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:

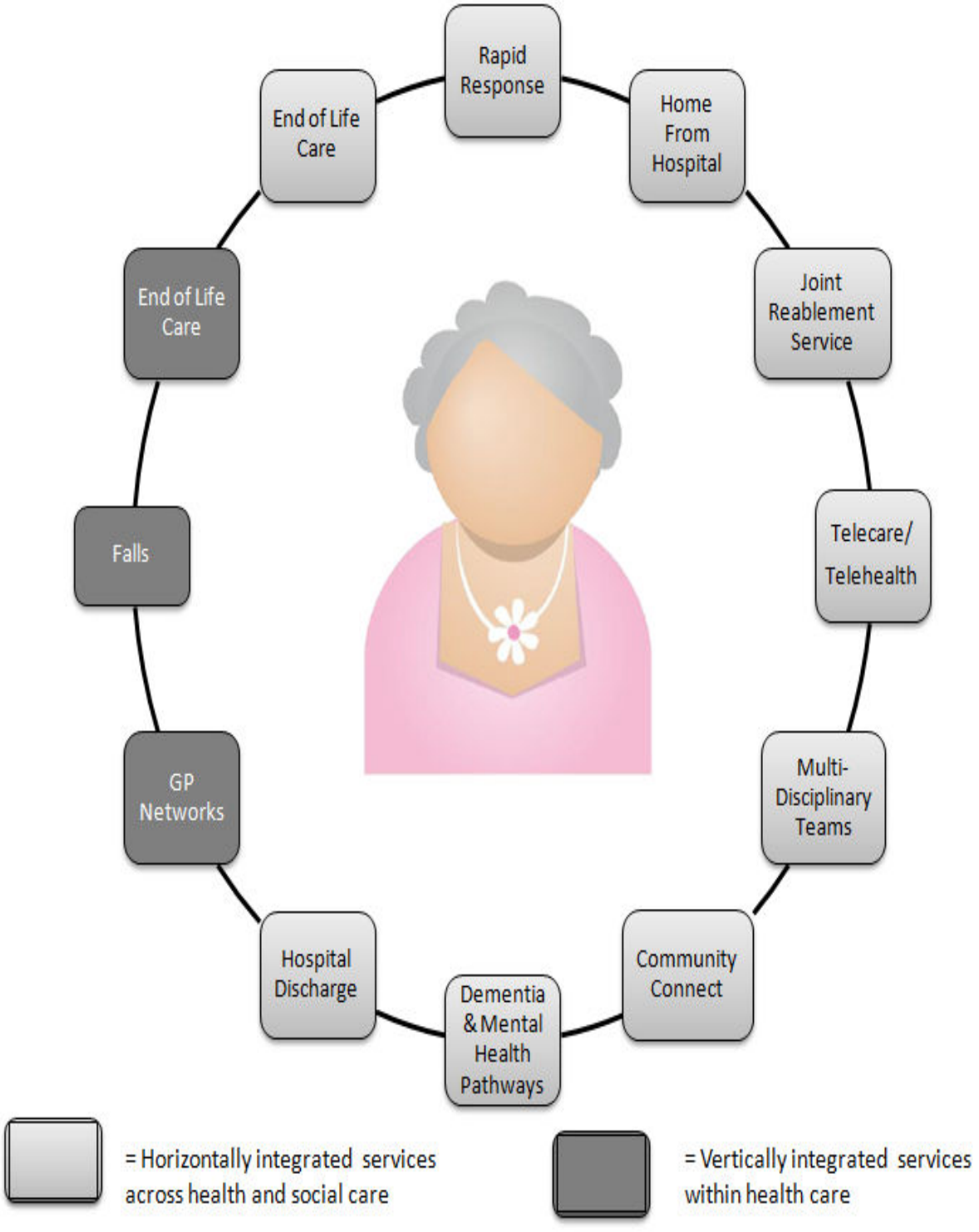
- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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

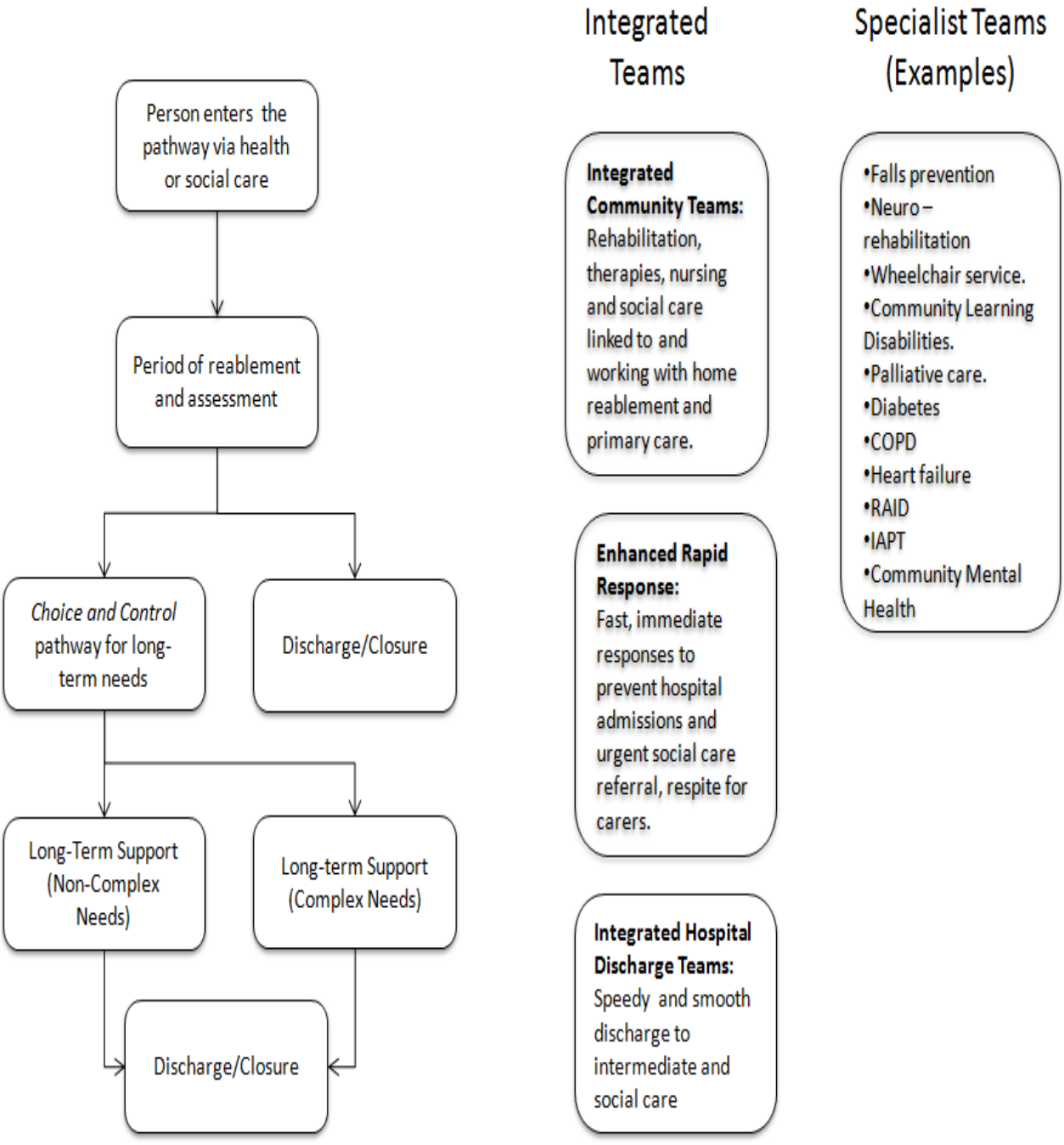
By the end of 2015/16 our default form of provision for most service users and patients will be will be integrated services. The proposed new service model is illustrated in Figure 2. The services described in this model will work alongside and complement those integrated services outline in Figure 1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

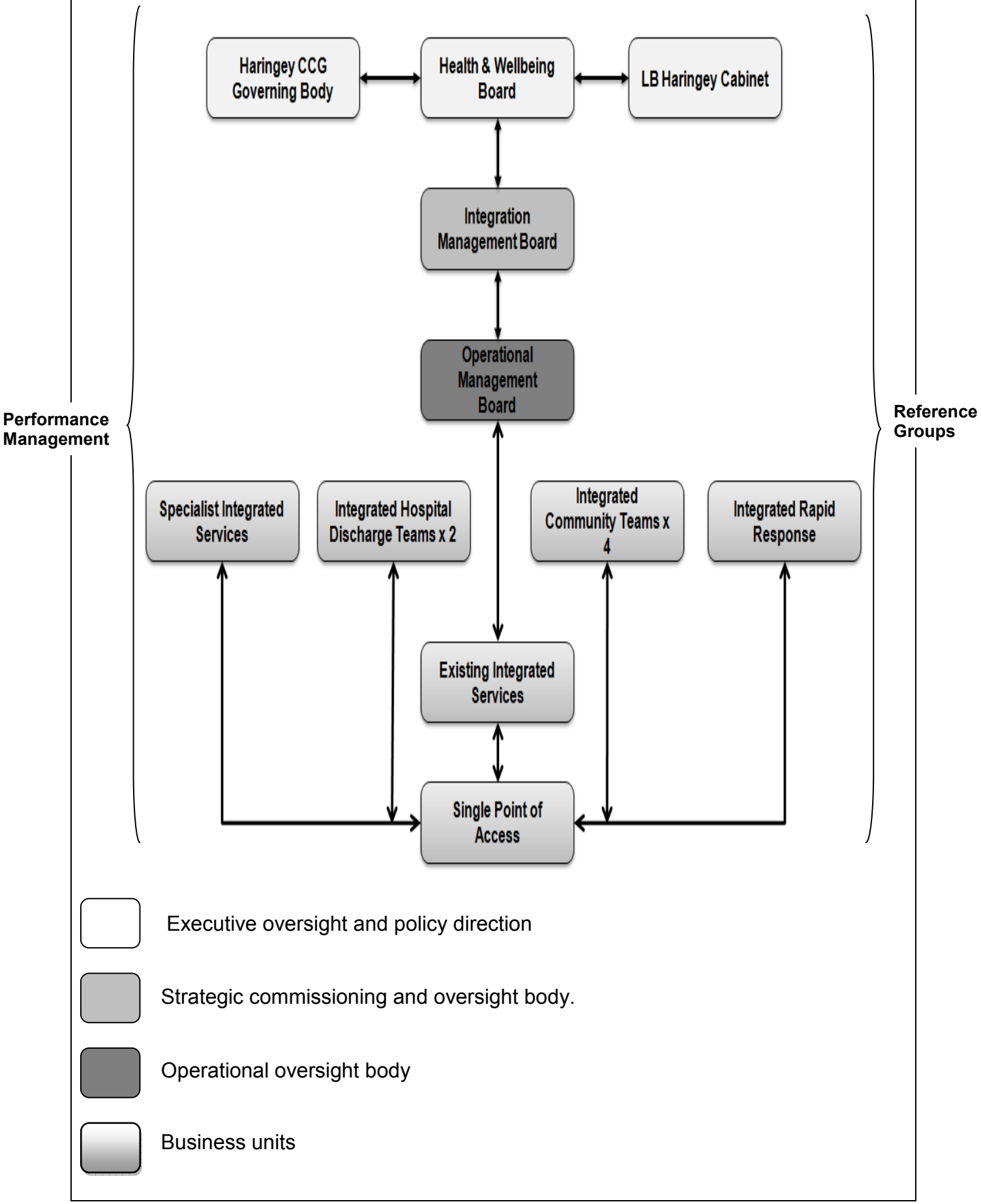
If the BCF Plan fails to deliver improvements some of the Fund may need to be used to alleviate the pressure on hospital services. Our plans in this regard are outlined in the contingency plan contained in part 2 of this Plan.

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.