Haringey Council

Adults and Health Scrutiny Panel – Second despatch

THURSDAY, 27TH FEBRUARY, 2014 at 18:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Adamou (Chair), Bull, Erskine, Stennett & Winskill

CO-OPTEES: Helena Kania (HFOP)

AGENDA

7. INTEGRATING SERVICES (PAGES 1 - 88)

To receive a report outlining work which is being done by the Health and Wellbeing Board on integrating services across health and social care.

Attendees:
David Cowell, Interim Service Manager (Health and Social Care Integration)

10. ACCESS TO PRIMARY CARE (PAGES 89 - 94)

To receive a report on work being done to improve access to primary care in the borough.

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Friday, 21 February 2014

Agenda Item 7

Haringey Council

Report for:	Adult and Health Scrutiny Panel 27th February 2014	Item Number:	

Title:	Better Care Fund: Local Health and Social Care Integration Plan

Report Authorised by:	Mun Thong Phung, Director Adult Social Services

Lead Officer:	Beverley Tarka, Acting Deputy Director, Adult Social Services

Ward(s) affected: All	Report for Key/Non Key Decisions: NA

1. Describe the issue under consideration

"To improve outcomes for the public, provide better value for money, and be more sustainable, health and social care services must work together to meet individuals' needs. The Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. The NHS will make available a further £200 million in 2014-15 to accelerate this transformation".

Spending Review (26/6/13), HM Treasury

1.1 This report: presents for noting Haringey's Better Care Fund (BCF) Health and Social Care Integration Plan, hereafter referred to as the 'Integration Plan'.

2. Cabinet Member introduction

2.1 I am delighted to present this report to the Adult and Health Scrutiny Panel, which is dedicated to the proposition that the integration of health and social care will produce better results for local people and significantly improve their experiences of services while increasing value for money. The BCF and our Integration Plan are transformational. They are catalysts for change which, in an extremely tough public spending environment, will allow damaging reductions in service volume and quality to be minimised. The BCF provides a real opportunity to reshape and join-

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Haringey Council

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Haringey Council

provision across health and social care and the Integration Plan describes the shared approach it is proposed to take to this task.

2.2 However, changing services and spending patterns will take time and the Integration Plan should be regarded as a two year operational plan, covering 2014/16, that forms part of a larger five year strategy for health and social care. The interests of Haringey's residents will, at all times, be at the heart of integration. There will be a relentless focus on the creation of real and robust integrated services leading to real benefits for people over which they will be able to exercise control, as far is practical and reasonable. The Integration Plan is designed to ensure that the BCF delivers these important objectives and to sustaining a well integrated and vibrant care economy that delivers great services for local people.

3. Recommendations

3.1 It is recommended that the Adults and Health Scrutiny Panel:

a) note the Integration Plan, as set out in Appendices 1a and 1b, as agreed by the Cabinet, the Health and Wellbeing Board and the Governing Body of Haringey Clinical Commissioning Group (CCG).

4. Alternative options considered

4.1 National guidance makes clear that if Haringey is to access the BCF and realise the benefits of integration for local people it must produce and implement an Integration Plan. As it is considered important that the Adults and Health Scrutiny Panel is apprised of this Plan no option, other than the presentation of this noting report, has been considered.

5. Background information

5.1 Closer integration of health and social care has been a recurrent goal of public policy for at least the past 40 years. Different solutions have been proposed including full structural integration into a single system. Other models are geared to overcome barriers and facilitate closer joint working and sharing of resources to give a seamless service. The successful integration of health and social care offers three potential benefits:

a) better outcomes for people, e.g. living independently at home with maximum choice and control;
b) more efficient use of existing resources by avoiding duplication and ensuring people receive the right care, in the right place, at the right time, and;
c) improved access to, experience of, and satisfaction with health and social care services.

5.2 The Coalition Government has taken up the challenge of integrating health and social care and wants the barriers between them swept away over the next five

Haringey Council

years. In the context of the intense financial and demographic challenges facing both services the BCF incentivises a decisive move towards integration. However, it is important to be clear what integration means.

Defining Integrated Care

5.3 In 2010 the Department of Communities and Local Government observed that people want joined up services and that it can be a source of great frustration when this does not happen. Integration means different things to different people but it has at its centre the building of services around individuals, not institutions. Work undertaken by National Voices confirms this view and it has formulated a definition of integrated care for which there is a strongly supportive national consensus. This definition holds that, from an individual's perspective, integrated care means:

> *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me".*
> http://www.nationalvoices.org.uk/defining-integrated-care-agreeing-narrative

5.4 This is the definition used in Haringey's Integration Plan. It is explicitly person centred, has a good fit with personalisation and takes forward choice and control for individuals over their services. The definition also emphasises that integration is not about organisational arrangements; it concerns the experience of people who receive services. Consequently, the main organising principle of integration must be the personal perspectives of service users and patients.

Details of the BCF - Funding

5.5 The June 2013 Spending Review set out the details of the BCF, which is to be used to Fund the Integration Plan as follows:

2014/2015

a) £200m transfer from NHS to social care, in addition to;
b) £900m transfer already planned.

2015/16

a) £3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements composed of:
   i. £1.9bn NHS funding;
   ii. £130m Carers Break funding;
   iii. £300m CCG Reablement funding;
   iv. £354m capital funding (including c.£220m of Disabled Facilities Grant), and;
   v. £1.1bn existing transfer from health to social care.

Haringey Council

5.6 It is emphasised that the money invested in the BCF is not new. The majority of the Fund consists of a financial transfer from health into the Fund. As a result, the BCF cannot be regarded as a *'windfall'*. It will create challenges within the health economy that will have to switch its pattern of investment with some of the funds placed in hospital provision being redirected into community based alternatives. This will have significant implications for the acute sector which are discussed in paragraphs 6.22 to 6.29, below.

5.7 National guidance also indicates that part of the BFC is to be used to cover part of the cost of new duties imposed on local authorities by the Care Bill. £135m of revenue monies is tied to funding new entitlements for carers, the introduction of a national minimum eligibility threshold, the provision of better information and advice, advocacy, safeguarding and other measures. A further £50m of capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system.

5.8 However, the BCF is not a prop for social care. It reflects the need to provide help to people at home and earlier, before crises arise. The BCF is about using resources differently and more effectively by building on the range of existing integrated services that Haringey already has in place – see below - and establishing new ones.

Haringey's Allocation of the BCF

5.9 In 2014/15 Haringey's allocation of the BCF funding will be £957,000, which will take the form of a Section 256 transfer from Haringey CCG to the Local Authority. This takes the total value of transfers for that year to £5.07m. This funding will be added to the existing Section 256 agreement with NHS England that was agreed by Cabinet at its meeting of 15 October 2013.

5.10 In 2015/16 the value of the BCF rises sharply to £18,061m consisting of:

	£000
Disabled Facilities Grant	£949
Social Care Capital Grant	£639
Transfer from CCG to BCF	£16,473
Total (2015/16)	**£18,061**

5.11 Guidance makes clear that the 2015/16 BCF allocation must be paid into a pooled budget. This will be by way of a one large, or a series of Section 75 agreements. It will be important for the Council and CCG to commence negotiations on the pool early in 2014/15 to ensure that these are in place when required. Before the Council can enter into any Section 75 agreements, the Cabinet's agreement will be required

Our Approach To Integration - Stakeholder Engagement.

Haringey Council

5.12 Led by Adult Social Care and Haringey CCG, the Integration Plan has been co-produced with service users, carers, professional groups, staff and NHS and care providers. In total, 211 service users, potential services users and professionals participated in a comprehensive engagement exercise. This avoided a one-size fits all approach consisting of workshops, focus groups and semi-structured one-to-one interviews. As a result, in line with the National Voices work we have been able to use the views expressed to construct a series of locally generated *'I'* and *'We'* statements – see Appendix 2. These summarise, respectively, what people want/need and how we propose to respond. The statements have informed the identification of the outcomes integration must deliver and thinking about the actions agencies will take to this end.

5.13 The establishment of reference groups (one has already been established under the auspices of the Older People's Forum) will embed on-going engagement at the heart of integration.

Our Approach To Integration – Building On What We Have Achieved.

5.14 The Integration Plan reflects a commitment to building on the integrated services Haringey already has in place. Services of this type, worth approximately £5.91m, are making a valuable contribution to health and wellbeing in the Borough.

5.15 However, while the Integration Plan is unashamedly practical it is also aspirational. It spells out a strong, clear vision which describes how services will be taken forward and reshaped to offer local people the integrated services they tell us they want and need. In so doing the Integration Plan takes forward the Council's and CCG's shared commitment to placing the outcomes people value most at the heart of the commissioning process.

The Assuring Process – Agreeing The Integration Plan

5.16 The Integration Plan has been approved by partners – Cabinet, the Health and Wellbeing Board and the Governing Body of the CCG - and submitted to NHSE, as required, on 14th February 2014 for scrutiny and approval. We are expecting NHS England to provide feedback on the Integration by no later than mid-March 2014. If amendments are suggested the Plan must be resubmitted to NHS England on the 4th April 2014 for Ministerial sign-off.

6. The Integration Plan

Scope - The Service User and Patient Cohort

6.1 Integrated services will be inclusive. They will be available to all adults living in Haringey but, based on an analysis of the Joint Strategic Needs Assessment (JSNA) and GP Collaboratives profiles we will prioritise frail older people, and older people with dementia in 2014/15 and adults (of all ages) with mental health needs in

Haringey Council

2015/16. These are the groups for whom integration will have the greatest and most immediate impact.

Vision for Transformation and Integration of Health and Social Care in Haringey

6.2 Haringey's Integration Plan is transformational. It calls for the reorientation of health and social care provision away from reactive to proactive services with the aim of providing people with the right care, in the right place and at the right time through a significant expansion of care in community settings. In so doing our intention is to reduce the need for acute interventions and, where such interventions become necessary, to return people to their homes as quickly and safely as possible. This is reflected in our vision which states:

> *"We want people in Haringey to be healthier and to have a higher quality of life for longer. We want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible."*
>
> (Haringey's Vision for Integration)

6.3 This vision is consistent with our definition of integrated care and to support its realisation the Integration Plan proposes a set of high level aims which will be operationalised through a series of associated objectives.

Aims and Objectives

6.4 The aims of the Integration Plan are:

a) ***Aim – Seamless Care and Support:*** To join-up systems for providing health and social care so that those receiving care and support experience seamless provision, regardless of who is providing it.
b) ***Aim – Person Centred and Personalised Services:*** To wrap care around service users and or patients, as unique individuals, with their wishes at the centre of care packages and pathways - they will be empowered to have their voices heard.
c) ***Aim – A Caring Community:*** To build the community's capacity to support its members, surrounding them with networks of support that combat loneliness and isolation.
d) ***Aim – The removal of organisational barriers:*** To remove organisational boundaries ensuring that they do not act as barriers to care, and are not noticed by service users.
e) ***Aim – The maximisation of Health and Wellbeing***: To maximise the health and wellbeing of individuals they will, wherever possible, be provided with integrated care and support in their own homes.

6.5 Collectively, these aims articulate partners' shared ambition to improve the results health and social care achieve for local people and their experiences of these

Haringey Council

important services. The objectives of the Integration Plan flow from its aims and are brief statements of the things we will do to realise its ambitions and to make its vision a reality.

6.6 In the language of the National Voices work, the objectives of the Integration Plan are expressed as a series of *'We'* statements:

a) ***Objective – Outcome focused:*** We will identify the outcomes that matter most to people and measure their attainment to learn and drive continuous improvement.
b) ***Objective – Policies, procedures and practices*****:** We will put in place policies, procedures and practices that enable, not hinder, the provision of integrated care with providers assuming joint accountability for achieving a person's outcomes and for showing how this delivers efficiencies across the system.
c) ***Objective – Monitoring attainment*****:** We will ensure that care is planned with individuals. Commissioners will monitor whether, or not, people are being successfully supported to attain the outcomes that they have set for themselves.
d) ***Objective – Integrated care plans:*** We will produce integrated care plans**,** cutting across health and social care, for all who need them. These plans will be accessible to their subjects and to the professionals they choose to share them with.
e) ***Objective – Prevention and proactive case management:*** We will undertake, by default, proactive and joined up case management to avoid unnecessary admissions to hospitals and care homes and to enable people to regain their independence as soon as possible after episodes of ill-health. This demands an emphasis on prevention and will result in services that are much more efficient, effective and more responsive to individuals' needs.
f) ***Objective – Prevention and increased support in the home and community:*** We will refocus services to offer increased support in the home and community to maximise the independence of people and enable them to self-manage their own health and wellbeing. This means responding proactively to the needs of individuals with, as above, an emphasis on prevention and working with the Third Sector to grow the range of community based solutions to people's needs.
g) ***Objective - Better information sharing:*** We will put in place better information sharing system that will allow key information about individuals' health care and support needs to be available to the social and health care professionals, subject to service users'/patients' consent.
h) ***Objective - Integrated community teams:*** We will introduce integrated community teams of social workers, nurses and therapists working closely with GPs and others to deliver joined-up care, reduce duplication and make the best use of skills and resources. Some of these teams will be based around groups of GP practices, while others operate across the borough and within hospitals in more specialist roles.
i) ***Objective - A single point of access***: We will put in place a 7 day week, 24 hour day single point of access to receive and respond to referrals from people

Haringey Council

living in the community, GPs and local organisations. The single point of access will streamline and make more accessible health and social care, offer signposting and meet the reasonable information needs of all who contact it.

j) ***Objective – Collaboration with GPs:*** We will work as closely as possible with GP practices and localise services, aligning them with Haringey's four GP Collaboratives.

Cultural Change and Challenge

6.7 Partners in Haringey recognise that the success of integration (the realisation of its aims and objectives) demands cultural change across the local health and social care system. To work well together health and social care organisations must develop a deeper mutual understanding and appreciation of the contributions they each make to the health and wellbeing of local people. They must also understand that they are parts of one whole integrated local health and social care economy and system.

6.8 Therefore, the integration of health and social care demands behavioural change as much as it requires organisations to adopt different ways of working. A shared culture has to be developed that allows the diverse professionals within health and social care to work together efficiently and effectively. To this end the development of integrated teams, joint assessments, case coordination across disciplines and multi-disciplinary training are cornerstones of the Integration Plan.

Description of Planned Changes – A System Wide Transformation

6.9 The vision underpinning the Integration Plan is about nothing less than the systems wide transformation of health and social care in Haringey with the changes described being the means by which this transformation will be delivered. A multi-faceted change programme will identify priority areas for change that will be the subjects of immediate action. In addition we will commit to working on and developing other areas for action over the next 2 – 5 years, a period which aligns with the Coalition Government's medium and long-term agendas on integration.

6.10 This is an exciting, but complex challenge, but we have a clear sense of direction that is provided by the Integration Plan's vision, aims and objectives. We will use the BCF to establish a range of new integrated services and to enhance those already in place. In so doing we will focus on reducing hospital and care home admissions, promoting timely discharges, preventing dependency and maintaining independence and improving individuals' experience of services.

6.11 Furthermore, Haringey is able to base transformation on the bedrock of experience health and social care partners already have of integrated services. The Integration Plan reflects our determination to learn from and make best use of this experience as we embark on a programme of change that broadens and widens the scope of integration, making integrated services the default form of provision. To reach this destination requires that health and social care undertake a shared journey that

Haringey Council

starts out by recognising where we are today, and where we will be in 2014/15 and 2015/16.

Building On What We Have Achieved - Where We Are Today

6.12 Haringey has already moved away from traditional service models that are segregated in terms of a health and social care divide. Services are increasingly integrated across health and social care (called horizontal integration) and between different health care services (called vertical integration). Examples of these forms of integration are provided in Figure 1. The BCF provides health and social care partners with an opportunity to build on their shared achievements by extending the range of integrated services available to local people.

6.13 In the course of 2014/15 we will review the integrated services already in place and undertake the detailed planning that will underpin the enhancement of some of these services and the launch of new initiatives focusing on frail older people, end of life care, discharge planning and self-management. Work on shared information systems and joint assessment will also be carried forward. In all these areas we expect to see substantial progress in 2014/15 and new service options coming on stream with an increased emphasis on services for adults with mental health needs.

Building on What We Have Achieved - where we will be tomorrow, 2014/15

6.14 In the course of 2014/15 we will review the integrated services already in place and undertake the detailed planning that will underpin the enhancement of some and the launch of new initiatives focusing on frail older people, older people with dementia, discharge planning and self-management. Work on shared information systems and joint assessment will also be carried forward. In all these areas we expect to see substantial progress in 2014/15 and new service options coming on stream with an increased emphasis on services for adults with mental health needs.

Figure 1. Example of Services That Are Already Integrated

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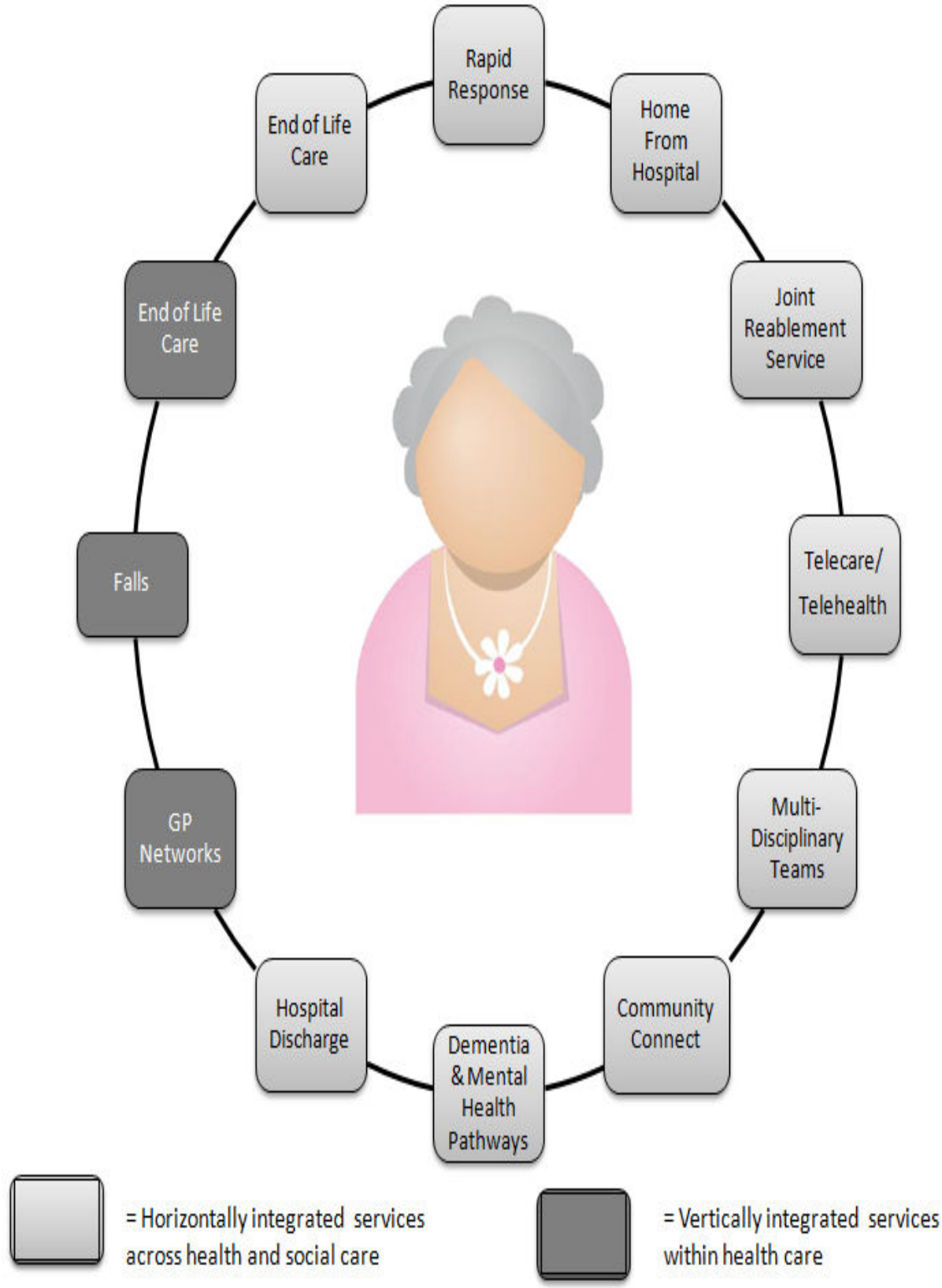

Building On What We Have Achieved - Where We Will Be Tomorrow, 2015/16

Haringey Council

6.15 By the end of 2015/16 our default form of provision for most service users and patients will be will be integrated services. The proposed new service model is illustrated in Figure 2. The services described in this model will work alongside and complement those integrated services outline in Figure 1 with the key new service developments being:

a) ***Integrated Community Teams.*** These will have a core membership of social workers, community nursing staff and therapists and be based upon groups of GP practices.
b) ***A Single Point of Access*** (not shown in Figure 2) across health and social care for people living in the community.
c) ***Integrated Hospital Discharge Teams*** to promote and make arrangements for the safe discharge of people from hospital to their own homes or other settings. An important aspect of the teams' work will be ensuring that discharge procedures work well for people, as well as hospitals.
d) ***An enhanced Integrated Rapid Response Team*** to promote hospital discharges and prevent admissions by offering support in the home including respite to carers, at short-notice.
e) ***Specialist teams*** some of which will be integrated while other will not. These teams will operate on a pan-borough basis, supporting people with complex needs.

6.16 Collectively the integrated services, referenced above in Figure 1 and below in Figure 2, will provide a whole systems response to intermediate care, hospital discharge, urgent care, and community rehabilitation. They will also contribute to prevention and ensure that people are cared for at home, or close to their homes. The intention is for Haringey's residents to remain as independent as possible for as long as possible with a good quality of life.

Establishing Ways of Working That Support Transformation – The Enablers

6.17 Alongside the development of new services will be the development of new ways of work to support and enable change. Previous discussion of the importance of cultural change provides a good example of such an enabler. However, this needs to be accompanied by changes to the health and social care infrastructure that will also take forward change. In addition, a robust governance structure (see paragraph 6.30 below) to superintend integration will be required, performance monitoring and the development of open information technology and information systems that support case coordination and joint assessment are vital. Work has commenced in these areas while the construction of joint commissioning strategies, shared procedures and processes and the development of other enablers will be actively pursued.

Figure 2. What the Proposed Model Looks Like.

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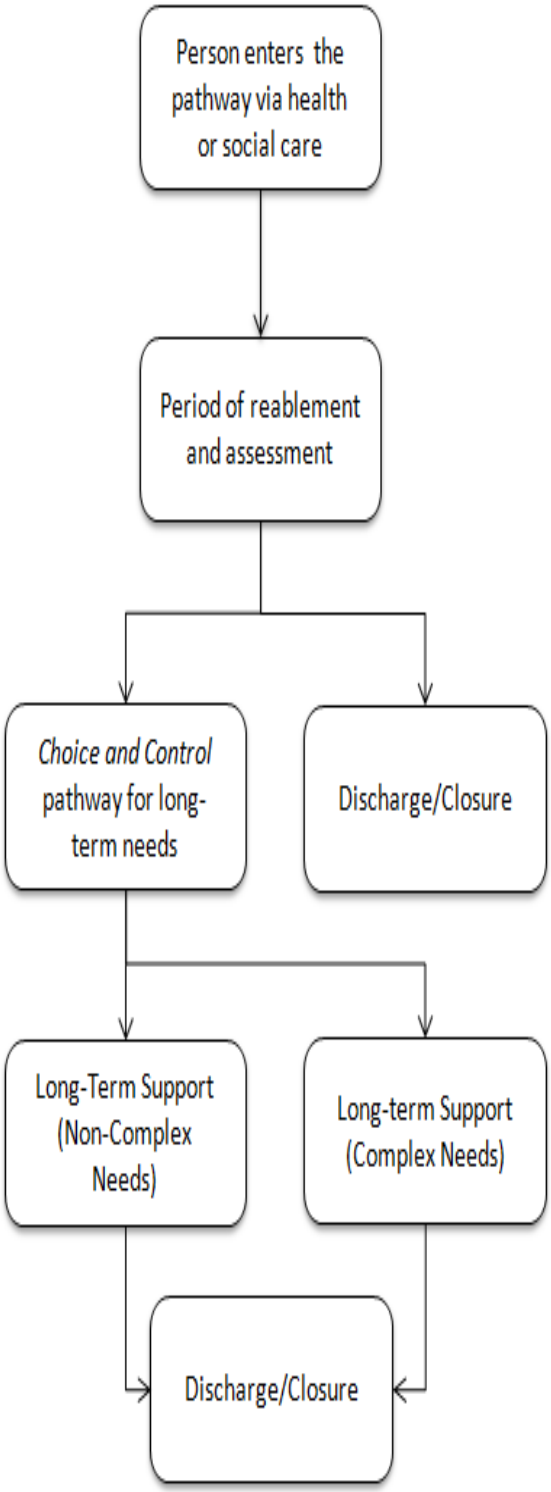


Integrated Teams

Integrated Community Teams: Rehabilitation, therapies, nursing and social care linked to and working with home reablement and primary care.

Enhanced Rapid Response: Fast, immediate responses to prevent hospital admissions and urgent social care referral, respite for carers.

Integrated Hospital Discharge Teams: Speedy and smooth discharge to intermediate and social care

Specialist Teams (Examples)

- Falls prevention
- Neuro – rehabilitation
- Wheelchair service.
- Community Learning Disabilities.
- Palliative care.
- Diabetes
- COPD
- Heart failure
- RAID
- IAPT
- Community Mental Health

Timescales (Estimated)

Haringey Council

6.18 **August - December 2013:**

a) Establish programme management approach and structure to the delivery of the integration of health and social care in Haringey.
b) Brief the Health and Wellbeing Board and CCG Governing body on the implications of integrations and the requirements of the BCF.
c) Commence engagement process, including providers, service users, patients, carers and public.
d) Agree service model and associated commissioning intensions.
e) Agree BFC investment intentions.
f) Adopt NHS numbers as primary identifier and commence discussions on shared IT solution for better data sharing.

6.19 **January - March 2014:**

a) Conclude engagement process.
b) Draft local Integration Plan completed.
c) Detailed joint commissioning strategy produced.
d) Reports to Health and Wellbeing Board, Haringey's Cabinet and Haringey CCG's Governing Body seeking their support of the local Integration Plan.
e) Submit first and final drafts of parts 1 and 2 of Haringey's Integration Plan.

6.20 **April 2014 – March 2015**

a) Complete detailed planning to implement concepts developed during co-design phase to achieve our aim and objectives.
b) Monitor financial flows to evaluate financial impact of possible models on different providers and on total cost to commissioners.
c) Review and roll forward existing Section 256 winter pressures schemes.
d) Manage the implementation and benefits tracking for the newly integrated services that are "live" and developing our next tranche of joint commissioning plans in line with local needs and the whole systems approach.
e) Plans to build on existing integrated schemes finalised (estimated May 2014).
f) Enhanced Rapid Response Team launched (estimated Oct 2014).
g) Revised and updated delivery plan for 2015/16 agreed (estimated Feb 15).
h) Negotiate and present to Cabinet and the CCG's Governing Body the Section 75 agreements in readiness for the 2015/16 pooled budgets.

6.21 **From April 2015**

a) Single point of access launched (estimated Apr 2014).
b) Roll-out of Integrated Community Teams commences (estimated Apr 15).
c) Roll-out Integrated Hospital Discharge Teams (estimated Apr 15).
d) Introduce regular annual customer satisfaction surveying to develop our baseline for user experience.
e) Provide Cabinet, Health and Wellbeing with and the CCG's Governing Body with updates on the progress made with respect to the implementation of the Integration Plan.

Haringey Council

Implications for the Acute Sector

6.22 Haringey CCG is the Lead Commissioner for the North Middlesex Hospital. The majority of acute services for Haringey residents are provided by the North Middlesex Hospital and Whittington Health Integrated Care Organisation, which also provides community services.

6.23 Since 2011/12 there has been detailed dialogue between commissioners and acute Trusts focused on schemes, initiated both by Trusts and by commissioners, to reduce unplanned hospital admissions and A&E attendances. Projected changes in activity patterns have been detailed in Quality Productivity and Prevention (QIPP) Programmes produced by the CCG. Transformation Boards have been in place since 2012, at the level of Chief Officer and CEO of partner organisations, to enable strategic focus on these programmes of work.

6.24 The impact of the Better Care Fund on the delivery of NHS services will be greater focus from a joint commissioning perspective on the linkages between:

a) NHS community services including; district nursing, community matrons, integrated care and therapies and community palliative care
b) Services commissioned by Local Authorities including: reablement, social care assessment, domiciliary care provision and residential care
c) Services provided by acute Trusts with a focus on reducing unplanned admissions such as ambulatory care, facilitated early discharge, older people's assessment unit and day hospitals

6.25 The focus on pro-active case management, locality based services and 7 day/wk care will enable NHS savings to be achieved through:

a) Reduction in unplanned hospital admissions, releasing CCG spend and capacity within acute trusts. Acute capacity will translate into improved efficiency, improvements in performance on Referral to Treatment Time (RTT) and A&E 4hr target and reduced spend on ad hoc capacity to manage peaks in demand.
b) Reductions in length of stay, representing savings to acute providers through improved efficiency, ability to manage peaks in demand and opportunities to repatriate patients.
c) Reduced duplication of care provision if there are areas of overlap between community and social care provision addressed through common assessment and co-location of service.
d) Reduced outpatient demand: better care planning and an emphasis on enabling self-management will aim to streamline, where appropriate, the numbers of outpatient appointments that patients are attending.

6.26 There is high value to both acute providers and to commissioners of delivering on the Better Care Fund with its focus on preventative community provision, enablement and maximising efficiency between community providers.

Haringey Council

6.27 How will the savings be realised:

a) Development of a shared transformation programme with identified savings targets for NHS commissioners and providers; and
b) Shared monitoring of transformation schemes.

6.28 Risks associated with failure to deliver:

a) Continued upward pressure on CCG budgets with rise in unplanned admissions; and
b) Continued risk to Trusts' ability to manage peaks in emergency attendances and admissions.

6.29 If the Integration Plan fails to deliver improvements some of the Fund may need to be used to alleviate the pressure on hospital services. Our plans in this regard are outlined in the contingency plan contained in part 2 of this Integration Plan.

Governance

6.30 Figure 3, describes the governance structure that will be put in place to maintain oversight of the Integration Plan and to ensure that it delivers required outcomes. The key features of this structure are:

a) ***Executive oversight and policy direction:*** Executive oversight and policy direction will be the responsibility the Health and Wellbeing Board, the Governing Body of Haringey Clinical Commissioning Group and the Local Authority's Cabinet as the senior executive bodies of the partners responsible for the integration of health and social care in the Borough. The chair of the Health and Wellbeing Board will receive briefings in the course of monthly meetings with senior managers and the Director of Public Health will assist the Health and Wellbeing Board to discharge its governance responsibilities.
b) ***Strategic oversight:*** The Integrated Management Board is the senior health and social care commission group responsible for maintaining strategic oversight of integration, including strategic commission. It will plan spend, set priorities, monitor the delivery of key outcomes and make recommendations to the executive level bodies (the Health and Wellbeing Board, the Cabinet and the CCG's Governing Body), as appropriate. It is also the forum to which problems, that cannot be resolved operationally, can be escalated for solution. The Integrated Management Board will meet on an, at least, monthly basis, receive regular monitoring reports and be co-chaired by the Chief Officer of the Clinical Commissioning Group and Director of Adult Social Care.
c) ***Operational oversight:*** The Operational Integration Board will maintain day-to-day oversight of business units (services). It will have an internal and external provider focus and work with them to identify and trouble shoot problems, ensure consistency of practice, promote learning and to progress service plans. In this way the Operational Management Board's oversight of micro

Haringey Council

commissioning will allow it to inform the strategic commissioning intentions framed by the Integrated Management Board.

d) **Business Units:** These are the integrated services providing people with care and support. They will be responsible for the services designated to them in keeping with good practice, policy and statutory requirements. Managers of business units will link to the Operational Management Board and provide such reports that may be reasonably asked of them.

e) ***Performance Management:*** This function will gather and coordinate performance data from the Business Units and Operational Management Board and distribute it across the entire governance structure. The data will provide that structure with the intelligence needed to inform decision making, policy formation, commissioning and the proactive management of integration. Performance Management will support excellence in data gathering and use by putting in place the systems and processes needed to capture and analyse required data, transforming it into useful information.

f) ***Monitoring performance:*** All business units, including the single access point, will be responsible for collecting their own monitoring data with the assistance of performance management colleagues. This will promote organisational and professional learning and support continuous improvement

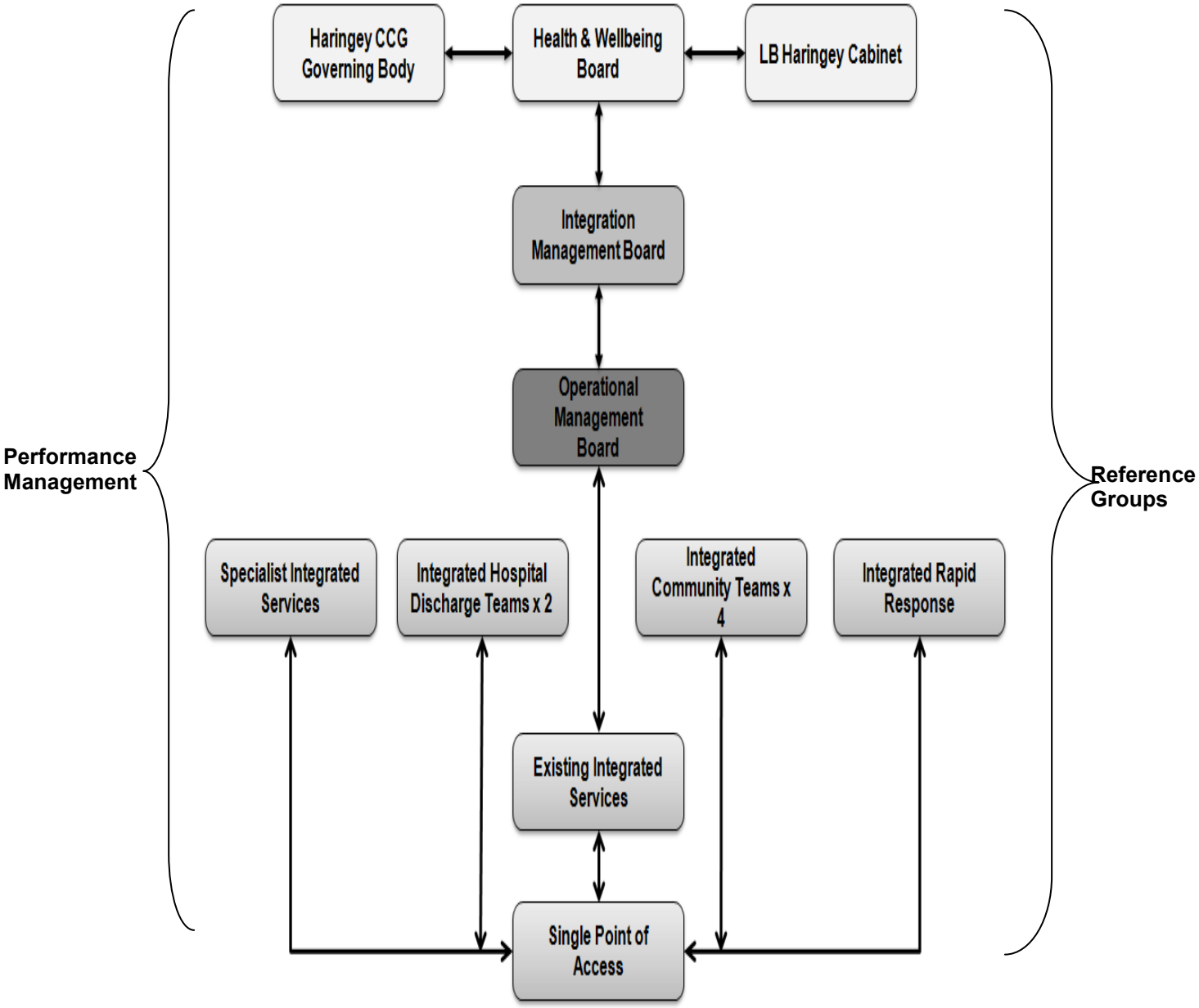
g) ***Reference Groups:*** These groups, which will include Haringey's Older People's Forum, carers, third sector etc, will ensure that the voices of services users, patients, carers and other key stakeholders are heard and able to influence the governance and development of integrated health and social care provision in Haringey. They will also expose the thinking of statutory agencies to a valuable external constructive critical challenge. This will help quality assure our approach to integration while providing a conduit of communication between local people, professionals, the Third Sector and community organisations.

h) ***Two way communication:*** Good governance demands excellent and systematic two way communications between the different layers of the governance structure to 1) ensure information exchange: 2) enhance clarity of understanding across the system; 3) escalate issues and bring about their resolution, and; 4) avoid silo working.

6.31 It is important to note the role of Haringey Healthwatch, the representative of patients and the public, in the governance structure. Healthwatch will be in a position of significant influence as its Chairperson is a member of the Health and Wellbeing Board and so able to feed into its discussions of the BCF and the ongoing integration of health and social care. It is envisaged that Healthwatch will also play an important role in establishing reference groups whose views it can represent to the Healthwatch and Wellbeing Board.

Figure 3. Governance Structure

Haringey Council



Executive oversight and policy direction

Strategic commissioning and oversight body.

Operational oversight body

Business units

Haringey Council

6.32 All parts of the governance structure are multi-disciplinary, bringing together an integrated health and social care approach to the governance of the Integration Plan and to the delivery of required outcomes. This is a pre-requisite for a vibrant integrated health and social care economy dedicated to delivering excellence to local people.

National Conditions

6.33 To access the BCF the Integration Plan must show how Haringey has or will meet prescribed national conditions:

a) ***Plans to be agreed jointly****:* This condition demands that the content of the Integration Plan be agreed between the Council and Haringey CCG. As a result the Integration Plan has been prepared by officers of the Council and the CCG and agreed by Cabinet, the CCG's Governing Body and the Health and Wellbeing Board.

b) ***Protecting Social Care:*** Adult Social Care and the CCG have agreed a process that confines eligibility for protection to services health and social care partners agree delivers health and social care benefits. As a result the protection of eligible services is in the interests of both parties (i.e. health and social care) and builds on their considerable their experience of s256 transfers. It will be a matter of negotiation to determine which eligible service will actually be protected.

c) ***7-Day Services To Support Discharge:*** All services commissioned through the use of the BCF will operate on a 7 day week basis. It will also be used mainstream some short-term funded 7 day week services (e.g. Rapid Response).

d) ***Data Sharing:*** The Integration Plan demonstrates Haringey's compliance with this condition by making clear that we have 1) adopted NHS Number as the primary identifier across health and social care; 2) that we are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards, and; 3) that required information governance controls are in place.

e) ***Joint-Assessments And Accountable Lead Professional:*** Health and social care partners in Haringey are committed to joint assessments and care planning with accountable lead professionals being allocated to ensure that all service users/patients receiving services from health and social care have a joint plan whose implementation is well coordinated. This function will be undertaken by appropriate health and social care professionals, as determined by the needs of individual service users/patients, using a common IT system and be supported by the use of a joint assessment tool to identify risk and required care and support. This tool has been developed and reflects established practice in our already integrated learning disabilities and reablement services. Care co-ordination and the allocation of accountable lead professionals will be part of our basic integrated service offer.

f) ***Agreement on the consequential impact on the acute sector –*** Paragraphs 6.22 to 6.29 above outline the ongoing work that is taking place with the acute

Haringey Council

sector to deal with any unwanted implications the BCF may have for the sector. The contingency plan, a sub-set of the Integration Plan, specifies the measures that will be taken should the need arise to protect the acute sector The view of the sector are important and meetings have taken place with its representatives and will continue to take place with them over the life-time of the Integration Plan.

Outcomes and Metrics

6.34 The Integration Plan template sets out the metrics that will be used monitor its impact . The measurement of the metrics used (at least initially) should not be too demanding as it will rest on the use of data that is already collected. They are:

a) Delayed transfers of care (a nationally prescribed metric);
b) Emergency admissions (a nationally prescribed metric);
c) Effectiveness of reablement (a nationally prescribed metric);
d) Admissions to residential and nursing care (a nationally prescribed metric);
e) Patient and service-user experience (a nationally prescribed metric); and
f) Injuries due to falls in people aged 65 and over (a locally selected metric).

6.35 The Integration Plan provides full year delivery projections for each metric for 2013/15 and 2015/16. Health and social care partners' are collaborating to ensure the collection of the required data and to monitor against these targets.

Finance

6.36 Details of the financial aspects of Haringey's BFC Integration Plan can be found in part 2 of the Integration Plan. Attention here is drawn to the summary of proposed expenditure of the BCF, provided in Tables 1.

6.37 Table 1 gives an overview, by scheme and year, of the planed expenditure and associated benefits of the BCF. The total spend must be equal to or more than Haringey's total BCF allocation which may be supplemented by any financial additions health and social care partners wish to make.

6.38 Approximately 25% of the BCF in 2015/16 is paid for improving outcomes. If planned improvements are not achieved a contingency plan is required that specifies how this funding will be used to alleviate the pressure on other services.

Table 1. Summary of Proposed BCF Expenditure 2014/16: Estimated Spend

Haringey Council

BCF Investment	Lead provider	2014/15 spend		2015/16 spend	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent
Older People and Dementia Pathway	London Borough of Haringey	475,000		475,000	
Mental Health Recovery Pathway	London Borough of Haringey	580,000		580,000	
Winterbourne Response	London Borough of Haringey	50,000		50,000	
Joint Commissioning	London Borough of Haringey/CCG	135,000		200,000	
Development and Enabling (Programme Management, Facilitating Integrated Locality Team Development, Initiating Integrated Care Planning, Staff Development, Scoping of Single Point of Access)	London Borough of Haringey/CCG		225,000	150,000	335,000
Integrated Locality Teams (Re-ablement, District Nursing, Community Matrons, Locality based social work teams)	London Borough of Haringey/Whittington Health			10,744,200	
Rapid Response - 7 days/wk	Whittington Health	340,000		500,000	
Step Down Care	London Borough of Haringey	625,000			
Reablement	London Borough of Haringey	2,450,000			
Reducing Delayed Discharges from hospital (Step-Down Care, Integrated Hospital Discharge Teams, Home from Hospital, Social Workers based in Hospitals 7 days/wk)	London Borough of Haringey	150,000		3,857,904	
GP Case Management and 7 day access	CCG	1,371,430		1,371,430	
Integrated End of Life Care Service	Whittington Health			1,379,389	
Additional Third Sector Investment	London Borough of Haringey	26,067		75,000	
Promotion of self management, measurement of patient engagement/activition, community development (Community Development Workers and Good Neighbours)	London Borough of Haringey	120,000		770,000	
Community Capacity Grant Schemes	London Borough of Haringey			639,000	
Promoting independence for people with disabilities	London Borough of Haringey			949,000	
Total		6,322,497	225000	21,740,923	335000
Note: benefits are put against the main contributor, but all schemes benefit					

6.39 Table 2 shows the amounts of the BCF required to support these services to achieve the Integration Plan's key outcomes if targets are not fully met.

Haringey Council

Table 2. Contingency Plan for Maintaining Services if Planned Improvements Are Not Achieved.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)	527,862	527,862
	Maximum support needed for other services (if targets not achieved)	527,862	527,862
Outcome 2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Planned savings (if targets fully achieved)	177,476	177,476
	Maximum support needed for other services (if targets not achieved)	177,476	177,476
Outcome 3 Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)	94,110	94,110
	Maximum support needed for other services (if targets not achieved)	94,110	94,110
Outcome 4 Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)	412,282	412,282
	Maximum support needed for other services (if targets not achieved)	412,282	412,282
Outcome 5 Patient / service user experience **National metric awaited**	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 6 Injuries due to falls in people aged 65 and over	Planned savings (if targets fully achieved)	61,230	61,230
	Maximum support needed for other services (if targets not achieved)	61,230	61,230

Note: Awaiting national data to complete row for outcome 5.

6.40 The relationship between the proposed investment of the BCF and the delivery of the outcomes as specified in tables 1 and 2, respectively, is summarised in Appendix 3.

Haringey Council

Implementation - Making Integration and Whole Systems Transformation Happen

6.41 This report and the Integration Plan outline an exciting but very challenging, large and complex programme of change. A whole systems transformation of the type described is not easy and its accomplishment will require a highly focused and well managed approach with excellent partnership working between the Council and CCG.

6.42 The importance of good and effective partnership working between the Council and CCG is amplified by the extremely tight timescales attached to the BCF. These demand that we *'hit the ground running'* in 2014/15 in order to review existing integrated services and make all necessary arrangements for the launch of an expanded integrated service offer in 2015/16. There is no time to waste and if this is not done Haringey will not receive its full BCF allocation and will fail to deliver on a key government priority (i.e. the integration of health and social care, which has all party support).

6.43. Therefore, a programme management approach is suggested to carry through the task of transformation and the Council and CCG will be appointing to a joint post to provide additional programme management capacity. Key areas of activity will include:

a) the establishment of the governance structure;
b) the agreement of a method by which to deliver better information sharing with all technical and information governance issues solved;
c) the review of existing integrated services – see Figure 1;
d) the completion of plans to in place integrated teams – see Figure 2 - and launch of the single point of access;
e) the agreement of a joint commissioning strategy;
f) the update of the current Section 256 and agreement of a Section 75 pooled budget into which the 2015/16 tranche of the BFC must be paid, and;
g) the ongoing engagement with all stakeholders, but especially service users and patients and their carers and NHS and social care providers.
h) the development and implementation of a comprehensive communications strategy. This will assist the Council and CCG to respond to and manage the considerable media, public and professional interest the integration will generate.

6.44 The above list is not all inclusive and all activities must be captured by a comprehensive programme plan. This is a detailed plan of action aimed at accomplishing the integration of health and social care. Work on the construction of the programme plan will commence in early April and be completed within 6 weeks, approximately.

Risks

Haringey Council

6.45 It is acknowledged that whilst the BCF represents a tremendous opportunity to integrate and transform health and social care provision for the benefit of local people it also carries risks. These are listed in the risk log, below, together with their treated RAG ratings and mitigating actions. No risks are rated red, which would have the potential to seriously compromise delivery of the Integration Plan. All risks are rate amber and while all require attention none are considered insurmountable.

6.46 The risk log is a living document and will be kept under regular review to ensure that existing, new and emergent risks are actively managed to minimise the impact they might have otherwise have on the realisation of the benefits of integration.

Risk Log

ID	Risk	Risk Rating (Treated)	Treatment
1	IF delays occur in launching BCF funded services THEN targets may not be achieved and outcomes realised.	Amber (Medium)	We will create and appoint to a joint (CCG and LA) post to provide the dedicated project management capacity need to plan and coordinate the launch of services.
2	IF political and organisational will across partner agencies cannot be aligned THEN integration will not take place.	Amber (Low)	We will brief and ensure that the HWB support proposals for integration. Health and social care leaders to champion and provide energetic support for integration. Work on integration to be joined-up across health and social care.
3	IF funding is not available to fund double running THEN gaps in service provision may appear as the transition is made to new integrated ways of working	Amber (Medium)	We will ensure that commissioning plans for new integrated services are fully funded and take into account decommissioning costs.

ID	Risk	Risk Rating (Treated)	Treatment
4	IF behavioural and cultural	Amber (Low)	We will bring diverse staff

Haringey Council

	changes do not accompany efforts at integration THEN service provision across health and social care will not be seamless.		groups together to build a new integrated professional identity reinforced by physical collocation, joint management structures and shared training.
5	IF we shift resources to fund new integrated services THEN current service providers, particularly in the acute sector may be destabilised	Amber (High)	• Our current plans are based on engagement with providers who are, broadly, supportive of the proposals to integrate health and social care in Haringey. • The development of our plans for 2014/15 and 2015/16 will be conducted within a whole system approach allowing for a holistic view of impact across the provider market with an emphasis on jointly defining the ultimate destination of transformation. • The QIPP process will be used work through the implications of integration with the acute sector.
6	IF the BCF runs out before integration is completed THEN we will be unable to complete this task without more resources and disrupting provision to patients and service users.	Amber (Low)	We will impose strict financial monitoring to ensure the best and most efficient use of Haringey's BCF allocation

ID	Risk	Risk Rating (Treated)	Treatment
7	IF additional costs (unquantified)	Amber (High)	• We undertake an initial

Haringey Council

	are imposed on Local Authorities by the Care Bill have to be met out of the BCF THEN the availability of funds to support integration and the financial assumptions on which Haringey's Integration Plan is based will be impacted upon.		impact assessment of the effects of the Care Bill and will continue to refine our assumptions around this as we develop begin to deliver integrated services • We believe there will be potential benefits that come out of this process, as well as potential risks. • We will offer transitional support if required.
8	IF activity levels do not change as planned THEN funding for integration may have to be diverted putting the realisation of this plan at risk.	Amber (Medium)	• A robust approach will be taken in commissioning plans to understand the demand and supply for different health and social care services to inform predicted activity level. • An approach to target setting will be taken which is realistic. We will set targets, for the use of the BCF, that stretch us but which we are confident can be achieved. • We will tightly manage and monitor, through commissioning, ongoing service demand. • We have taken account of the need to respond to unplanned contingencies (e.g. activity levels not changing as planned) in our financial plan.

Note. Green risk are not listed as these as this rating indicates that a risk is within tolerance and requires no action.

7. Comments of the Chief Finance Officer and financial implications

7.1 This report provides an update to the Scrutiny Panel about the Better Care Fund and its implications for Haringey. The Better Care Fund was announced by the Chancellor in the Autumn Statement and indicative allocations to Local Authorities

Haringey Council

were provided in December 2013. However the 2015-16 figures should not be regarded as confirmed as some aspects of the funding distribution formula may change. In addition we know that £1bn of the £3.8bn awarded nationally will be top-sliced and used to provide an element of performance award. Further guidance about the implications of this will be provided by the Department of Health at a later date.

7.2 It is important to be aware that the first half of the money is likely to be awarded on the basis of performance in 2014-15. Although we have no reason to believe that performance in Haringey will not be satisfactory, the targets are likely to be challenging and so there is some risk to the funding. Delivery of milestones and performance against targets will need to be closely monitored in year and action taken to redress any weaknesses in a timely fashion.

7.3 £4.1m of health funding was allocated to Adults in the 2013-4 budget and the expenditure plan was approved by Cabinet in October. It has been assumed in the MTFS that the additional £957k in 2014 will also be allocated to Adults. Plans to spend this money in order to meet the objectives of the funding have been discussed with the CCG and an initial high level allocation is set out above.

7.4 Further work between LBH and the CCG is needed to finalise some of the details for the 2015-6 fund but the high level areas for investment are set out above.

7.5 It is very important to understand that this is not new money but a realignment of existing budgets across the two organisations. Where new services are created or existing services extended (for example in the further use of 7 day working) then this can only be funded through disinvestment elsewhere including the reduction or stopping of existing health and social care services.

8. Assistant Director of Corporate Governance Comments and legal implications

8.1 There are no specific legal implications arising out of the recommendations in this report.

9. Equalities and Community Cohesion Comments

9.1 The proposed Better Care Fund Plan is designed to provide health and social care services that produce better results and a better experience for all local people. As a result it serves the interests of all protected groups, whose health and wellbeing it promotes, and is aligned with the Council's commitment to equalities. The Equalities Impact Assessments Screening Tool has been completed which indicates that a full Equalities Impact Assessments is not required at this time for the following reasons, as recorded in the in the Tool:

9.2 *"The BCF represents a fantastic opportunity to transform health and social care services for local people. Our aim is to use the fund to improve the results these important services achieve for local people and their experiences of using them.*

Haringey Council

This means that the organising principle of transformation will be the personal perspectives of people.

9.3 *Our intention is to use the Fund to ensure that health and social care provide a comprehensive seamless service offer with services being much more accessible and available to individuals when they need them. As a corollary of this 7 day week services will be established which place emphasises on prevention, reablement, the maintenance of independence, reducing delayed discharges and admissions to care homes and closer working with GPs. In addition integrated community health and social care and hospital discharge teams will be put in place as a 24/7 single point of access. These measures will lead to significant improvements in the efficiency, economy and effectiveness of services.*

9.4 *The BCF Plan stresses that at all times partners (the LB of Haringey and Haringey CCG) will be relentlessly person focused and seek to provide services which are personalised, offer choice and control and respect personal dignity at all times. It is a commitment that is, particularly, relevant to all protected groups and honouring their right to equality and excellence in service provision. Services currently being provided are not being reduced in any way and are in fact being enhanced and intended to produce positive outcomes for all service users without any detriment to any protected characteristics. On this basis, we do not think a full equality impact assessment is require"*

10. Head of Procurement Comments

10.1 There are no current procurement issues within to the Integration Plan for the Better Care Fund, in readiness for its submission to NHS England by 14 February 2014.

11. Policy Implication

11.1 Policy on the Better Care Fund is being set out jointly by NHS England and the LGA. It is expected this funding will be used to significantly affect the pattern of local services, shifting resource and demand away from acute services focused on treatment and towards community based services, focused on prevention. The plan has the potential to have a positive impact on integration. While it is not all new money, pulling it together may well ensure better use of current funding.

11.2 This plan for the Better Care Fund is based on the work Haringey's CCG and the Council which have undertaken jointly to develop integrated commissioning and integrated services. The work supports the strategic approach adopted in Haringey's Health and Wellbeing Strategy: ' *A Healthier Haringey: We will reduce health inequalities through working with communities and residents to improve opportunities for adults and children to enjoy a healthy, safe and fulfilling life.*

11.3 The plan should be read together with the following documents:

a) Joint Strategic Needs Assessment

Haringey Council

b) Haringey's Health and Well-being Strategy 2012-15 and delivery plans
c) Improving the health and wellbeing of people in Haringey: Clinical Commissioning Group (CCG)prospectus 2013

Key documents

NHS Guidance on Better Care Fund http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

12 Reasons for Decision

12.1 To ensure that the Adults Health and Scrutiny Panel is informed of Haringey's Integration Plan. This will maximise value for money (efficiency, economy and effectiveness) and deliver the best possible range of integrated health and social care service to local people and local communities in compliance with Haringey's Health and Wellbeing Strategy.

13. Use of Appendices

Appendix 1a and 1b. BCF Health and Social Care Integration Plan
Appendix 2. *'I'* and *'We'* Statements
Appendix 3. The Relationship Between Proposed Investments and the Delivery of Outcomes

14. Local Government (Access to Information) Act 1985

14.1 Not applicable

Appendix 1a
Better Care Fund planning template – Part 1

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Haringey**
Clinical Commissioning Groups	**Haringey Clinical Commissioning Group**
Boundary Differences	**None - boundaries are co-terminus**
Date agreed at Health and Well-Being Board:	**11/02/2014**
Date submitted:	**12/04/2014**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£18,061,000**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Sarah Price
Position	Chief Officer
Date	<date>

Signed on behalf of the Council	
By	Mun Thong Phung
Position	Director Adult Social Services
Date	<date>

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Bernice Vanier
Date	<date>

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

Haringey's Better Care Fund (BCF) Plan, hereafter referred to as the Integration Plan, has been developed by Haringey Council and Clinical Commissioning Group (CCG) in partnership with health and social care providers. The Plan is dedicated to nothing less than the whole systems transformation. It is an unequivocal statement of health and social care partners' determination to unite and make fundamental changes the services they offer local people through the integration of health and social care.

Therefore, Haringey's Integration Plan sets the course for the ongoing integration of health and social care which will extend beyond the lifetime of the BCF. This Plan should be regarded as an operational plan that provides a platform from which the strategic objective of transformation through integration will be realised, reflecting the intent and direction of the strategic documents referenced below and in the joint commissioning strategy the Council and CCG are proposing to develop in coming months.

The approach taken to the development of Haringey's Integration Plan has relentlessly focused on identifying how the BCF and integrated services can deliver better results and an improved experience for patients and service users while boosting the sustainability of the system through services that are more efficient, effective and economic. Engagement with providers has played a pivotal role in shaping this Plan to this end.

Health Providers

Local acute providers confront high demand and operate at, or near to, full capacity at all times. It is acknowledged that demand will not diminish, nor will the discharge process improve without transforming the way in which health and social care are delivered. All parties regard the BCF as a valuable transformational opportunity and are determined to realise the potential that it presents.

The investment of the BCF and the accompanying integration of health and social service, as specified in section 2 of this Plan, are positive responses to the challenges confronting local NHS providers. They are supportive of our proposals which have been presented to them at the Transformation Boards of the Whittington and North Middlesex Hospitals. The contribution the proposals make to preventing unnecessary admissions and to reducing delayed discharges have been, particularly, welcomed by providers. Local GPs have had an opportunity to influence the proposals contained herein. They are an important stakeholder group and at a recent conference, convened by Haringey CCG, were invited to comment on what they hope integration will achieve for their patients. There was considerable unanimity with most GPs believing that integration will allow them to access a greater range of service much more quickly, make available better information about provision and allow increasingly holistic responses to individuals' needs.

Engagement indicated that GPs experience of participating in Haringey's Multi-disciplinary Teams, which allow them to review patients with a range of health and social care colleagues, means that their support for integration is grounded in their experience

of this way of working.

In addition, detailed discussions are taking place with Haringey's community health provider, Whittington Health. It is an enthusiastic and highly valued partner that has made an important contribution to the development of this Plan and is playing a central role in recently commenced work to introduce community based integrated teams, joint assessments and better data sharing across health and social care. This work will be taken forward in coming months and be completed in time for the launch of the teams in March 2015.

Social Care Providers

A total of 32 social care providers, many of whom work in the Third Sector, have participated in Haringey's engagement process. They provide a wide range of services to adults and older people, with all forms of disabilities, in institutional and community settings. Providers are generally supportive of integration and want to play an on-going part in work to this end. This is welcomed and their wealth of experience and knowledge will be important assets to this enterprise.

Haringey is fortunate in having a social care providers' forum which will allow the voices of providers to be heard and to be influential as we integrate services. An undertaking has been given to the forum that reference to it will be made to it on a regular basis.

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

Our vision for whole systems integration in Haringey is based on the experiences of local people and what they tell us is important to them and reflects the output of Haringey CCG's *Value Based Commissioning* engagement. Avoiding a *'one size fits all'* approach, we have combined large and small group meetings, focus groups, semi-structured interviews and workshops. Through this process and in collaboration with our Third Sector we have engaged directly with 211 patients, service users, their carers and professionals. This has allowed us to paint a rich picture of people's experiences of health and social care. We have generated a list of local *'I'* statements which articulate the priorities for change of users/patients/carers. This is translating into the outcomes that matter most to patients and services users which commissioners will use when contracting with providers.

The outputs from this engagement have been distilled in a number of cross-cutting themes that summarise what local people want from an integrated health and social care service offer. In no particular order of importance, they encompass:

a) **Services that are easy to access:** A key outcome of engagement is the indication provided of the routes into health and social care as being confused and confusing. As a result, there is uneven, often only partial, knowledge about what services are available and a lack of clarity about which of a plurality of access points should be used to obtain services. In short, there is a demand for the pathway into health and social care to be clearer and shorter with less '*hand-offs'*.
b) **Services that are well managed and provided by competent professionals and staff:** This theme is related to the confidence people have in their health and social care services and how safe they feel in their hands. The following comments were received:
    - *"Social workers should really know what they are doing and be sufficiently*

qualified."
- *"Mangers need training too."*
- *Services should be monitored and take stock of where we are and where we are going."*
- *"I must have confidence that the people who care for me are well managed."*

c) **Service must respect dignity and promotes choice and control:** This translates theme translates**,** in the words of one respondent, into:
- *"being treated decently and with kindness".*
- In a similar vein a carer stated:
- *"I want good basic customer care - a smile, a greeting, eye contact as I enter the ward."*

Many respondents emphasised that their care and support are intensely personal services and the ways in which they are delivered have a direct impact on, not only, the quality of their experiences, but also, on their general sense of wellbeing. This means that health and social care must be person centred and provide services that are highly personalised to ensure that that they value the experiences and views of patients and service users, uphold their sense of self worth and offer them as much choice and control as is possible and reasonable.

d) **Good and timely information:** To exercise choice and control individuals need information and respondents repeatedly identified their need for high quality up-to-date information which identifies available services and how to access them. They also stressed the need to protect their personal information and for it to only be shared with their consent.

e) **Services the enable individuals to do things for themselves.** People do not want services that take-over and do things for them, thereby, creating avoidable dependency. People are worried about being a *'burden'* on carers. They want to maximise the amount of time spent in good health and want services that support them to do things for themselves, promoting their independence. This places a clear emphasis on the importance of prevention and reablement.

f) **Services the work together as one team** whose members talk to each other, with the service user/patient being the key team member. In the words of one members of the public:
- "I want *people to speak to each other* – pick-*up the old telephone instead of unnecessary paperwork".*

g) **Services that promote wellbeing and reduce loneliness** with older people commenting that:
- "*I want to see people, to have companionship, to have someone to talk to."*
- *"I want to be able to meet others and have places to go"*.

The ongoing engagement of local people and organisations will be central to the success of Haringey's integration journey and its accompanying transformation of health and social care. To ensure that their views continue to inform the development and implementation of integration and to expose our proposals to ongoing constructive external challenge reference groups will be established and one already has. These will help ensure that the views of patients, service users and the public remain at the heart of this important work.

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

Underpinning the development of this Integration Plan are the documents referred to below. We regard it as imperative that our approach to the integration of health and social care is consistent with what local strategic documents tell us about the health and social care needs of local people, now and in the future, with commissioning plans and reflects key national documents.

Document or information title	Synopsis and links
LB Haringey (2012), *"Joint Strategic Needs Assessment (JSNA)".* http://www.haringey.gov.uk/index/social_care_and_health/health/jsna.htm	Joint local authority and CCG assessments of the health needs of the local population in order to improve the physical and mental health and well-being of individuals and our communities.
LB Haringey (2012), *"Joint Health & Wellbeing Strategy (JHWS)"* http://www.haringey.gov.uk/hwbstrategy	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016.
LB Haringey (2013), *"GP Collaborative Profiles."*	Public Health analyses of the populations and their health needs of each of Haringey's four GP Collaboratives.
Barnet, Enfield and Haringey CCGs (2013), *"Barnet, Enfield and Haringey Clinical Strategy."* **http://www.barnetccg.nhs.uk/about-us/beh-clinical-strategy.htm**	Describes the planned changes to local healthcare services with emphasis on the future of hospital services.
LB Haringey (2011), *"Haringey Ward Profiles"* **http://www.haringey.gov.uk/index/council/how_the_council_works/fact_file/wardprofiles.htm**	These ward profiles examine the demographic, social and economic, health, housing and labour market characteristics of the 19 Haringey wards and are based on Census 2011 data from the Office of National Statistics.
A Khaladi (undated), *"A Question of Behaviours,"* iMPOWER	A report which addresses the increasing dependency on

http://www.impower.co.uk/en/a-question-of-behaviours-the-latest-report-from-impower-453.html	acute settings and urgent care, particularly for the elderly and the positive agenda to integrate care in home and community settings. The thesis of the paper is that big system change alone will not work if it is not accompanied by changes in the behavioural norms of professionals and the public.
London Borough of Haringey (2013), *"2013/14 Commissioning Plan – Section 256 Social Care Funding."*	A commissioning proposal outlining proposals for the use section 256 funding to purchase or contribute to the costs of a wide range of social care services producing positive health outcomes.
National Collaboration for Integrated Care and Support *(May 2013)* "*Integrated Care and Support: Our Shared Commitment"* **https://www.gov.uk/government/publications/integrated-care**	Presents a shared vision for integrated care and support to become the norm in the next five years combined with a call for a sustained national collaborative programme to help organisations find local solutions.
NHSE (July, 2013), *"The NHS belongs To The People: A Call To Action"* **http://www.england.nhs.uk/2013/07/11/call-to-action/**	Sets out these challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. The document says clearly that the NHS must change to meet these demands and make the most of new medicines and technology and that it will not contemplate reducing or charging for core services.
LB Haringey and Haringey CCG (2014), *"Dementia Joint Commissioning Strategy and Delivery Plan"*	Maps existing and future demand for dementia

	services in Haringey, identifying future service options and associated costs in order to deliver sustainable service provision that reflect best practice and which will underpin a better quality of life for people with dementia, their carers and others effected by their condition.

2) VISION AND SCHEMES

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

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

The Haringey Vision

Haringey's Integration Plan is transformational. It calls for the reorientation of health and social care provision away from reactive to proactive services with the aim of providing people with the right care, in the right place and at the right time through a significant expansion of care in community settings. In so doing our intention is to reduce the need for acute interventions and, where such interventions become necessary, to return people to their homes as quickly and safely as possible. This is reflected in our vision which states:

> *"We want people in Haringey to be healthier and to have a higher quality of life for longer. We want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible."*

We believe that this vision is entirely consistent with the person centred definition of integrated care arising from the National Voices work:

> *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."*
>
> National Voices

Our vision builds on the definition of integrated care and commits partners to ensuring that we will:

a) adopt the personal perspectives of service users and patients as the key organising principle of service provision, to improve their experiences of services and the results achieved for them;

b) empower people, as far as possible and reasonable, to direct their care and support and to receive the care they need in their homes;

c) ensure that health and social care work seamlessly together and focus on people as individuals;

d) require staff to work around and with individual service users and patients as integrated teams bringing together the skills, experience and expertise of diverse disciplines and organisations;

e) build the community's capacity to support its members, surrounding them with networks of support that combat loneliness and isolation;

f) identify the outcomes that matter most to people and measure their attainment to

drive organisational learning and continuous improvement, and;

g) enable, not hinder, the provision of integrated care with providers assuming joint accountability for achieving a person's outcomes and for showing how this delivers efficiencies across the system.

In practice, our vision means that we will relentlessly concentrate on people's experiences of health and social care and the results achieved for them. We are dedicated to enabling people in Haringey to live long, healthy and fulfilling lives through improved access to safe, well co-ordinated, high quality and person centred services that provide great results and a tremendous experience of care. These services will, at all times, respects individuals' dignity and seek to maximise choice and control in line with the requirements of personalisation. People will be helped to remain healthy and independent for long as possible and be supported to build lives beyond illness and disability.

We will work to understand and map the experiences, capabilities, needs and wants of local people and engage with them, as partners, to develop our service offer to address priority areas. This is not limited to looking at people in terms of the cost of their care or the types of interactions they currently have with local services, but encompasses a real commitment to understanding the challenges individuals face in their lives and how these can be converted into more positive experiences and outcomes in the future. We know from the engagement that this will mean putting in place a new and transformational service model based on integrated multi-disciplinary teams working closely with primary care and specialist services. It also means that we will place a strong emphasis on speed of response, enabling independence, self-management, prevention and providing services in people's own homes.

Changes in the Pattern and Configuration of Services

The realisation of our vision means that the way in which health and social care are delivered in Haringey will be transformed. Currently, pockets of services are integrated and jointly commissioned. By 2015/16 a significant proportion of the community health and social care services used by frail older people will be jointly commissioned. Local pilot schemes targeted towards *'admissions avoidance'* and *'improving discharge'* will have been mainstreamed and upscaled. The strong and unifying focus will be on enabling independence; reducing duplication, avoiding crises that result in admissions and building people's ability to manage at home following hospitalisation.

By 2018/19 we expect integrated services to be the norm across a broad swathe of local health and social care provision. Integration will take place at the operational and strategic levels with integrated teams, integrated management and integrated governance structures combining to provide local people with the high quality services they need, want and deserve while delivering significantly improved value for money (i.e. efficiency, economy and effectiveness). We will re-orientate service away from hospital and institutional provision towards care at home; from reactive to proactive preventative interventions, and; from disjointed and inefficient service responses to joined-up and efficient responses with services working together as a consolidated whole. These developments will be accompanied by the growth of our, already, important Third Sector which is ideally positioned to provide flexible and fast preventative responses at the levels of communities and neighbourhoods.

What Difference will this Make to Patient and Service User Outcomes

Our vision strikes a balance between being aspiration and pragmatism. The desire to achieve as highly as possible for local people must be tempered by recognition that we

must also be realistic about what is possible. We cannot and will not make promises that we cannot keep.

Partners in Haringey are hugely committed to making integration a success and our vision articulates the most basic difference we are determined it will make to patients and service users who will be able to say:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

The attainment of this goal will be contingent on delivering the outcomes and themes identified in the course of patient, service user and public engagement – see above. To this end we have developed a new service offer that commits health and social care partners to:

a) Work together as a unified multi-disciplinary team which includes the patient or service user.
b) At all times respect and defend individuals' dignity and give them as much choice and control over their services as is possible – we will not define people by their illnesses or disabilities.
c) Enable the proactive management of long term conditions and complex needs so that people can remain as independent as possible for as long as possible.
d) Bring together existing components in primary, community, social and acute care into one comprehensive and cohesive framework.
e) Work alongside the Third Sector as an equal partner, building community capacity and caring networks.
f) Focus all parts of system on admission avoidance to hospital and care homes, the reduction of delayed discharges and A&E attendances while developing community options that promote prevention and care closer to home.
g) Support the families and friends of services users and patients so that they can continue to care.
h) Do our best to ensure that people who use health and social care have a good experience and feel decently treated at all times.

To achieve all this we will work with the Third Sector to ensure that those not yet experiencing acute needs, but are beginning to require support are helped to remain healthy, independent and well. We will invest in empowering people through advocacy, care navigation and peer support to maximise their independence and wellbeing to combat isolation and loneliness. We will also and work with those who use services, and health and social care providers in addition to community and voluntary groups to co-produce models of care and support. These models will resonate to and meet people's aspirations and needs.

b) Aims and objectives

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

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The aims of this Integration Plan are:

a) ***Aim – Seamless Care and Support:*** To join-up systems for providing health and social care so that those receiving care and support experience seamless provision, regardless of who is providing it.

b) ***Aim – Person Centred and Personalised Services:*** To wrap care around service users and or patients, as unique individuals, with their wishes at the centre of care packages and pathways - they will be empowered to have their voices heard.

c) ***Aim – A Caring Community:*** To build the community's capacity to support its members, surrounding them with networks of support that combat loneliness and isolation.

d) ***Aim – The removal of organisational barriers:*** To remove organisational boundaries ensuring that they do not act as barriers to care, and are not noticed by service users.

e) ***Aim – The maximisation of Health and Wellbeing***: To maximise the health and wellbeing of individuals they will, wherever possible, be provided with integrated care and support in their own homes.

Collectively, these aims articulate partners' shared ambition to improve the results health and social care achieve for local people and their experiences of these important services. The objectives of the Integration Plan flow from its aims and are brief statements of the things we will do to realise its ambition and to make its vision a reality.

In the language of the National Voices work, the objectives of the Integration Plan are expressed as a series of *'We'* statements:

a) ***Objective – Outcome focused:*** We will identify the outcomes that matter most to people and measure their attainment to learn and drive continuous improvement.

b) ***Objective – Policies, procedures and practices*****:** We will put in place policies, procedures and practices that enable, not hinder, the provision of integrated care with providers assuming joint accountability for achieving a person's outcomes and for showing how this delivers efficiencies across the system.

c) ***Objective – Monitoring attainment*****:** We will ensure that care is planned with individuals. Commissioners will monitor whether, or not, people are being successfully supported to attain the outcomes that they have set for themselves.

d) ***Objective – Integrated care plans:*** We will produce integrated care plans**,** cutting across health and social care, for all who need them. These plans will be accessible to their subjects and to the professionals they choose to share them with.

e) ***Objective – Prevention and proactive case management:*** We will undertake, by default, proactive and joined up case management to avoid unnecessary admissions to hospitals and care homes and to enable people to regain their independence as soon as possible after episodes of ill-health. This demands an emphasis on prevention and will result in services that are much more efficient, effective and more responsive to individuals' needs.

f) ***Objective – Prevention and increased support in the home and community:*** We will refocus services to offer increased support in the home and community to maximise the independence of people and enable them to self-manage their own health and wellbeing. This means responding proactively to the needs of individuals with, as above, an emphasis on prevention and working with the Third Sector to grow the range of community based solutions to people's needs.

g) ***Objective - Better information sharing:*** We will put in place better information sharing system that will allow key information about individuals' health care and support needs to be available to the social and health care professionals, subject to service users'/patients' consent.

h) ***Objective - Integrated community teams:*** We will introduce integrated community teams of social workers, nurses and therapists working closely with GPs and others to deliver joined-up care, reduce duplication and make the best use of skills and resources. Some of these teams will be based around groups of GP practices, while others operate across the borough and within hospitals in more specialist roles.

i) ***Objective - A single point of access***: We will put in place a 7 day week, 24 hour day single point of access to receive and respond to referrals from people living in the community, GPs and local organisations. The single point of access will streamline and make more accessible health and social care, offer signposting and meet the reasonable information needs of all who contact it.

j) ***Objective – Collaboration with GPs:*** We will work as closely as possible with GP practices and localise services, aligning them with Haringey's four GP Collaboratives.

We recognise that the attainment of our aims and their accompanying objectives means that the way in which we think about, design, commission and deliver services must change. This will create challenges. However, Haringey already has considerable experiences of integrating services across learning disabilities, mental health and reablement. Integration is a journey we have begun and are keen to progress to its conclusion in coming years. We will learn from and build on these experiences.

c) Description of planned changes

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

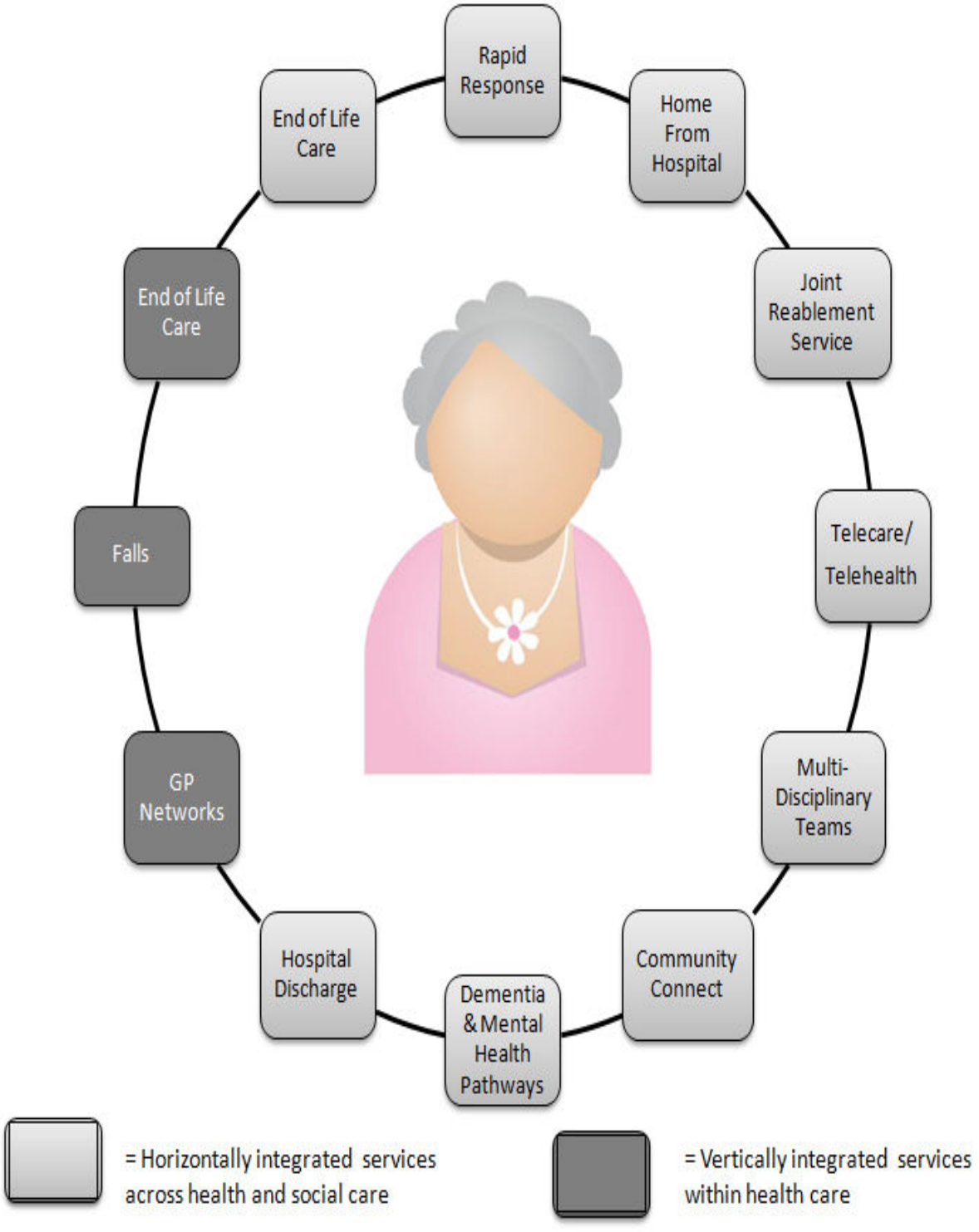
- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Health and social care in Haringey will take advantage of the BCF to establish a range of new integrated services and to enhance those already in place. We will focus on reducing avoidable hospital admissions, promoting timely discharges, reducing admissions to care homes, the provision of effective preventative services (including rehabilitation and reablement) and improving individuals' experience of services. We will develop a series of outcomes that allow the whole system to concentrate on delivering those outcomes that matter most to people.

Building On What We Have Achieved - Where We Are Today

Haringey has already moved away from traditional service models that are segregated in terms of a health and social care divide. Services have increasingly been integrated across health and social care (called horizontal integration) and between different health care services (called vertical integration). Examples of these forms of integration are provided in Figure 1. The BCF provides health and social care partners with an opportunity to build on their shared achievements by extending the range of integrated services available to local people.

Figure 1. Example of Currently Integrated Services



Building on What We Have Achieved - where we will be tomorrow, 2014/15

In the course of 2014/15 we will review the integrated services that already in place and undertake the detailed planning that will underpin the enhancement of some and the launch of new initiatives focusing on frail older people, older people with dementia, end of life care, discharge planning and self-management. Work on shared information systems and joint assessment will also be carried forward. In all these areas we expect to see substantial progress in 2014/15 and new service options offered people.

More specifically, Haringey will take forward the development of:

a) the Integrated Community and Joint Reablement and Rapid Response services, provided 7 days a week, to maximise independence, prevent avoidable admissions to hospital and care homes, promote hospital discharges and provide carers with respite;

b) Telehealth and Telecare, provided 7 days a week, to enable people to remain in their own homes with an increased sense of security while providing carers with reassurance that their loved ones are being monitored;

c) our Community Development (Community Connects) scheme to build community engagement and volunteering for and with older people and people with disabilities to reduce social isolation, provide signposting and promote wellbeing;

d) the Mental Health Recovery and Dementia Pathways, provided 7 days a week, to help people remain independent within the community and functioning as successfully as possible while offering carers respite;

e) improved pathways and services, provided 7 days a week, for people with other long term conditions, such as diabetes and COPD;

f) the extension of Multi-Disciplinary Team working in the community, using teleconferences where teams review high risk cases, better identify individuals support needs and take proactive actions to avoid crises;

g) the Home From Hospital service, provided 7 days a week, to ensure that the homes of patients, especially those of people living alone, are ready to receive them on discharge;

h) the GP Networks, operating 7 days a week, around which integrated teams can offer a coordinated response to the health and social care needs of patients and service users.

i) A single point of access for people living in the community.

Building On What We Have Achieved - Where We Will Be Tomorrow, 2015/16

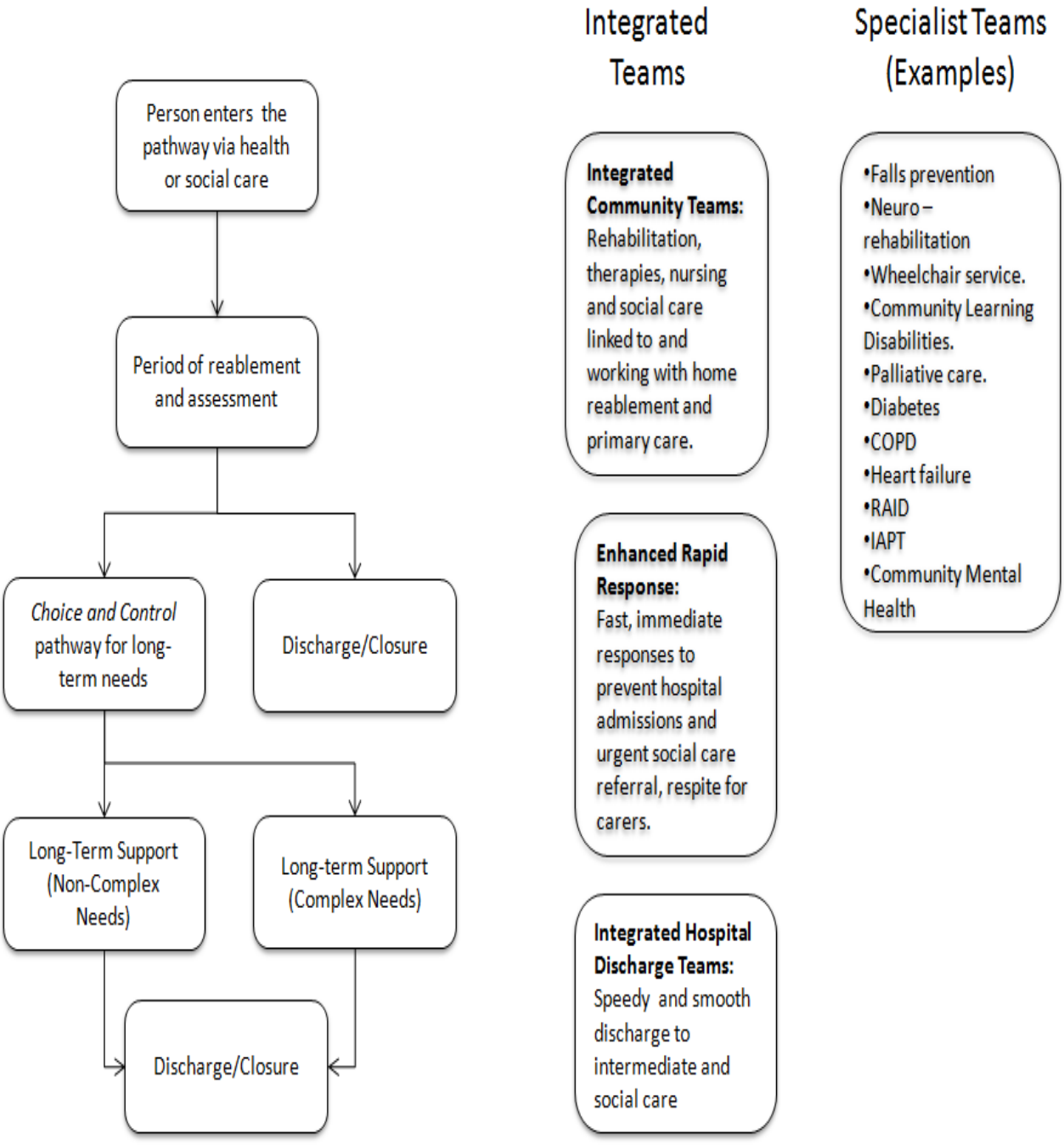
By the end of 2015/16 our default form of provision for most service users and patients will be will be integrated services. The proposed new service model is illustrated in Figure 2. The services described in this model will work alongside and complement those integrated services outline in Figure 1 with the key new service developments being:

a) ***Integrated Community Teams.*** These will have a core membership of social workers, community nursing staff and therapists and be based upon groups of GP practices.
b) ***A Single Point of Access*** (not shown in Figure 2) across health and social care

for people living in the community.

c) ***Integrated Hospital Discharge Teams*** to promote and make arrangements for the safe discharge of people from hospital to their own homes or other settings. An important aspect of the teams' work will be ensuring that discharge procedures work well for people, not just hospitals.
d) ***An enhanced Integrated Rapid Response Team*** to promote hospital discharges and prevent admissions by offering support in the home including respite to carers, at short-notice.
e) ***Specialist teams*** some of which will be integrated while other will not. These teams will operate on a pan-borough basis, supporting people with complex needs.

Figure 2. What the Proposed Model Looks Like.



Collectively the integrated services, referenced above, will to provide a whole systems response to intermediate care, hospital discharge, urgent care, and community rehabilitation. They will also contribute to prevention and ensure that people are cared for in their homes. The intention is for Haringey's residents to remain as independent as possible for as long as possible with a good quality of life.

Key Success Factors - Outline of Process

Haringey's approach to shaping integration is robust, but simple. It is informed by our understanding of the health and social care needs of residents, the views of providers and carers and is responsive to important local and national policy imperatives (e.g. personalisation, prevention and choice and control) that exist alongside the integration agenda.

The integration of health and social care will be managed through a transparent governance process, described below, in which work on integration is overseen by Haringey's Health and Wellbeing Board with reports also being submitted to the Governing Body of Haringey Clinical Commissioning Group and the Cabinet of Haringey Council. The overarching objective of this process is to ensure that integration provides people with better results and a better experience of health and social care. To provide constructive external challenge and ensure that the people who use services with influence over the process a Service Users and Carers Reference Group has been established and more will follow.

Key Success Factors – Cultural Change

Partners in Haringey recognise that the success of integration (the realisation of its aims and objectives) demands cultural change across the local health and social care system. This is the key to establishing ways of working that support integration and transformation. To work together well health and social care organisations must develop a deeper mutual understanding and appreciation of the contributions they each make to the health and wellbeing of local people. They must also understand that they are parts of one integrated local health and social care economy.

Therefore, the integration of health and social care demands behavioural change as much as it requires organisations to adopt different ways of working. A shared culture has to be developed that will allow the diverse professionals within health and social care to work together efficiently and effectively. To this end the development of integrated teams, joint assessments, case coordination across disciplines and multi-disciplinary training are cornerstones of this Integration Plan.

Key Success Factors - Enablers

Alongside the development of new services will be the development of new ways of working which will enable change. Previous discussion of the importance of cultural change provides a good example of such an enabler. However, this needs to be accompanied by changes to the health and social care infrastructure that will also enable change. In addition, a robust governance structure (see below) to superintend integration will be required, performance monitoring and the development of open information technology and information systems that support case coordination and joint assessment are vital. Work has commenced in all these areas while the construction of joint commissioning strategies, shared procedures and processes and the development of other enablers will be actively pursued.

Key Success Factors - End Points and Time Frames for Delivery

An overview of the overall estimated timeline to be followed by Haringey is provided below. Where services can be rolled-out earlier than the dates shown this will be done.

6.18 **August - December 2013:**

a) Establish programme management approach and structure to the delivery of the integration of health and social care in Haringey.

b) Brief the Health and Wellbeing Board and CCG Governing body on the implications of integrations and the requirements of the BCF.

c) Commence engagement process, including providers, service users, patients, carers and public.

d) Agree service model and associated commissioning intensions.

e) Agree BFC investment intentions.

f) Adopt NHS numbers as primary identifier and commence discussions on shared IT solution for better data sharing.

6.19 **January - March 2014:**

a) Conclude engagement process.

b) Draft local integration plan completed.

c) Detailed joint commissioning strategy produced.

d) Reports to Health and Wellbeing Board, Haringey's Cabinet and Haringey CCG's Governing Body seeking their support of the local integration plan.

e) Submit first and final drafts of parts 1 and 2 of Haringey's Integration Plan.

6.20 **April 2014 – March 2015**

a) Complete detailed planning to implement concepts developed during co-design phase to achieve our aim and objectives.

b) Monitor financial flows to evaluate financial impact of possible models on different providers and on total cost to commissioners.

c) Review and roll forward existing Section 256 winter pressures schemes.

d) Manage the implementation and benefits tracking for the newly integrated services that are "live" and developing our next tranche of joint commissioning plans in line with local needs and the whole systems approach.

e) Plans to build on existing integrated schemes finalised (estimated May 2014).

f) Enhanced Rapid Response Team launched (estimated Oct 2014).

g) Revised and updated delivery plan for 2015/16 agreed (estimated Feb 15).

h) Negotiate and present to Cabinet and the CCG's Governing Body the Section 75 agreements in readiness for the 2015/16 pooled budgets.

6.21 **From April 2015**

a) Single point of access launched (estimated Apr 2014).

b) Roll-out of Integrated Community Teams commences (estimated Apr 15).

c) Roll-out Integrated Hospital Discharge Teams (estimated Apr 15).

d) Introduce regular annual customer satisfaction surveying to develop our baseline for user experience.

Aligning Activity the JSNA, JHWS, CCG Commissioning Plan And Local Authority Plans For Social Care

As stated above, Haringey's approach to integration is premised on the strategic documents cited in section 1e. these have played a critical role in defining our service user cohort. Integrated health and social care will be available to all adults living in Haringey but, based on an analysis of the JSNA and GP Collaboratives profiles, we will prioritise frail older people and older people with dementia in 2014/ and adults (of all ages) with mental health needs in 2015/16. These are the groups for whom integration will have the greatest and most immediate impact.

Our approach to integration also resonates to the priorities of *Haringey's Health and Wellbeing Strategy* as it relates to *Improving Health and Wellbeing:*

- Prevention and early intervention
- Think family
- Choice, control and empowerment
- Partnership working

Finally, this plan reflects Haringey CCG's vision of: *"Enabling the people of Haringey to live long and healthy lives with access to safe, well co-ordinated and high quality services"* and pulls together the commissioning plans from across health and social care. There is no disconnect between the integration of health and social care in Haringey and other key strategic drivers. Integration is based on these drivers. It is responsive to and works with them.

d) Implications for the acute sector

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

Haringey CCG is the Lead Commissioner for North Middlesex Hospital. The majority of acute services for Haringey residents are provided by North Middlesex Hospital and Whittington Health Integrated Care Organisation, which also provides community services.

Since 2011/12 there has been detailed dialogue between commissioners and acute Trusts focused on schemes, initiated both by Trusts and by commissioners, to reduce unplanned hospital admissions and A&E attendances. Projected changes in activity patterns have been detailed in Quality Productivity and Prevention (QIPP) Programmes produced by the CCG. Transformation Boards have been in place since 2012, at the level of Chief Officer and CEO of partner organisations, to enable strategic focus on these programmes of work.

The impact of the Better Care Fund on the delivery of NHS services will be greater focus from a joint commissioning perspective on the linkages between:

a) NHS community services including; district nursing, community matrons, integrated care and therapies and community palliative care
b) Services commissioned by Local Authorities including: reablement, social care assessment, domiciliary care provision and residential care
c) Services provided by acute Trusts with a focus on reducing unplanned admissions such as ambulatory care, facilitated early discharge, older peole's assessment unit and day hospitals

The focus on pro-active case management, locality based services and 7 day/wk care will enable NHS savings to be achieved through:

a) Reduction in unplanned hospital admissions, releasing CCG spend and capacity within acute trusts. Acute capacity will translate into improved efficiency; improvements in performance on Referral to Treatment Time (RTT) and A&E 4hr target and reduced spend on ad hoc capacity to manage peaks in demand
b) Reductions in length of stay, representing savings to acute providers through improved efficiency, ability to manage peaks in demand and opportunities to repatriate patients
c) Reduced duplication of care provision if there are areas of ovelap between community and social care provision addressed through common assessment and co-location of service
d) Reduced outpatient demand: better care planning and an emphasis on enabling self-management will aim to streamline, where appropriate, the numbers of outpatient appointments that patients are attending

There is high value to both acute providers and to commissioners of delivering on the Better Care Fund with its focus on preventative community provision, enablement and maximising efficiency between community providers.

How will the savings be realised

a) Development of a shared transformation programme with identified savings targets for NHS commissioners and providers
b) Shared PMO monitoring of transformation schemes

Risks associated with failure to deliver:

a) Continued upward pressure on CCG budgets with rise in unplanned admissions
b) Continued risk to Trusts' ability to manage peaks in emergency attendances and admissions

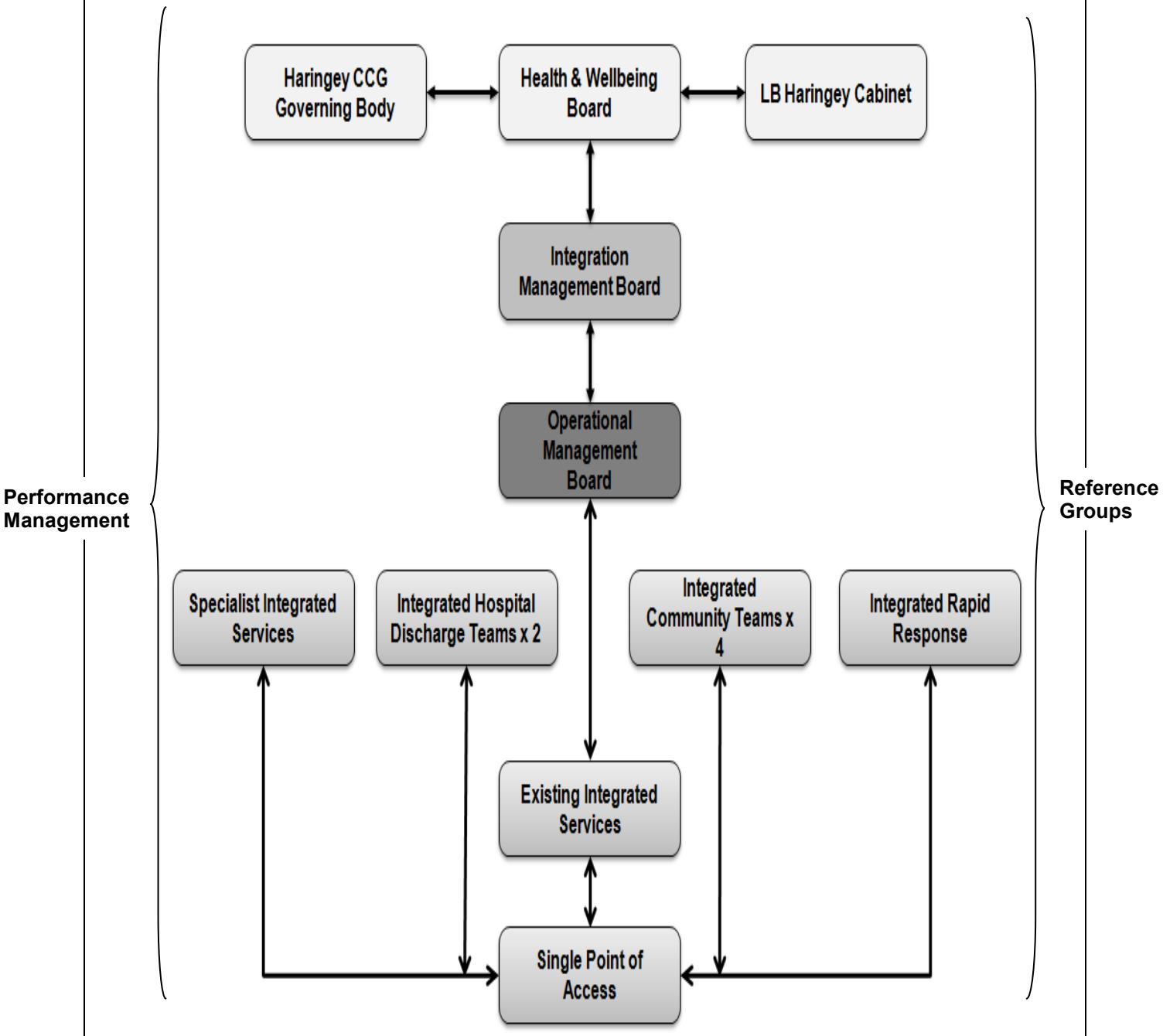
If the BCF Plan fails to deliver improvements some of the Fund may need to be used to alleviate the pressure on hospital services. Our plans in this regard are outlined in the contingency plan contained in part 2 of this Plan.

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

Figure 3, describes the governance structure that will be put in place to maintain oversight of the Integration Plan and to ensure that it delivers required outcomes. The key features of this structure are:

a) ***Executive oversight and policy direction:*** Executive oversight and policy direction will be the responsibility the Health and Wellbeing Board, the Governing Body of Haringey Clinical Commissioning Group and the Local Authority's Cabinet as the senior executive bodies of the partners responsible for the integration of health and social care in the Borough. Ultimate responsibility for the delivery of this Integration Plan rests with the Health and Wellbeing Board which has, in line with guidance, been briefed on the BCF. The chair of the Health and Wellbeing Board will receive briefings in the course of monthly meetings with senior managers and the Director of Public Health will assist the Health and Wellbeing Board to discharge its governance responsibilities.
b) ***Strategic oversight:*** The Integrated Management Board is the senior health and social care commission group responsible for maintaining strategic oversight of integration, including strategic commission. It will plan spend, set priorities, monitor the delivery of key outcomes and make recommendations to the executive level bodies (the Health and Wellbeing Board, the Cabinet and the CCG's Governing Body), as appropriate. It is also the forum to which problems, that cannot be resolved operationally, can be escalated for solution. The Integrated Management Board will meet on an, at least, monthly basis, receive regular monitoring reports and be co-chaired by the Chief Officer of the Clinical Commissioning Group and Director of Adult Social Care.
c) ***Operational oversight:*** The Operational Integration Board will maintain day-to-day oversight of business units (services). It will have an internal and external provider focus and work with them to identify and trouble shoot problems, ensure consistency of practice, promote learning and to progress service plans. In this way the Operational Management Board's oversight of micro commissioning will allow it to inform the strategic commissioning intentions framed by the Integrated Management Board.
d) **Business Units:** These are the integrated services providing people with care and support. They will be responsible for the services designated to them in keeping with good practice, policy and statutory requirements. Managers of business units will link to the Operational Management Board and provide such reports that may be reasonably asked of them.
e) ***Performance Management:*** This function will gather and coordinate performance data from the Business Units and Operational Management Board and distribute it across the entire governance structure. The data will provide that structure with the intelligence needed to inform decision making, policy formation, commissioning and the proactive management of integration. Performance Management will support excellence in data gathering and use by putting in place the systems and processes needed to capture and analyse required data, transforming it into useful information.

Figure 3. Oversight and Governance Structure



f) .***Monitoring performance:*** All business units including the single access point, will be responsible for collecting their own monitoring data with the assistance of performance management colleagues. This will promote organisational and professional learning and support continuous improvement.

g) ***Reference Groups:*** These groups, which will include Haringey's Older People's Forum, carers, third sector etc, will ensure that the voices of services users, patients, carers and other key stakeholders are heard and able to influence the governance and development of integrated health and social care provision in Haringey. They will also expose the thinking of statutory agencies to a valuable external constructive critical challenge. This will help quality assure our approach to integration while providing a conduit of communication between local people, professionals, the Third Sector and community organisations.

h) ***Two way communication:*** Good governance demands excellent and systematic two way communications between the different layers of the governance structure to 1) ensure information exchange: 2) enhance clarity of understanding across the system; 3) escalate issues and bring about their resolution, and; 4) avoid silo working.

It is important to note the role of Haringey Healthwatch, the representative of patients and the public, in the governance structure. Healthwatch will be in a position of significant influence as its Chief Executive is a member of the Health and Wellbeing Board and so able to feed into its discussions of the BCF and the ongoing integration of health and social care. It is envisaged that Healthwatch will also play an important role in establishing reference groups whose views it can represent to the Healthwatch and Wellbeing Board.

All parts of the governance structure are multi-disciplinary, bringing together an integrated health and social care approach to the governance of the Integration Plan and to the delivery of required outcomes. This is a pre-requisite for a vibrant integrated health and social care economy dedicated to delivering excellence to local people.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Haringey's agreed definition of protecting social care services consists of two inter-related parts. The first describes the criteria which must be met for a service to be eligible for protection. The second concerns the identification of those eligible services that will be protected.

Part 1. Eligibility Criteria.

The first part of the proposed definition of protecting social care services focuses on the selection of those criteria used to identify social care services which are eligible for protection. In this regard the *"Next Steps on Implementing the Integration Transformation*

Fund" guidance and that issued by the Department of Health to NHS England on 19 December 2012 on funding transfers from NHS to social care in 2013/14[1] are helpful. They both stress that, in 2014/15:

> *"The funding must be used to support adult social care services in each local authority, which also has a health benefit".*

Therefore, eligibility for protection is restricted to those social care services which health and social care partners jointly consider deliver health, as well as, social care benefits. As a result the protection eligible services is in the interests of both parties (i.e. health and social care) and builds on their considerable experience of section 256 transfers.

Part 2. Identifying Those Eligible Services To Be Protected.

The criteria, discussed above, identify social care services which may be protected but does not identify those that will be protected. This is to be the subject of negotiation and future decision taking over the life-time of the BCF but might include, for the purposes of illustration:

a) Intensive social care reablement services that promote independence, reduce reliance on health services and the need for long-term social care support.

b) Mainstreaming telecare/telehealth.

c) Care Home placements including step-up and step-down provision.

d) Rapid response services to promote hospital discharge and prevent avoidable admissions.

e) The maintenance of social work capacity in integrated teams.

f) Community development to build prevention through community engagement and volunteering for and with elderly and disabled people; reducing social isolation, signposting and preventative work.

Conclusion

A simple approach to the defining social care services that will be protected has been offered which is aligned with current section 256 practices and assures both the CCG and Council that they will be able to influence decisions about what services will actually be protected.

It is noted that, the national guidance relating to the Care Bill indicates that the BFC is to be subject to ringfencing to cover new duties and associated costs imposed on local authorities by the Bill. Advice received from the Local Government Association indicates that once we are informed of the impact ringfencing will have on Haringey the Integration Plan will have to be adjusted to reflect this in its section dealing with *'protecting social care services'.* This will not occur before the submission of the current iteration of the Plan.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

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

Haringey agreed definition of protecting adult social care services, as outlined immediately above, incorporates a description of the process that will allow those services to be protected to be identified and agreed between partners. This process is modelled on our tried and tested section 256 procedure.

b) 7 day services to support discharge

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

Haringey's Strategic Commitment To 7 Day Services

This Integration Plan reflects our commitment to the continuance of those 7 day week services already in place and to using the BCF to commission new and enhanced services. Our intention is to ensure that this 7 day week services are always available to support hospital discharges and can be accessed by people when they need them.

Our strategic commitment to the extension and normalisation of 7 day working is unambiguously demonstrated by the ownership taken of this plan by Haringey's Health and Wellbeing Board. Hosted by the local authority, the Board is a top level strategic body that brings together the NHS, public health, adult social care and children's services, including elected representatives and Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health. It is central to our vision and work to create a more integrated approach to health and social care.

The support given to 7 day week working by the Health and Wellbeing Board is backed-up by the support Haringey's Joint Health and Wellbeing Strategy gives to putting in place services that promote hospital discharges. For example, it commits local partners to:

"Continue to implement the new joint reablement pathway that offers intensive support after hospital discharge or prevents hospital admissions in patients with LTCs, particularly those who are vulnerable".

This statement makes no reference to, but is entirely consistent with 7 day working. Our Plan recognises that the intensity of support referred to can only be offered on whole week (i.e. 7 day) basis. This we are committed to providing.

Local Plans for Implementing 7 Services

Haringey will roll out 7 day services in two phases in the period of the BCF. These are:

- ***2014/15:*** Existing 7 day Section 256 services that support discharges will be funded and similar services receiving short-term winter pressures money will be mainstreamed (e.g. Home form Hospital, Rapid Response, Community Reablement). This will give Haringey a solid foundation of 7 day week services covering health and social care, enhancing our Rapid Response and Community Reablement Capacity.
- **2015/16:** A range of new 7 day week services will come on stream throughout the year, earlier where possible. These will include a Single Point of Access for people living in the community, Integrated Hospital Discharge Teams, and Integrated

Locality Teams. The whole week availability of these teams combined with the range of expertise they offer means that will prove an asset to patients, service users, their carers and professionals in hospital and community settings.

Haringey is confident that it can put into place a comprehensive 7 day week service offer and is determined to do so. This is an important national and local strategic imperative which Haringey is already delivering on. This Plan signals our intention to use the BCF to make 7 day week services the norm, available to all who need them and to reduce delayed discharges.

c) Data sharing

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

All health and care systems will use the NHS Number. To ensure the use of NHS numbers as primary identifiers Haringey Council (Adult Social Care) has issued instructions to all staff members requiring them to routinely record these numbers for all service users and has modified its Framework-I (service user database) interface to make this requirement clear. Use has been made of MACS to insert NHS numbers into the Framework-I record where these are missing.

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

N/A

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

In the procurement of new systems we are committed to looking for systems that have open API's and open standards but they are only one of a number of elements that would be assessed in our search for a value for money solution. We already operate a secure e-mail exchange via the GCSX network.

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

We are committed to ensuring that our Information Governance controls are of the highest standard. Overall responsibility for Information Governance rests with the Council's Information Governance Board, chaired by the Council's Senior Information Risk Officer. We have a comprehensive range of policies and procedures in place to ensure compliance with relevant legislation such as the Data Protection Act. Haringey Council's information security policies are certified to this standard to the ISO 27001 International Standard for Information Security Management. Haringey Council has a valid Information Governance Toolkit Assessment as is required to access the NHS N3 secure network.

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

Haringey employs the *Health Intelligence* risk stratification tool which predicts the likelihood of a person having an unscheduled hospital admission within the next 12 months. The algorithm used references a number of variables but the most important are age, types and number of long-term conditions (LTCs) and the number of A&E attendances and unplanned admissions in the past 12 months.

Table 1. Risk Stratification: Haringey CCG Patients Over 65 Years

Risk Level	Over 65 With an LTC (one or more)	Over 65 Without an LTC	Total over 65	% of patients 65 and over with one or more LTC	% of patient 65 and over without LTC
Very High Risk	876	35	911	96%	4%
High Risk	3,768	239	4,007	94%	6%
Moderate Risk	12,136	2,520	14,656	83%	17%
Low Risk	3,739	3,498	7,237	52%	48%
Total	20,519	6,292	26,811	77%	23%

Report run 3rd October 2013

Table 1 reflects Haringey's focus on understanding health risks of people aged over 65 years and shows that of this group 4,918 (18%) are classified as being at a very high or high risk of hospital admission in the next 12 months. With a further 14,656 (55%) of over 65's identified as being at moderate risk, up to 73% of this age group in Haringey are at some level of risk of admission.

However, while the risk stratification tool supports service planning and case finding it measures potential, not actual, demand for admissions. It is our intention to use the BCF to ensure that actual demand always falls short of potential demand. We will do this by enhancing and introducing services designed to prevent dependence, promote wellbeing and maintain people in the community while taking forward initiatives to squeeze down delayed discharges out of the system and reduce A&E attendances.

To translate this intention into meaningful action for individuals our basic service offer commits health and social care partners to ensuring that all who need a joint assessment and care plan receive them and that their care and support is coordinated by a named accountable professional. Working with Whittington Health we have already started developing a joint assessment and care planning tools and commenced discussions about the development of a shared IT system (a shared information portal) that will support the use of the tools and, more widely, joint working and the work of accountable

professionals.

Nevertheless, not everyone identified as being at very high, high or moderate risk will require a joint assessment/care plan or need an accountable lead professional. To estimate those who will the number of Haringey's residents, requiring large care packages (i.e. packages costing > £150 or >21 hours per week) has been identified to give an annualised total of, approximately, 700 adults and older people which is equivalent to 0.4% of the local population over 19 years of age.

A pragmatic approach will be taken to the identification of accountable lead professional which is defined as a function, not as a discrete role, that can be performed by any member of an integrated team. The allocation of this function will be dependent on a combination of the needs of the service user or patient, the predominant type of service required (health or social care) and the views of the individual and his/her carers. This approach is modelled on that which has been taken by Haringey successful Learning Disability Partnership.

4) RISKS

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

It is acknowledged that whilst the BCF represents a tremendous opportunity to integrate and transform health and social care provision for the benefit of local people it also carries risks. These are listed in the risk log, below, together with their treated RAG ratings and mitigating actions. No risks are rated red, which would have the potential to seriously compromise delivery of the Integration Plan. All risks are rate amber and while all require attention none are considered insurmountable.

The risk log is a living document. It will be jointly managed and shared by social care partners through the programme management structure, which will implement integration. This will allow all risks will be kept under regular review and ensure that existing, new and emergent risks are actively managed to minimise the impact they might have otherwise have on the realisation of the benefits of integration.

Risk	Risk Rating (Treated)	Mitigating Actions
IF delays occur in launching BCF funded services THEN targets may not be achieved and outcomes realised.	Amber (Medium)	We will create and appoint to a joint (CCG and LA) post to provide the dedicated project management capacity need to plan and coordinate the launch of services.
IF political and organisational will across partner agencies cannot be aligned THEN integration will not take place.	Amber (Low)	We will brief and ensure that the HWB support proposals for integration. Health and social care leaders to champion and provide energetic support for integration. Work on integration to be joined-up across health and social

		care.
IF funding is not available to fund double running THEN gaps in service provision may appear as the transition is made to new integrated ways of working	Amber (Medium)	We will ensure that commissioning plans for new integrated services are fully funded and take into account decommissioning costs.
IF behavioural and cultural changes do not accompany efforts at integration THEN service provision across health and social care will not be seamless.	Amber (Low)	We will bring diverse staff groups together to build a new integrated professional identity reinforced by physical collocation, joint management structures and shared training.
IF we shift resources to fund new integrated services THEN current service providers, particularly in the acute sector may be destabilised	Amber (Medium)	• Our current plans are based on engagement with providers who are, broadly, supportive of the proposals to integrate health and social care in Haringey. • The development of our plans for 2014/15 and 2015/16 will be conducted within a whole system approach allowing for a holistic view of impact across the provider market with an emphasis on jointly defining the ultimate destination of transformation.
IF the BCF runs out before integration is completed THEN we will be unable to complete this task without more resources and disrupting provision to patients and service users.	Amber (Low)	We will impose strict financial monitoring to ensure the best and most efficient use of Haringey's BCF allocation
IF the introduction of the Care Bill results in a significant increase in the cost of care provision from April 2016 onwards that is not currently fully quantifiable locally THEN the sustainability of current social care funding and plans will be impacted upon.	Amber (High)	• We undertake an initial impact assessment of the effects of the Care Bill and will continue to refine our assumptions around this as we develop begin to deliver integrated services • We believe there will be potential benefits that come out of this process, as well as potential risks.

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Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority #1	Yes	5,066,000	6,654,000	9,079,200
CCG #1	Yes	1,371,430	11,407,000	12,996,723
BCF Total		**6,437,430**	**18,061,000**	**22,075,923**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)	527,862	527,862
	Maximum support needed for other services (if targets not achieved)	527,862	527,862
Outcome 2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Planned savings (if targets fully achieved)	177,476	177,476
	Maximum support needed for other services (if targets not achieved)	177,476	177,476
Outcome 3 Delayed transfers of care from hospital per 100,000 population	Planned savings (if targets fully achieved)	94,110	94,110

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Older People and Dementia Pathway	London Borough of Haringey	**475,000**		131,966		**475,000**		*263,931*	
Mental Health Recovery Pathway	London Borough of Haringey	**580,000**				**580,000**			
Winterbourne Response	London Borough of Haringey	**50,000**				**50,000**			
Joint Commissioning	London Borough of Haringey/CCG	**135,000**				**200,000**			
Development and Enabling (Programme Management, Facilitating Integrated Locality Team Development, Initiating Integrated Care Planning, Staff Development, Scoping of Single Point of Access)	London Borough of Haringey/CCG		**225,000**			**150,000**	*335,000*		
Integrated Locality Teams (Re-ablement, District Nursing, Community Matrons, Locality based social work teams)	London Borough of Haringey/Whittington Health			61,230		**10,744,200**		*61,230*	
Rapid Response - 7 days/wk	Whittington Health	**340,000**		158,178		**500,000**		*206,141*	
Step Down Care	London Borough of Haringey	**625,000**							
Reablement	London Borough of Haringey	**2,450,000**		88,738				*177,476*	
Reducing Delayed Discharges from hospital (Step-Down Care, Integrated Hospital Discharge Teams, Home from Hospital, Social Workers based in Hospitals 7 days/wk)	London Borough of Haringey	**150,000**		58,580		**3,857,904**		*94,110*	
GP Case Management and 7 day access	CCG	**1,371,430**		158,178		**1,371,430**		*206,141*	
Integrated End of Life Care Service	Whittington Health					**1,379,389**			
Additional Third Sector Investment	London Borough of Haringey	**26,067**				75,000			
Promotion of self management, measurement of patient engagement/activition, community development (Community Development Workers and Good Neighbours)	London Borough of Haringey	**120,000**		131,966		**770,000**		*263,931*	
Community Capacity Grant Schemes	London Borough of Haringey					*639,000*			
Promoting independence for people with disabilities	London Borough of Haringey					949,000			
Total		**6,322,497**	***225000***	***788835***	***0***	***21,740,923***	***335000***	***1,272,960***	**0**

Note: benefits are put against the main contributor, but all schemes benefit

Association

England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

1. Permanent Admissions of Older People: This target will be achieved through increased and enhanced reablement services, the development of Integrated Health and Social Care Community Teams (holistic provision), which will be aligned to and work with Haringey's GP Collaboratives, and developing our dementia pathway. In addition, investment in building community capacity will surround frail older people with local networks of support that will help sustain their independence, thereby, delaying or preventing the need for institutional care. We also intend to investment in falls prevention and Rapid Response to, respectively, address a major cause of permanent admissions and ensure older people have the help they need when they need it.

To measure measuring performance against this metric we will apply the following algorithm:

• Description: rate of council-supported permanent admissions of older people to residential and nursing care.

• Numerator: Number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over). This is from the ASC-CAR survey.

• Denominator: Size of the older people population in area (aged 65 and over). This is the ONS mid-year estimate.

2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services: Haringey's BFC Plan proposes a significant additional investment in our already successful Integrated Reablement Services. Our experience of reablement shows that most people who receive this service require less support than otherwise would have been the case. Supplementing reablement services will be arranged of other supports purchased through the BCF. For example, our Home From Hospital service ensures that the homes of older people living alone are ready to receive them on discharge from hospital, whilst our use of the third sector will be expanded to provide a range of flexible and highly personalised support that will help people maintain their independence as long as possible.

To measure measuring performance against this metric we will apply the following algorithm:

• Description: The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.

• Numerator: The number of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital. This excludes those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months.

• Denominator: The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. Alongside this measure is the requirement that there is no decrease in the proportion of people (aged 65 and over) discharged alive from hospitals in England between 1 October 2012 and 31 December 2012 (including all specialities and zero-length stays) that are offered this service.

3. Delayed transfers of care from hospital per 100,000 population (average per month): Reducing delayed transfers of care represents a challenge and we will use the BCF to enhance our Rapid Response service, invest in step down and Integrated Hospital Discharge Teams to ensure that the discharge processes works smoothly, that patients are provided with a much better experience and delays are reduced to a minimum. The Integrated Hospital Discharge Teams will be responsible for ensuring that all parts of the discharge process work together. Once again the Home From Hospital service has an important part to play in realising our ambitions for the BCF; it will support discharge by making sure that people's homes are ready to receive them.

To measure measuring performance against this metric we will apply the following algorithm:

• Numerator: The total number of delayed transfers of care (for those aged 18 and over) for each month included

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Using national metric

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

1. Permanent admissions to care homes: data collected as part of national ASCOF framework.
2. Proportion of older people still at home 91 days after discharge: data collected as part of national ASCOF framework
3. Delayed transfers of care: data collected as part of national ASCOF framework
4. Avoidable emergency admissions: data collated as part of NHSOF
5. Injuries due to falls: data collected as part of the Public Health Outcome Framework

For each metric the same assurance process applies and consists of the following:

1, The development of a commissioning strategy which encompasses contracting. All contracts will contain SMART specifications whose delivery will be monitored and measured.

2, The appointment to joint commissioning and data analyst posts that will be responsible for developing quality assurance and performance measurement tools. These posts will work with providers to ensure that they have in place the processes required to gather required performance data. Our expectation is that providers will return reports on, at least, a quarterly basis.

3. The joint commissioning and data analyst posts will aggregate this information to produce performance reports. Performance monitoring reports will be fed into the governance structure (see Part 1 of Haringey's BCF Plan) where it will be presented to the Operational Management Board, the Integrated Programme Management Board, Haringey's Cabinet, the Governing Body of our

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	458.2	N/A	396
	Numerator	106		95
	Denominator	23,134		23,967
		(April 2012 - March 2013)		(April 2014-March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services RL to look into to get basic numbers	*Metric Value*	88.4	N/A	94
	Numerator	76		81
	Denominator	86		86
		(April 2012 - March 2013)		(April 2014-March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	255	246	238
	Numerator	4182 (over 8 months)	4,612	2,967
	Denominator	204,609	207,901	207,901
		(April 2013 - November 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	1564.2	1501.7	1447
	Numerator	4050	3942 (full year effect)	3848 (full Year effect)
	Denominator	258912	262506	265929
		(April 2012 - March 2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		National metric to be used (currently under development)	N/A	
Social care related quality of life				
Proportion of people who use services who have control over their daily life				
Injuries due to falls in people aged 65 and over	*Metric Value*	461		431.0
	Numerator	38.4		35.9
	Denominator	27765		27765
		(April 2012 - March 2013)		(April 2014-March 2015)

Note: DETOCs based on miod-point of bed day costs beyond the trim point

Note: We will continue to refine our figures as more guidance and data is released

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Haringey Council

APPENDIX 2. Local *'I'* and *'We'* Statements

'I' and 'We' Statements

A series of locally generated *'I'* and *'We'* statements are juxtaposed to compare what service users and patients want and need (the *'I'* statements) with responses agencies feel they must make (the *'We'* statements). For ease of reference both sets of statements have been organised in terms of a series of overlapping summary themes.

Theme 1. Information	
***'I'* Statements**	***'We'* Statements**
• I want) good high quality signposting.	• (We will) make sure that if someone calls our agency they will get through to the right person with one transfer (we will minimise *'hand-offs'*)
• (I want) information that is regularly updated and remains current.	• (We will) be informative about services available for service users.
• (I want) the people who provide support have access to good information.	• (We will) ensure we have access to up-to-date information on local services.
• (I want) information the enables choice.	
• I want information on what services are available for people	
• I want clear pathways.	
• (I want) good information about eligibility.	
• I want clear governance and accountability – good information about who is responsible for what.	
• (I want) my information to be shared when it needs to be and protected when it needs to be.	
• (I want) to be supplied with contact numbers.	
• (I want) clear information available as and when needed.	
Theme 2. Control	
***'I'* Statements**	***'We'* Statements**
• I want to have professional to have in-depth knowledge of my needs and future and to work with me.	
I want to be given the confidence to cope with my situation, not to be	

Haringey Council

harassed and for somebody to be there when I need them.	
Theme 3. Services That Work Together As One Team	
'I' Statements	***'We' Statements***
• (I want) a system that really works with everyone who is part of it all working together.	• We will give) care co-ordination a high priority.
• (I want) better communication between agencies.	• (We will) employ suitably qualified managers who have a collective vision of what integration means.
• (I want) a common assessment.	• (We will) have one computer system.
• (I want) a clinical team that listens to the provider.	
• (I want) to have confidence that my care team is well managed.	
• *(I want) people to speak to each other – "pick-up the old telephone instead of unnecessary paperwork".*	
Theme 4. Continuity	
'I' Statements	***'We' Statements***
• (I want) single responsible person managing my care plan.	• (We will) ensure that that one person is responsible for each service user (e.g. a keyworker).
• (I want) continuity of care.	• (We will) provide continuity of care.
	• (We will) have one person to do assessments.
Theme 5. Accessible Services	
'I' Statements	***'We' Statements***
• I want) easy access (to services).	
• (I want) a single point of access.	
• (I want) clearer pathways.	
• (I want) access to good quality services (e.g. new social workers visits every 2 weeks and another never seen).	
• (I want) someone to help me navigate my way.	
Theme 6. Wellbeing	
'I' Statements	***'We' Statements***
• I want) befriending.	
• (I want) to see people, to have companionship, to have someone to talk to.	
• (I want) to live in a safe environment – a home I know and understand.	

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• (I want) drop-in centres.	
• (I want) to meet others.	
• (I want) to be socially included.	
Theme 7. A Clearly Defined Service	
***'I'* Statements**	***'We'* Statements**
• (I want) a responsive service.	• (We will) ensure that one authority is accountability (relates to need for accountability to be clear).
• (I want) a well defined support	• (We will) integrate the NHS – very fragmented.
Theme 8. A Personalised Service That Respects Dignity And Promotes Choice And Control	
***'I'* Statements**	***'We'* Statements**
• (I want) a high quality.	• (We will) focus on the individual need, not costs – we will be needs led.
• (I want) a reliability.	• (We will) be bold, innovate and challenge the stigmatisation of older people.
• (I want) respect.	• (We will) be flexible in outlook, open minded and not *'tick boxes'*
• (I want) dignity.	
• (I want) choices (e.g. food, environment, staff).	
• (I want) kindness.	
• (I want) services that are responsive to people's needs.	
• (I want) timely diagnostic service and interventions.	
• (I want) service to be informed (about me).	
• (I want) my experience valued.	
• I want to be asked what I want.	
• (I want) support, professional advice and advocacy to manage personalisation.	
• (I want) to feel *'equal'*, to feel valued.	
• (I want) to be treated with dignity and recognised as a person	
• (I want) good basic customer care e.g. a smile, greeting, eye contact as I enter the ward, to be treated decently.	
• (I want) services that reflect my	

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needs and maintain my dignity.	
• (I want) to be treated with compassion and dignity.	
• (I want) my care to feel personal.	
• (I want) to feel satisfied and keep happy, safe and worthy.	
Theme 9. Advocacy	
***'I'* Statements**	***'We'* Statements**
• I want) investment in advocacy. Need good advocates, but currently mainly voluntary. Need to be salaried to get consistency and quality. If you do not have advocacy will go to legal aid – another cost on government/taxpayer.	
Theme 10. Prevention	
***'I'* Statements**	***'We'* Statements**
• (I want) preventative services.	• (We will) invest in prevention.
• (I want) timely help to avoid crises.	
Theme 10. Competence	
***'I'* Statements**	***'We'* Statements**
• (I want) social workers who really know what they are doing and who are sufficiently qualified.	• We will) learn from failure
• (I want) good managers/training.	• (We will) work harder and be dedicated.
• (I want people to) stop, reflect and take stock of who we are and where we are going.	• (We will) employ suitably qualified managers who have a collective vision of what integration means.
• (I want) robust monitoring and review processes in place to follow the tendering and commissioning stage.	• (We will) stop and take stock of where we are and where going. Frontline staff are overwhelmed by the pace of change.
Other	
***'I'* Statements**	***'We'* Statements**
• (I want) transport as part of integration	• (We will give) Adult Safeguarding the importance it deserves.
• (I want) better use of telecare and telehealth I want better use of telecare and telehealth.	

	Outcome 1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	**Outcome 2** Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Outcome 3** Delayed transfers of care from hospital per 100,000 population (average per month)	**Outcome 4** Avoidable emergency admissions (composite measure)	**Outcome 5** Patient / service user experience	**Outcome 6.** Injuries due to falls in people aged 65 and over
Integrated Locality Teams	X	X	X	X	X	X
Hospital Based Admissions Avoidance (Ambulatory Care, Older People's Assessment Unit, UCC)	X	X	X	X	X	X
Reducing Delayed Discharges from hospital (Integrated Hospital Discharge Teams, Home from Hospital, Social Workers based in Hospitals 7 days/wk)			X		X	
Integrated End of Life Care Service					X	
	Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**	**Outcome 5**	**Outcome 6.**

	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Delayed transfers of care from hospital per 100,000 population (average per month)	Avoidable emergency admissions (composite measure)	Patient / service user experience	Injuries due to falls in people aged 65 and over
RAID				X	X	
Older People and Dementia Pathway	X		X	X	X	
Mental Health Recovery Pathway			X	X	X	
Joint Commissioning	X	X	X	X	X	X
Winterbourne Response					X	
Additional Third Sector Investment	X	X	X	X	X	X
Information Technology & Better Data Sharing	X	X	X	X	X	X
Step Down Care			X			
GP Case Management and 7 day access	X	X	X	X	X	X
Psychiatric Liaison Service				X	X	
Dementia Services	X		X	X	X	
Reablement	X	X	X	X	X	X
	Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**	**Outcome 5**	**Outcome 6.**

	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Delayed transfers of care from hospital per 100,000 population (average per month)	Avoidable emergency admissions (composite measure)	Patient / service user experience	Injuries due to falls in people aged 65 and over
Community Development Workers + expansion of Good Neighbours scheme	X	X		X	X	
Mental Health Recovery Pathway				X	X	
Home From Hospital			X		X	
Information Technology & Better Data Sharing		X		X	X	
Single Point of Access				X	X	

The Table is intended to provide a guide to the relevance of the proposed investments of the BCF to the delivery of key outcomes, as expressed by the metrics attached to Haringey's Integration Plan. It will be noted that all proposed investments, with the exception of the investment in Winterbourne response, are cross-cutting, contributing to the delivery of more than one outcome. However, this investment will contribute to reducing the permanent admission of younger adults with learning disabilities to institutional care and support them to live independently in the community.

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Better Care Fund (BCF): Integrating Health & Social Care in Haringey

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What Is The BCF

- The BCF:
  - is a single pooled budget for health and social care services to work more closely together in local areas, based on local 'Integration Plan's agreed between CCGs and local authorities;
  - is worth £3.8bn nationally; and
  - can only be accessed when local Integration Plans are in place **and** agreed by Ministers.
- The Conditions
  - Plans to be jointly agreed
  - Agreement reached on protecting adult social care
  - 7 day services to support hospital discharges
  - Data sharing
  - Joint assessments and accountable lead professionals
  - Agreement on consequential impacts for the acute sector

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The Government's Aims

- The Government's stated aims are for 'transformational change'. It wants the BCF to:
  - bring resources together to address immediate pressures on services, and:
  - lay foundations for a much more integrated system of health and care delivered at scale and pace.
- Anticipated benefits include:
  - better outcomes and experiences of services for people;
  - increased efficiency, economy and effectiveness across health and social care, and;
  - increased sustainability of health and social care provision.

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Timescales

- 26th June 2013 – BCF announced in the Spending Round.
- Dec 2013 – Local BCF allocations released.
- 30th January CCG Governing Body will consider Haringey Integration Plan.
- 11th February – HWB and Cabinet will consider the Integration Plan.
- 14th February – First cut of the Integration Plan submitted to NHS England for initial scrutiny.
- 4th April – Final cut of the Integration Plan submitted to Ministers for approval.
- 1st April 2015 – Sect 75 Pooled Budget Agreement to be in place.

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Where we are today – the Current Experience of Care

"We are sick of falling through gaps. We are tired of organisational barriers and boundaries that delay or prevent our access to care. We do not accept being discharged from a service into a void. We want services to be seamless and care to be continuous".

The future - defining Integrated Care

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

Quotes from 'National Voices'

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Adults Health Scrutiny

Cabinet is asked:

- To be aware and agree that under the terms of the BCF the Council will be transferring £1,588,000 into the Fund in 2015/16. This consists of the Disabled Facilities Grant (£949,000) + Social Care Capital Grant (£639,000).
- To see and agree the overall Plan for the BCF.

CAB is asked:

- To understand the overall aims and direction of integration.

The Implications of not submitting the Plan are:

- Access to the BCF denied.
- Loss of the opportunity to integrate health and social care and to put in place improved and more cost effective services for local people.
- Failure to deliver an important national policy imperative that has all party backing.
- Reputational, economic and financial risks/damage.

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The Vision and Aims of the Integration Plan

Vision

- *"We want people in Haringey to be healthier and to have a higher quality of life for longer. We want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible."*

Aims

- Seamless Care and Support
- Person Centred and Personalised Services
- A Caring Community
- The removal of organisational barriers
- The maximisation of Health and Wellbeing

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Scope

- Integrated services in Haringey will initially:
  - be available to all adults who require them;
  - prioritise frail older people and older people with dementia in 2014/15, and;
  - extend priority to adults (of all ages) with mental health needs in 2015/16.

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Haringey's BCF Allocation

- £957k in 2014/15 (As a financial transfer from Health to LB Haringey)
- £18,061,000 in 15/16 (To be paid into a LB Haringey/Health pooled budget)
- The BCF is NOT a windfall. There is NO new money.
- In 2015/16 the CCG will make a transfer of £16,473,000 into the Fund, creating challenges for health partners.

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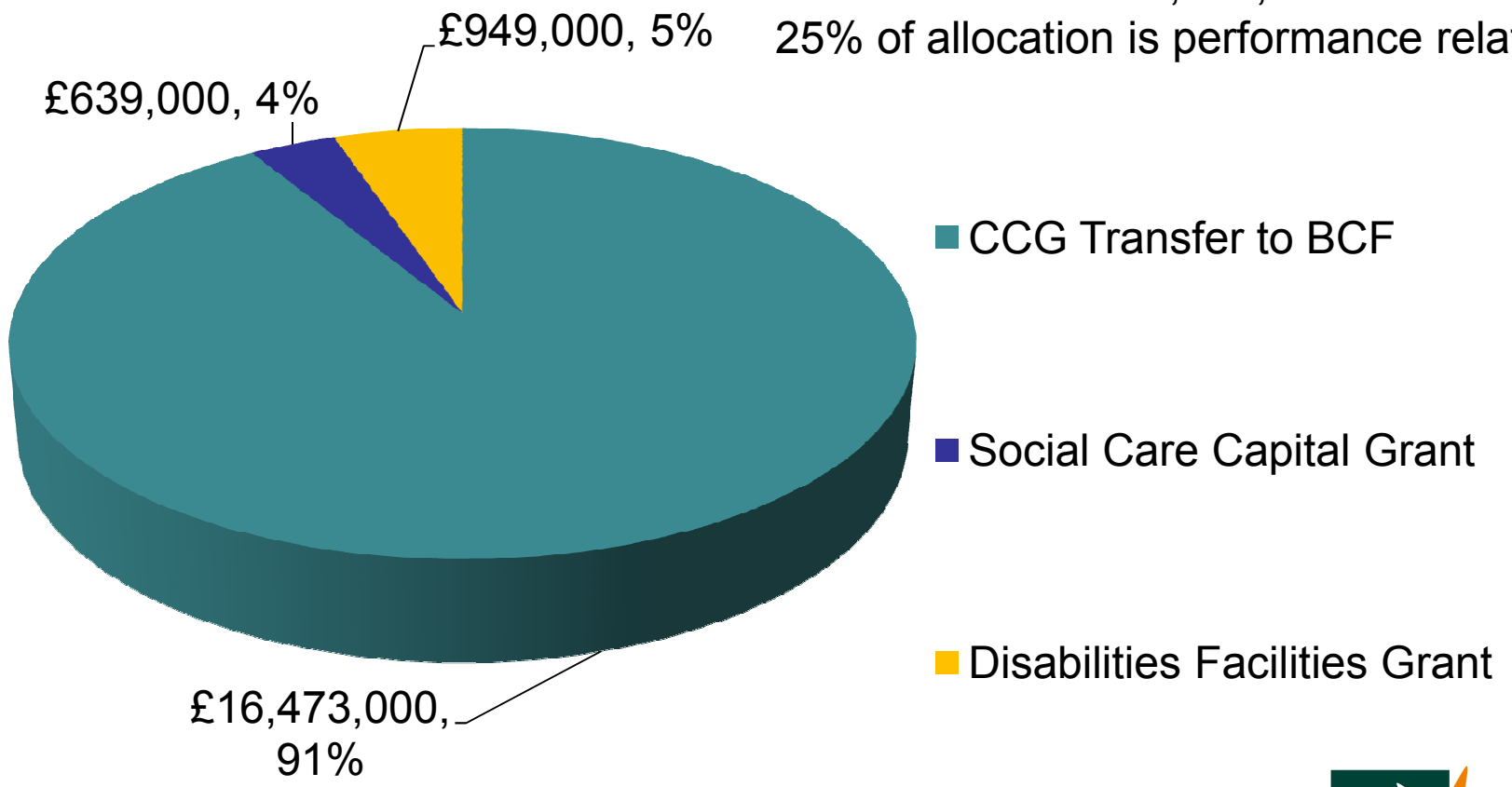
Haringey's Allocation - The Funding Streams 2015/16

Total 2015/16 = £18,061,000
25% of allocation is performance related



Note: 100% of the contribution to the BCF in 2015/16 is from health amounting to £957k

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What will be different?

- People will receive a joined-up service from health and social care professionals, centred around their individual needs.
- Services will be easier to access and available 7/7.
- Service users will be provided with better information and supported in exercising choice and control.
- Integrated teams will become the norm, breaking down professional barriers.
- People will not have to repeat their stories to a succession of services and professionals.
- An increased role for the Third Sector.
- Increased effectiveness and efficiency.

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Community Engagement

- Our commitment is to co-production.
- Our approach to integration is built on community engagement – 211 people have contributed to the Integration Plan.
- There will be continuing community engagement throughout the life of the BCF – a Reference Group has already been established, others will follow.
- We will survey people's satisfaction with their health and social care services.
- We will work with community groups to deliver services and grow their contribution.

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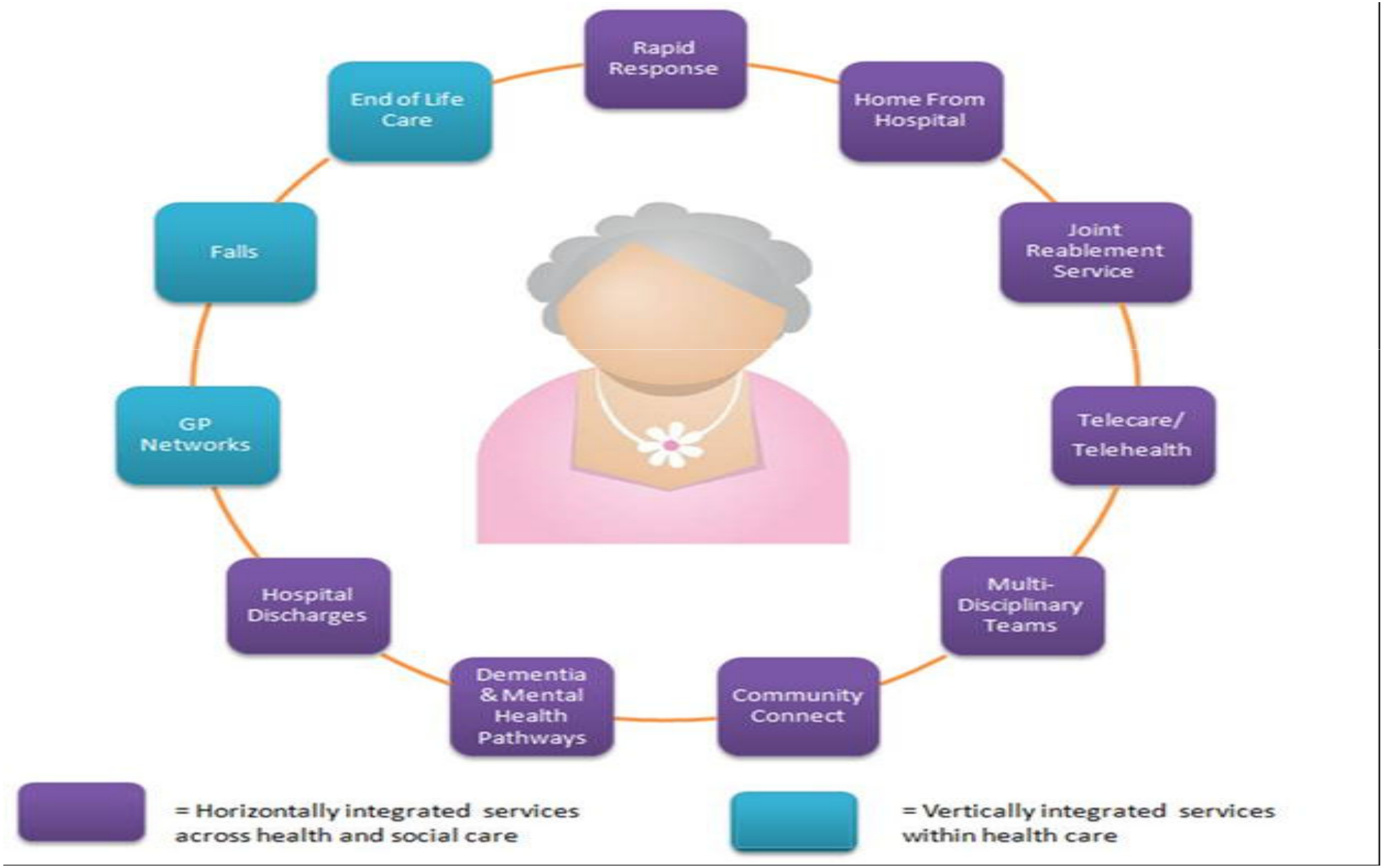
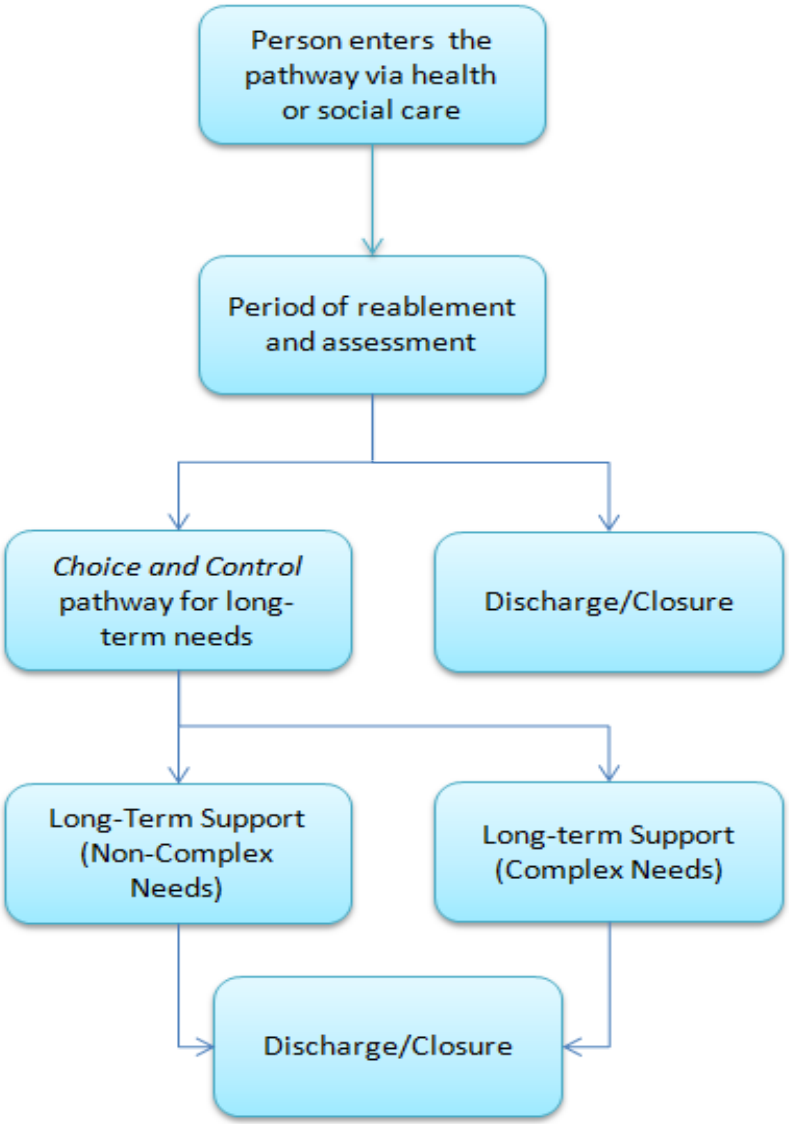
Where We Are Today: Services That Are Already Integrated



Where We Will Be Tomorrow – 2015/16



Integrated Teams

Integrated Community Teams: Rehabilitation, therapies, nursing and social care linked to and working with home reablement and primary care.

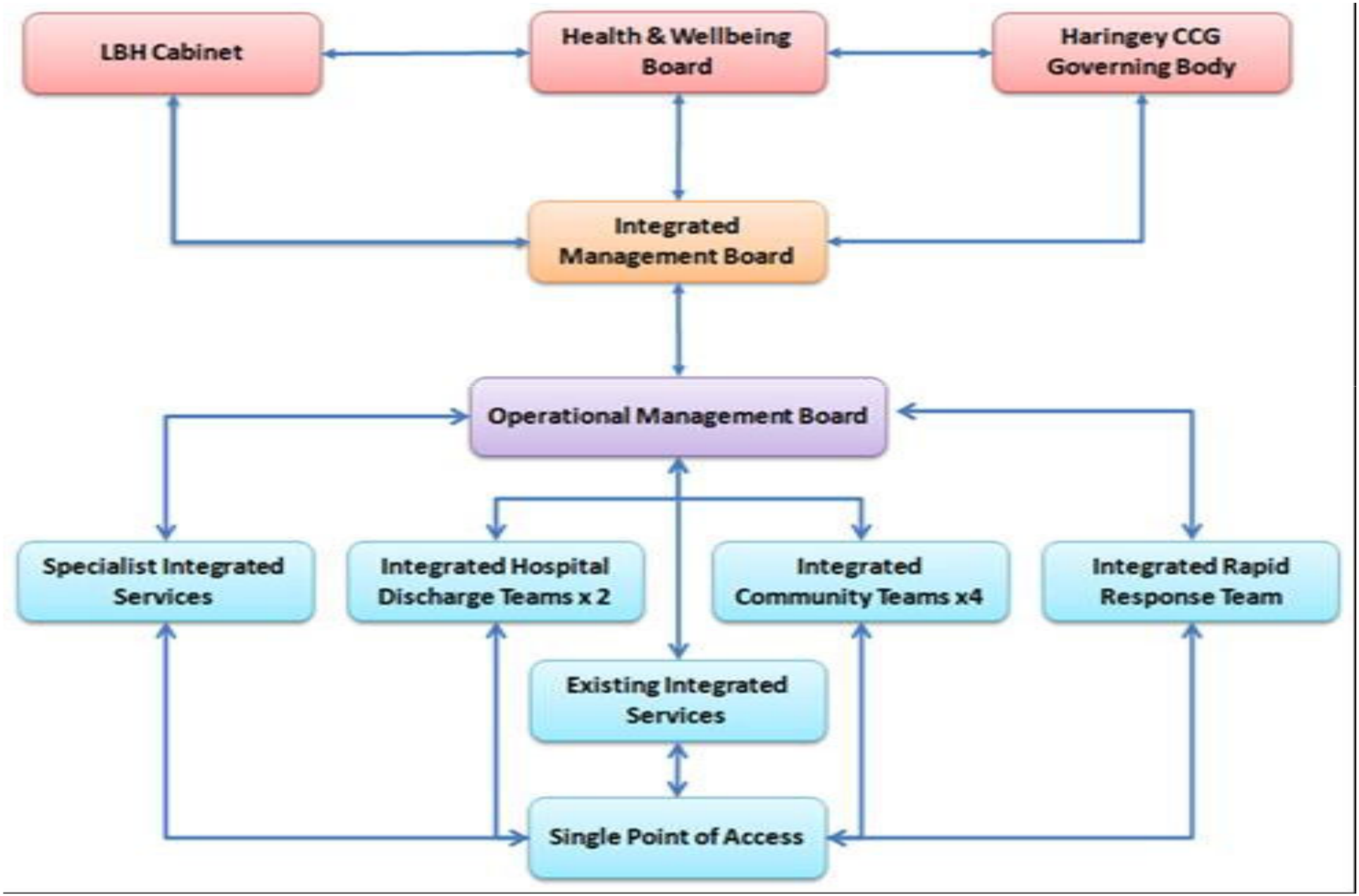
Enhanced Rapid Response: Fast, immediate responses to prevent hospital admissions and urgent social care referral, respite for carers.

Integrated Hospital Discharge Teams: Speedy and smooth discharge to intermediate and social care

Specialist Teams (Examples)

- Falls prevention
- Neuro – rehabilitation
- Wheelchair service.
- Community Learning Disabilities.
- Palliative care.
- Diabetes
- COPD
- Heart failure
- RAID
- IAPT
- Community Mental Health

Governance


LBH Cabinet
Health & Wellbeing Board
Haringey CCG Governing Body
Integrated Management Board
Operational Management Board
Specialist Integrated Services
Integrated Hospital Discharge Teams x 2
Integrated Community Teams x4
Integrated Rapid Response Team
Existing Integrated Services
Single Point of Access

Exciting But Challenging: Some Issues

- **Cultural Change:** The success of integration demands cultural change across the local health and social care system.
- **Implications for acute providers:** Loss of income and, potentially, destabilisation of services.
- **Commissioning:** We'll need a joint health and social care commissioning strategy, and associated governance.
- **Decommissioning:** As there is no new money to invest in new services, some existing services will be decommissioned. This will involve hard choices, especially with respect to hospital services. The challenge is to do this while maintaining continuity of provision.
- **Putting in place the enablers of transformation:** The development of new ways of working and changes to infrastructure (eg IT).
- **Performance:** Targets must be hit to obtain the performance related element of the BCF.
- **Making Integration and Whole Systems Transformation Happen:** Programme management and organisational capacity.

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Agenda Item 10

NHS
Haringey
Clinical Commissioning Group

MEETING:	Haringey Clinical Commissioning Group
DATE:	20th February 2014
TITLE:	Primary Care Access
LEAD DIRECTOR/ MANAGER:	Sarah Price
AUTHOR:	Michael Hepworth
CONTACT DETAILS:	020 3688 2765

SUMMARY:

Across Haringey primary care there is variability in quality and outcomes for patients. Significant financial and patient demand pressures on all sectors of the NHS have resulted in a need for efficiency gains and greater flexibility in the models of care provided. It is generally acknowledged that the current model of general practice is constrained when considering how to improve the provision of out-of-hospital care.

Clinical Commissioning Groups are responsible for designing local health. They will do this by commissioning or buying health and care services including elective hospital care, rehabilitation care, urgent and emergency care, most community health services, mental health and learning disability services. Clinical Commissioning Groups share a 'joint responsibility' with NHS England in improving the quality of primary care. NHS England have the responsibility of managing the primary care contracts, ensuring that practices are compliant with and adhere to the key performance indicators and the CCG have a developmental role in supporting the practices to change/improve the service they offer.

Haringey Clinical Commissioning Group is made up from 52 GP practices of varying size, ranging from single handed practices to large multi-disciplinary practices. The constituent practices and CCG have long recognised the need to balance need, demand and supply. The diversity of the local population, combined with the proximity of acute settings have meant that certain barriers to access in primary care have resulted in unmet need, inappropriate use of acute care services in unscheduled encounters and poor patient satisfaction.

SUPPORTING PAPERS:

N/A

RECOMMENDED ACTION:

The [Committee/group] is asked to:
N/A

Objective(s) / Plans supported by this paper:

Audit Trail: N/A

Patient & Public Involvement (PPI): N/A

Equality Analysis: N/A

Risks: N/A

Resource Implications: N/A

Primary Care Access

1. INTRODUCTION

Across Haringey primary care there is variability in quality and outcomes for patients. Significant financial and patient demand pressures on all sectors of the NHS have resulted in a need for efficiency gains and greater flexibility in the models of care provided. It is generally acknowledged that the current model of general practice is constrained when considering how to improve the provision of out-of-hospital care.

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Haringey Clinical Commissioning Group is made up from 52 GP practices of varying size, ranging from single handed practices to large multi-disciplinary practices. The constituent practices and CCG have long recognised the need to balance need, demand and supply. The diversity of the local population, combined with the proximity of acute settings have meant that certain barriers to access in primary care have resulted in unmet need, inappropriate use of acute care services in unscheduled encounters and poor patient satisfaction.

2. YEAR ONE

The CCG has worked with a number of our practices to help them identify ways to improve their capacity, access, productivity and management. For example, Haringey CCG has invested in two initiatives Doctor First and Productive Primary Care which have been piloted in a number of our practices. A key element of these initiatives is to focus on helping practices to look at the way all appointments are scheduled, and what practices could do to improve? The pilot sites have shown significant improvements in terms of ease of access in terms of booking an appointment. The Dr First sites, schedule phone consultations throughout the day when patients are phoned back by the

doctor to have a brief telephone consultation. This will result in an appointment being booked, a referral elsewhere or medical advice on the phone. This initiative has made a significant impact on the Haringey practice with the highest footfall at the A&E department at North Middlesex University Hospital Trust. This practice has shown a fall in A&E attendances and we are awaiting the outcome of the MORI Patient Satisfaction Survey to see if this is shown in an improved patient satisfaction score.

In addition, the CCG has developed an Urgent Care Local Enhanced Scheme, which asked the practices to review their current capacity and activity profiles, to examine their processes and procedures and identify improvements that could be made to the way they respond to urgent requests for appointments. Approximately sixty percent of our practices signed up to the Urgent Care initiative. We have now been able to examine the first six months of data following the introduction of the Urgent Care LES and the A&E activity at our local secondary care providers have shown an encouraging downturn in activity for the majority of participating practices.

In addition, our practices have been piloting a number of local practice initiatives for example nurse triage and improved registration to see if this has a demonstrable impact on access to the practice.

Information technology allows us to communicate more effectively with patients. The majority of practices are using text messaging; the initial focus has been to use the technology to confirm appointments and to reduce ‘non-attenders’. This winter has seen SMS texting used to remind people about flu vaccination as well and moving forward we hope to use this technology to improve long term conditions management. Improved management of ‘non-attenders’ allows more capacity to be freed up in the system to be re-offered to patients who can attend their appointment. Non-attendance remains a significant problem across the whole health system as lost capacity can never be regained.

Haringey has an established Minor Ailments Scheme which was expanded. This service is active across Haringey practices and pharmacies, providing an alternative setting for consultations for minor ailments. This scheme means that people can get help and prescriptions for some minor conditions at their local pharmacy without the need for a GP appointment. In 2012/13 there were 15,537 consultations with GPs for minor ailment

conditions; these people can now be seen in one of 38 Haringey pharmacies if they choose.

3. YEAR TWO

Learning from the initial pilots with Dr First and the Productive General Practice has led to a rethink in how we promote improved access across the Haringey primary care system. Whilst both initiatives have demonstrable benefits, uptake was slow because of the significant time, resource and staff commitment required in measuring and reducing the entire backlog in the system and training the doctors to manage consultations in a new way. There is also a time lag, as patients become accustomed to the new appointment systems and they trust that they will be able to access the practice on the day that they phone for an appointment.

Haringey approached an external company, BDO who are experienced in helping practices review how they work to deliver a borough wide programme on demand management in primary care for the GP practices of Haringey CCG. The main goal of the project is to help improve patient access to practices across the borough. BDO will run a 3 month borough wide programme starting in March 14.

The BDO programme is less intensive than Dr First, but has been shown to have demonstrable benefits in the economies that have adopted their principles. They have typically found:

- Too much demand vs. capacity to deliver: This is the key problem which is affecting access to practices.
- Patients – this is both perceived and real and leads to patient dissatisfaction and potentially health concerns if ailments are not dealt with in a timely manner.
- Mismatch between patient and practice expectations: Patients' view of the service they receive differs from what the practices think they are providing in terms of access to the practice. This is often highlighted when patient satisfaction survey results are published.
- Staff feel overworked: Staff are coming under increasing pressure from patients to provide a service that they are unable to deliver at times. Frontline staff often gets the brunt of patient dissatisfaction meaning morale is affected and in turn the practice often suffers from poor staff satisfaction & performance and high sickness rates.

Following this demand and capacity work the CCG will have a good picture of what demand and capacity looks like.

Underpinning these issues is the ongoing agenda to treat more patients in the community rather than in acute settings. In order to meet these challenges head-on, practices need to work smarter and not necessarily harder. Working together practices will consider a series of systems and behavioural approaches to better manage demand. They will be offered an array of different interventions to consider, which are evidenced based, measureable and realistic.

- Increase doctors, change appointment times.
- Ensure patients are seen by the most appropriate person freeing up valuable GP time
- Fully utilise nursing capacity through 'empowering handovers' at the point of transfer of care from GP to Practice Nurse
- Allocating the Practice's resources effectively, to ensure that the 'demand-heavy' days, are closely matched with increased capacity, to eliminate 'demand recycling' of appointments or problems elsewhere in the system.

In addition the CCG is exploring the greater use of technology to support the improved management of patients, for example can we pilot teleconferencing to enable patients with long term conditions to be better managed in their homes, avoid the need to visit the surgery. This may be of particular value to the young and those who are carers/parents and find leaving their residence problematic.

Finally, practices are looking at how they might work together to deliver better services by building on the strengths of different practices. This is at an early stage, but we hope will mean that there is an improvement in what is available to patients through practices in their area and that GPs, Nurses and other health professionals will be able to work in a more joined up way. This links to the wider work on the 'Better Care Fund'.

The Health Panel of the Overview and Scrutiny Committee have asked for an update on primary care access. The paper sets out the work being undertaken to improve the experience of patients.