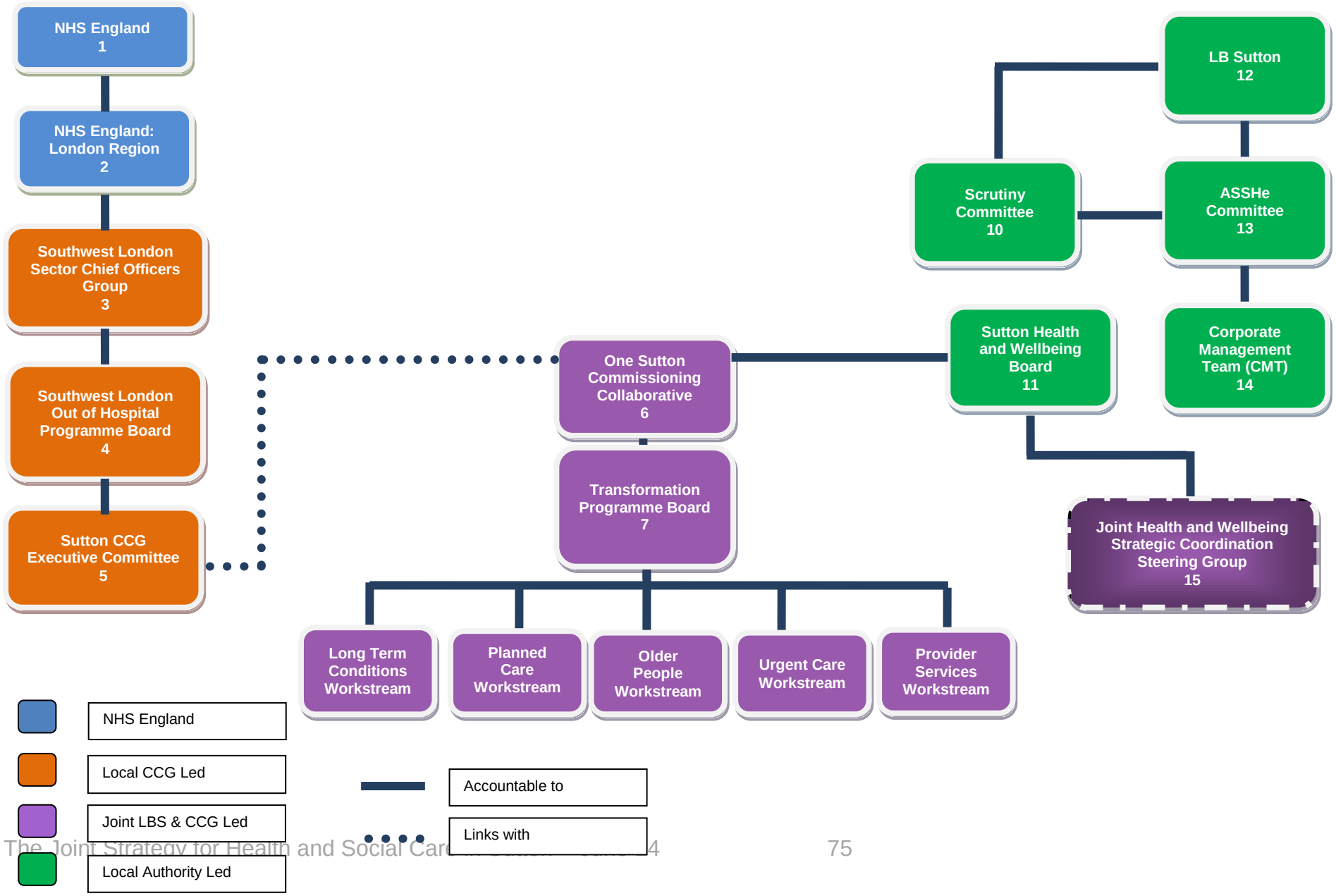
Complementary and Dependent Strategies			
	Vision	**Key Priorities**	**Other Commitments**
Joint Health & Wellbeing Strategy 2012/13	"To improve the health and wellbeing of people in Sutton"	•Improving and protecting health and wellbeing •Improving the health and wellbeing of those who have illness or disability •Improving mental health and wellbeing •Empowering communities and individuals to lead healthy lives	•Safeguard our young and vulnerable populations, especially those at risk of harm or abuse •Reduce inequalities in health and wellbeing, recognising the needs of people from different cultural backgrounds and social circumstances •Deliver high quality social care and health services, making best use of available resources •Take a whole life approach
Adult Social Services Commissioning Strategy 2013-16	Linked to the council's vision to "build a community in which we can all take part and have pride"	•Enabling communities and individuals to look after their own needs, whether health, care or support •Promoting independence personalisation, choice and control •Support for prevention and early intervention to reduce or delay the requirements for social care or health services •Reducing the risks of people reaching a crisis point requiring statutory	•Promoting personalisation, choice and control through personalised budgets and self-directed support for citizens eligible under Fair Access to Care Services • Supporting adults in community rather than institutional settings •Work with individuals and communities to focus on people's assets in order to build or develop further social networks and support systems to enable communities to be healthy, strong, safe and resilient
Joint Mental Health Commissioning	To meet the needs of older people by addressing the	•To maximise the opportunities of commissioning community services with resources needed to facilitate this	•Monitor the way people use services so that they can be adapted to need and demand; • Promote the development of informal networks and peer

Strategy 2010-15	inequalities of access, ensuring services are delivered on the basis of need rather than age.	coming from inpatient services •Help people to make good and informed decisions about the care they choose by providing information, advice and advocacy; • Enable people to jointly commission services by encouraging the development of social enterprises and similar agencies	support groups; •Develop more flexible and adaptable ways of contracting for services.
Joint Strategy for Carers 2011-13	Carers to be recognised as 'expert partners in care' – valued, recognised and respected for the contribution they make.	•Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role. •Carers will be able to have a life of their own alongside their caring role. •Carers will be supported so that they are not forced into financial hardship by their caring role. •Carers will be supported to stay mentally and physically well and treated with dignity. • Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive and to enjoy positive childhoods.	• Supporting those with caring responsibilities to identify themselves as Carers at an early stage: recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages. • Enabling those with caring responsibilities to fulfil their educational and employment potential. • Personalised support both for Carers and those they support, enabling them to have a family and a community life.

Integrated Complex Older Persons Pathway 2013	"Working together to improve the quality of care for elderly services users with complex needs, their families and carers."	• *Enabling optimum independence and wellbeing* – Enhancing community based therapy and reablement services. Improving links with Voluntary Sector to ensure access to all appropriate services • *Proactive Health Care* – Integrating working at practice and locality. • *Crises intervention, right service, right time* – Using a single access point to the Community Prevention or Admission Team and Social Care. • *In Hospital Care* – One Team approach ensuring integration with social care and health providers across acute and community care. Admission to ward/service using agreed criteria. • *Discharge to assess* – Improving continuity of care and discharge planning with in-reach/out-reach from community and social services.	• Improving timely access to services enabling independence with care-coordination/navigation. • Risk stratisfication to identify patients with greatest need • SCCG to commission four prevention of admission beds. • Facilitating information sharing with primary care led Multi-disciplinary Team meetings. • Enabling prevention of admission the SCCG are commissioning four prevention of admission beds. • Facilitating admission/crisis avoidance the SCCG are commissioning the Home from Hospital service. • Supporting people within their own home the Urgent Care at Home and the Falls Prevention service are available. • Defining an agreed criteria supports the admission to ward/service. • Maximising service to patients and reducing length of stay and enhanced OPALS/Therapy service is offered. • Improvement of discharge planning, there are daily integrated MDT meetings, including primary care, community care, social services and the voluntary sector. • To support the patient being discharged, they are discharged to either the hospital at home virtual ward; the Home from Hospital Service or to Community Rehab beds or community rehab at home.
CQUIN 2013/14	To improve the quality of services	• To develop quality innovative pathway improvements.	• Whilst the minimum requirements for providers are set nationally, providers will need to work with local

	in provider trusts by agreeing targets that develop and improve pathways of care.	• To improve quality of care • To follow national targets and develop local improvement targets.	commissioners to ensure that plans are aligned with local commissioning strategies. • Local commissioners will be responsible for assessing whether providers meet the prequalification criteria.

Appendix 2 – Governance Arrangements



1: NHS England

The executive non-departmental public body of the Department of Health
That aims to improve the health outcomes for people in England. NHS England oversees the budget, planning, delivery and day-to-day operation of the NHS in England as established in the Health and Social Care Act 2012.

2: NHS England: London Region

A commissioning region for NHS England which is composed of CCGs for every London Borough. The commissioning include general practitioners and over 140 specialised services, and works in partnership with local authorities, CCGs, Healthwatch, NHS trusts, the London Ambulance Service, Public Health England, and more organisations to deliver the best health outcomes for the London population.

3: Southwest London Sector Chief Officers Group

Comprises the organisations that commission and provide health and social care to the residents of the London Boroughs of Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth. Member organisations work together through the SW London System to help ensure that high quality services are provided to the people in south west London.

4: Southwest London Out of Hospital Programme Board

Established to monitor Out of Hospital (OOH) programmes and to develop a consistent way of reporting the effectiveness of OOH care in reducing hospital admissions.

5: Sutton CCG Management Board

On behalf of its members (the 27 local GP practices in Sutton), the function of NHS Sutton CCH's Board is to ensure strong and effective leadership, management and accountability.

6: One Sutton Commissioning Collaborative

To support the Sutton HWB to commission in new ways to meet the social and health care needs of the people in Sutton, ensuring that the commissioning of all services achieves best value for money and reflects the priorities within the Joint Health and Wellbeing Strategy 2013-16. This collaborative will operate in two parts, one including key stakeholders such as provider trusts, voluntary sector and other key stakeholders. This will be an opportunity to set strategic direction and at a senior level unblock and agree implementation for the transformation board /operational workstreams.

7: Transformation Programme Board

The Transformation Programme Board is created to deliver the Joint Strategy for Health and Social Care and commissioning decisions of the HWB and OSCC. Five separate workstreams, aligned to the five categories of initiative, would report in to the Transformation Programme Board on progress. This structure of workstreams is still to be finalised, however the current thinking is set out below.

Transformation – workstreams

1) Long-Term Conditions
2) Planned Care
3) Older People
4) Providing Services Closer to Home
5) Urgent Care

8: Mental Health Delivery Group – Proposed to be replaced by the Transformation Programme Board.

To support the One Sutton Commissioning Collaborative by taking the lead in commissioning in new ways and through joint working to meet the health and social care needs of people with a mental health problem, ensuring that the commissioning of all services achieves best value for money.

9: Out of Hospital Sub-committee – Proposed to be replaced by the Transformation Programme Board.

Supports the One Sutton Commissioning Collaborative by taking the lead in commissioning in new ways and through joint working to meet the health and social care needs of people in Sutton. both registered and resident, ensuring that the commissioning of all services achieves best value for money. The sub-committee provides a forum for commissioning activity between Sutton CCG and LB Sutton, supported by provider organisations to ensure holistic commissioning. The Jubilee Health Centre also reports into the Out of Hospital sub-committee and forms part of their governance arrangements.

10: Scrutiny Committee

Formally established to undertake LB Sutton's statutory scrutiny responsibilities in respect to health, crime and disorder, and floor risk management. The Scrutiny Committee is responsible for investigating, taking evidence and consulting upon issues within its remit.

11: Sutton Health and Wellbeing Board (HWB)

A Council committee leading on Public Health improvement, the ongoing development of the Joint Strategic Needs Assessment (JSNA), , and joint health and wellbeing strategy and making recommendations about health and social care commissioning. Currently identified as the lead Board on delivery of the BCF and progressing the integration of health and social care services. Enables collaboration through multi-organisational membership including elected Members;, Sutton CCG, voluntary organisations, Healthwatch, LB Sutton Strategic Directors, LB Sutton Chief Executive and NHS England representative.

12: LB Sutton

The local authority for the London Borough of Sutton in Greater London, England (also called Sutton Council).

13: ASSHe Committee

A Council Committee which considers matters relating to the provision of adult social services and health functions within the remit of the local authority.

14: Corporate Management Team (CMT)

Consists of strategic directors of the Council who represent the main directorates within LB Sutton.

15: Joint Health and Wellbeing Strategic Coordination Steering Group

A Task & Finish group of the HWB, responsible for developing draft annual delivery plans for the JHWS, which include Smart targets, and for monitoring performance against targets set.