NHS Haringey Clinical Commissioning Group

Haringey CCG Network – Feedback Report

Introduction:

In July the Network met for the first time and the Haringey Director of Public Health gave a presentation about Haringey's Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy. This presentation informed the Network about the profile of the Haringey population and their health needs. The Chief Officer from Haringey Clinical Commissioning Group (CCG) gave a presentation which informed the Network about the CCG's strategic priorities and the context in which decisions will be made. In September, the Network met to discuss six key topics with specific questions to elicit feedback which could help to shape commissioning intentions. We committed to tell the Network about how the outcomes of these discussions have been used. This report summarises what you told us in September and some of the ways that your insight has been used.

1. Keeping people with long-term conditions well

We asked you how hospitals could better contribute to the wellbeing of people with long term conditions and self-management of their conditions by providing better education and support.

You said:

- Hospital staff could brief patients better about how to look after themselves – but staff need more time, training and an education/information resource pack to help them to do this. The pack should include information about healthy living as well as tools to help people make healthier decisions.
- There should be more of a focus on treating the whole person rather than just the symptoms.
- There needs to be better liaison between the hospital, the GP and the patient
- More physiotherapists and occupational therapists were needed on wards.

What's happened?

Health promoting hospitals:

- Brief interventions for smoking and alcohol will be included in the contracts with North Middlesex Hospital and Whittington Health for 2014/15. Contracts are currently being negotiated, but we want the hospitals to continue with the brief interventions and increase referrals to the Haringey smoking cessation service.
- Haringey Council's Public Health team already funds a number of additional support initiatives such as the local smoking cessation service, additional stop

smoking support to the Mental Health Trust and a Children and Young People's Alcohol Worker in the North Middlesex's emergency department – all of which they are proposing to continue in 2014/15.

- Working jointly with the council, we will also support the North Middlesex Hospital to make sure more patients in the emergency department are screened for alcohol misuse.
- Things which are still under discussion include extending stop smoking brief interventions to mental health patients and staff (with a specific emphasis on Mental Health Trust staff). We are also working with the North Middlesex hospital to set up a system in the emergency department to record domestic violence incidents.

Physiotherapists on wards:

- We aren't in a position to increase the number of physiotherapists and occupational therapists on wards at hospitals – but this is something that could be shared directly with the hospitals for them to consider.
- We have, however, been piloting a scheme at the North Middlesex Hospital to fund community physiotherapists to provide an 'in reach' service to help patients recover more quickly in a community setting. The physiotherapists come in to the hospital and assess patients who are medically fit but in need of additional support before they can go home. Usually this means moving them out of hospital into a care home, and providing therapy and rehabilitation before they are able to go home permanently. This scheme will be evaluated in full in the summer.

To improve liaison between hospitals and GPs:

- The three main trusts in Haringey (North Middlesex, Whittington Health and Barnet, Enfield and Haringey Mental Health Trust) have put in place a number of 'Hotlines' to make it easier for GPs to speak to hospital consultants directly.
- A series of clinician to clinician education events (with hospital staff and GPs) are planned for 2014/15 to improve communication and understanding on both sides.
- All GP practices in Haringey are now using a computer tool which helps them to identify patients who are at high risk of having to go hospital. These patients are discussed each week by all the health professionals involved in their care at a weekly telephone conference. This includes GPs, hospital doctors, community health care staff and social services. These teleconferences are happening weekly, across the whole of Haringey, and are really making a big difference to helping keep people out of hospital and cared for better in or near their homes.

We asked how the voluntary and community sector could help with this.

You said:

- Hospitals and GP surgeries need much better information about the voluntary and community services which are available and can support people with long term conditions e.g. patient support groups, buddying and befriending services etc. This should be available to hand to the patient alongside any education/information material.

What's happened?

- As a starting point, the CCG has created a list of some key voluntary sector organisations in Haringey that could support patients, carers and their families. The list provides links to existing directories that already exist e.g. HArinet (adult social care directory), as well as other support organisations categorised by area covered e.g. mental health, young people, stroke, dementia. This list has been made available on the CCG's public website. It has also been promoted to GPs and practice staff through a dedicated intranet site and news bulletin which we have for GPs in Haringey.
- We have commissioned (jointly with the local authority) two voluntary sector organisations – Age UK and Living Under One Sun – to run a 'Neighbourhood Connects' project in Haringey. 12 Neighbourhood Connectors are now working across the borough helping to 'Connect People' to each other and to their communities. The Connectors will also provide information on local social activities and community schemes that help prevent loneliness and social isolation. The Connectors are working with GPs, social care and the voluntary sector to identify people who might benefit from being 'connected'.

2. Telehealth and Technology

We asked how can we build on our use of telehealth to improve people's health and reduce social isolation in older people?

You said:

- There needs to be an assessment of the capability of the patient to use telehealth and train them. Could District Nurses help? Is this a role for volunteers and befrienders?
- Specific apps could be used to monitor long term conditions e.g. an app to monitor sickle cell in the under 40s.
- Existing apps and technology to help people monitor their condition or receive reminders should be explored. Could these be used more? For example, partially sighted people could benefit from specific applications e.g. through Smart TVs. You also felt it would be helpful to remind people of appointments, or when a repeat prescription is due for example.

We asked what we need to be careful of and what the potential risks are

You said:

- Telehealth has the potential to reinforce social isolation for older people and not reduce it, and vulnerable adults may need special help.
- Commissioners must remember the importance of personal contact and connection that is intrinsic to effective healthcare, and have to be careful that technology doesn't replace this. It is also important for commissioners to look at when new technology becomes cost effective – is new technology cheaper than current practice(s)?

We asked how we could work with communities and the voluntary sector to prevent potential isolation caused by increased use of telehealth?

You said:

- The voluntary and community sector has a role in befriending and countering isolation and helping people to use new technologies could be a part of this work.

What's happened?

- The CCG is looking at how technology could be used to support its entire transformation agenda through the development of its five year plan. We are mindful that we need to address this across every Haringey CCG area of work. Technology is also being looked at by the CCG's Communications and Engagement Sub-Committee who have already had some interesting discussions, for example, about how some apps could be used to help people monitor their conditions or improve access to primary care.

Some immediate things that have happened include:

- We have commissioned (jointly with the local authority) two voluntary sector organisations – Age UK and Living Under One Sun – to run a 'Neighbourhood Connects' project in Haringey. These organisations will be helping to develop real networks (as oppose to virtual networks) around older and more isolated people in Haringey. 12 Neighbourhood Connectors are now working across the borough helping to 'Connect People' to each other and to their communities. The aim is to build supportive neighbourhoods to help older people maintain their independence and participate within their own community. The Connectors will also provide information on local social activities and community schemes that help prevent loneliness and social isolation. You can read more about this work on the Age UK website: http://www.ageuk.org.uk/haringey/news/neighbourhoods-connect/

- The Big White Wall (www.bigwhitewall.com) is an online mental wellbeing service, providing peer support to improve wellbeing. Haringey's public health team has commissioned 250 online peer support places from Big White Wall as part of their anti-stigma work. In addition, the CCG bid for some money from an NHS England innovation fund for an additional 250 peer support places as well as 38 live therapy places. The live therapy gives people 8-10 one to one online counselling or cognitive behavioural therapy sessions. This service will be launched in early April 2014.

3. Urgent Care

We asked what we could do to help people better understand the urgent care system and how to access it.

You said:

- There needs to be a very clear and 'shared' description of urgent care which gives people an understanding of the different services available, what they are for and the roles of different professionals e.g. a community pharmacist.
- Further work is needed to provide information in accessible formats and languages to help people to understand what to do in an urgent care situation e.g. fridge magnets; flow charts and diagrams (rather than too many words).
- We need to ensure that understanding is developed of how and why black and minority ethnic groups use A&E and a different, more targeted model to communicate in community contexts is used.

What's happened?

- We developed a 'choose well' campaign which has been running across Barnet, Enfield and Haringey since late October 2013. The campaign aims to explain the different health services available locally and signpost people to the most appropriate one for their needs. Examples include NHS 111, GPs, pharmacy and the local mental health crisis phone number. Materials (posters, leaflets and wallet sized 'z cards') have been widely distributed to libraries, GP practices, health centres, dentists, pharmacies and voluntary and community organisations in the three boroughs. A number of outdoor advertising sites (bus shelters and local cinemas) were also booked in December and January. A 'choose well' app has been developed and tested with some patients, and launched in February. The app is also available in three of our main community languages (Polish, Turkish and Somali).
- In light of your feedback, we are now planning to develop a more local approach for Haringey to continue promotion of the campaign, with a particular focus on getting the campaign out to different communities. For example, we are planning to work with Healthwatch and the Muslim Network to share, explain and disseminate messages from the 'choose well' campaign

to the Muslim community in Haringey. We are also thinking about commissioning a local community organisation to do some further work with different communities to disseminate the campaign's key messages and better understand how these groups use A&E and primary care services.

- We are also carrying out a series of engagement visits to different community organisations in Haringey, through which one of the things we are hearing about is how different people experience and use different health services. This insight is helping us refine the way we communicate with different groups e.g. the Roma community.
- We have commissioned a rapid assessment, interface and discharge (RAID) service in local A&E departments so that patients with mental health needs who come into A&E can be seen quickly by a specialist team in the appropriate setting. The RAID service already has had an impressive impact on facilitating the discharge of elderly patients to their own homes, reducing the time spent in hospital and supporting people with mental health needs to better understand and access urgent care.
- Barnet, Enfield and Haringey Mental Health Trust have recently introduced a new Crisis Resolution and Home treatment (CRHT) service for urgent referrals for anyone in a crisis. This is an urgent outreach service, assessing service users 24 hours a day, 7 days a week, wherever they are at the point of referral e.g. GP surgery, A&E, their own home etc. The phone number for the urgent service has been widely promoted to GPs, as well as to the public via the 'choose well' campaign.

We asked how useful you thought the role of a navigator in A&E would be to help people who turn up to A&E with a non-urgent condition.

You said:

- You wanted more clarity about the navigator role and it would need to be carefully explained so that the public are clear about what they would do.
- You thought that navigators could be useful, but would need to be well trained, work across sectors e.g. health and social care and voluntary, and have easy access to interpreting services and up to date local service information.

What's happened?

- Enfield CCG are piloting having a navigator in A&E. Enfield will be sharing their learning with us so we can decide if this is an approach we want to take.
- We have decided to look at the navigator role in a wider sense than just in A&E. For example, the Neighbourhood Connectors (a group of local volunteers), have been trained as befrienders, navigators, advocates and people who can offer advice on accessing benefits and services to people within their communities.

- We also know that we want to improve coordination for older people with complex needs. GPs are now being asked to identify a named lead for their patients over 75 years and we are going to look in detail at how we support them to plan care and coordinate to meet the needs of this population group. National Government policy, particularly the Better Care Fund, is driving the CCG and the council to look much more closely at how to bring together the care that is received by people and reduce unnecessary 'hand-offs' between different professionals and agencies. We have attached a summary paper on the Better Care Fund for your information (appendix 2).

4. Mental Health

We asked how we could better support people with mental health problems to improve and think about their physical health.

You said:

- Service users need a safe environment for exercise, access to a wide range of activities e.g. low level chair exercises, and it needs to be recognised that goals and recovery need to be self-defined at the person's own pace. (e.g. not giving up smoking when very stressed).
- Provision needs to be accessible (e.g. cost barriers removed) and well publicised.

What's happened?

- The CCG is supporting the voluntary sector to provide drop-in sessions and offer longer term informal support to Haringey residents, in non-traditional settings. Support offered is personalised to assist individuals to meet their specific support needs and signpost to alternative/additional services in the borough. There are a number of organisations we are currently working with to do this – and we have recently listed them on our website and promoted them to GPs to try and raise awareness of them: http://www.haringeyccg.nhs.uk/about-us/support-organisations-in-haringey.htm
- Haringey CCG is committed to improve support for people with physical and mental health problems, enabling service users to have more control over the service they receive. Through the roll out of Personal Health Budgets, eligible service users will, through their care and support plan, be able to receive a Personal Health Budget directly or via a third party organisation. This will mean service users will be able to choose their support services provider and purchase the appropriate support to meet their clinical needs. This provision will now offer people with both physical and mental health needs the freedom to purchase personalised care and support from a wider range of service providers.

- There is a Health and Wellbeing Board seminar in March to discuss how best to integrate the local mental health recovery pathway across health, social care, the voluntary sector, housing and employment.
- Haringey CCG is actively working with the local mental health trust (Barnet, Enfield and Haringey) to ensure that physical health is considered alongside mental health needs. This will be managed through a local CQUIN in 2014/15 ('Commissioning for Quality and Innovation') which requires the trust to report their performance against this measure.

We asked how we can better support people with a long-term condition with their mental health needs.

You said:

- When people are diagnosed they should be offered a range of support options which could suit them as an individual. This could be an expert patient group or something completely unrelated to their specific condition. For example, somebody might prefer to access a group which focuses on befriending/peer support so that they don't feel isolated. It would be important that people were given information about the range of support services available and that they were easy to access. Let the patient choose.

What's happened?

- Two voluntary sector organisations, Living Under One Sun and Age UK have trained Neighbourhood Connectors (local volunteers who can offer a range of different types of support to people including befriending and advocacy). We hope that this group of volunteers will be able to give information and let people decide what types of offers they want to take up.
- We are investigating how to offer more supported self-management training for people who have long term conditions. We have talked to people with diabetes and COPD who have been through supported self-management training or were part of groups like BreatheEasy and we were told this made a real difference. We want to be better at helping people achieve the outcomes that they prioritise and usually this is independence, ability to manage their condition and freedom from symptoms. So we know that we need to shift resource away from reactive treatment and towards helping people to maintain their own health.
- We have commissioned the Big White Wall (www.bigwhitewall.com), an online mental wellbeing service, to provide people with access to online peer support to improve their wellbeing. People will be able to self-refer to use the service, and it will also be promoted to GPs in Haringey so that they can advise people of its existence as another support tool.

We asked if you have any ideas about how we could tackle stigma around mental health, and whether you think this is a priority.

You said:

- This is a priority and that we should tackle stigma and discrimination around mental health. You said that Mental Health First Aid training for frontline staff and the 'Time to Change' campaign are crucial and that we should support those programmes (for example, to reinforce the message that conditions can be managed).
- More should be done to educate children on mental illness in schools.

What's happened?

- A big anti-stigma campaign will be launched by Haringey's public health team later this year. There will be a number of different elements to the campaign, including:
    - Lots of work and projects in primary and secondary schools in Haringey, including training for teachers;
    - A focus on addressing mental health stigma in the Turkish Kurdish communities and addressing mental health stigma through sport
    - A number of mental health first aid training courses for a variety of frontline staff in Haringey

5. Children and Young People

We asked how to improve services for children with respiratory problems either through increasing community services or giving parents the confidence to provide more self-care to their children.

You said:

- Parents are crucial – they need to be as committed as the GP and hospital, and therefore they should be educated in areas such as smoking, nutrition, exercise etc. – anything that helps to prevent or lessen the impact of long term conditions. Could a parent education programme be commissioned for children with respiratory problems?
- Community centres and places that families and children and young people use to have fun should be used to provide education
- Schools have a really big role – more work is needed for education on obesity, asthma, sickle cell etc. to help tackle and resolve health issues that impact on children and young people.

What's happened?

- There are plans in place to open allergy and asthma services in primary care in Haringey. Part of this work includes supporting schools and parents around respiratory problems.

We asked whether there is work we should be considering around parenting skills at different points in children's lives. Specifically, a lot of children get referred to the child and adolescent mental health service, but we wonder if there is anything we could do to help parents manage crises with their children without the need for a referral to this service.

You said:

- There needs to be support for parents that may not be able manage these types of crises as they have mental health problems or substance misuse issues themselves. The language used is vitally important, as it may alienate parents/children and stop them presenting their problem(s) early. Language needs to be non-stigmatising.
- Parenting classes for affluent parents who are in full-time employment and may not be tending to their children's emotional needs should be considered
- An holistic approach is the best way forward – other skilled providers (e.g. the voluntary and community sector) will be needed to support families and children and young people. Youth Services also need to be involved (i.e. integrated support).

What's happened?

- There are plans to develop a primary care mental health service for Haringey children and young people. The aim of this service will be to intervene as early as possible and where appropriate, prevent the need for treatment services. The service will also aim to improve access for people who need it to the appropriate level of CAMHS services.
- Public health commissions a number of programmes from the voluntary sector (e.g. Young Minds) to improve the emotional health and wellbeing of children and young people. These programmes are delivered in Haringey schools within the Healthy Schools programme. In addition, a big anti-stigma campaign will be launched by public health later this year. There will be a number of different elements to the campaign, including lots of work and projects in primary and secondary schools in Haringey.

6. Dementia

We asked how we could better identify, manage and support people with dementia and their families and carers.

You said:

- It is important to educate GPs to be more alert to early warning signs and to target 'at risk' people, for example isolated older people who won't have family/friends to spot deterioration, or older people after they have had operations.
- You also suggested that GPs could review diagnoses of depression, especially in older people, give annual mini mental assessments of over 75s and use the risk stratification computer tool to identify people who could be at risk.
- An information campaign should be developed for the public, local communities, neighbours etc to help them recognise symptoms and could help to tackle stigma. How can we reach into communities where the concept of dementia is taboo or not recognised?
- Support for families and carers was very important – e.g. separate appointments, provide information about respite, equipment, clubs. Are carers prioritised for health checks and psychological support? Carers may well be older themselves.
- A broad range of community-based services are needed to provide stimulation and exercise e.g. dementia cafes where nurses can answer questions; singing for the brain etc.

What's happened?

- We have procured a risk stratification tool which is able to identify people who are at high risk of hospital admission. GPs are then able to talk about the needs of their high risk patients with geriatricians and the community nursing, mental health or social work teams. This is helping us to make sure that care is coordinated and that people, even those without carers and families, are being identified.
- The CCG is looking specifically at what more we can do to meet the needs of people with frailty and dementia. We want to build local teams of nurses, community health, therapies and social care workers, around groups of GP practices so that care for the local population is joined up and effective.
- Haringey CCG is now working with Barnet, Enfield and Haringey Mental Health Trust, North Middlesex University Hospital, Whittington Health and Haringey Council to implement a dementia pathway, raising awareness and encouraging early access for assessment to improve quality of life of people with dementia and their carers.
- The CCG has recently commissioned a 'Psychiatric Liaison Service' at North Middlesex Hospital that aims to improve the detection of dementia in people who get admitted to the hospital as a result of physical problems. This service is also supporting people with mental illness and physical illness to recover faster and be discharged from hospital earlier.
- Public Health have commissioned an additional element to the NHS Health Checks programme to help raise awareness of dementia. The NHS Health

Check is aimed at people aged 40-74 to assess their risk for vascular disease. In addition to BMI, BP, cholesterol and other risk factors, an additional element will be included from April 2014: people aged 65-74 will be given information on the signs and symptoms of dementia, a leaflet with this information and signposted to their GP if they have concerns.

7. Better Care Fund and Value-Based Outcome Commissioning

Feedback from Network meetings and Network members has also been used to inform two key areas of work: plans for the Better Care Fund in Haringey and the development of a programme which looks at how we can commission for value and outcomes that matter to people in the areas of diabetes, mental health and frail elderly.

As appendices, we have given you two papers from January's Governing Body meeting which introduce and summarise both areas of work:

- Appendix 1 – Value-based outcomes commissioning
- Appendix 2 –Better Care Fund