



**Haringey** Council

---

## Health and Wellbeing Board

---

TUESDAY, 11TH FEBRUARY, 2014 at 13:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

**MEMBERS:** Please see attached membership list.

### **AGENDA**

**1. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)**

**2. APOLOGIES**

To receive any apologies for absence.

**3. URGENT BUSINESS**

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at agenda item 9).

**4. DECLARATIONS OF INTEREST**

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and

(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

**5. BETTER CARE FUND (BCF): LOCAL HEALTH AND SOCIAL CARE INTEGRATION PLAN (PAGES 3 - 76)**

To present for consideration and approval Haringey's proposed Better Care Fund (BCF) Health and Social Care Integration Plan, hereafter referred to as the 'Integration Plan', prior to its dispatch to NHS England on 14<sup>th</sup> February 2014, for initial scrutiny. If required, a revised final version of the Plan must be submitted for ministerial sign-off no later than 4<sup>th</sup> April 2014.

**6. NHS PLANNING - DRAFT 2-YEAR PLAN**

Report to follow.

**7. NHSE PERFORMANCE IN PRIMARY CARE (PAGES 77 - 88)**

Presentation outlining the contractual and individual performance arrangements of NHS England (London).

**8. TOTTENHAM STRATEGIC REGENERATION FRAMEWORK**

Presentation on the Tottenham Strategic Regeneration Framework.

**9. NEW ITEMS OF URGENT BUSINESS**

To consider any new items of urgent business admitted at item 3 above.

**10. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS**

Members of the Board are invited to suggest future agenda items.

The dates of future meetings are as follows:

Tuesday, 8 April 2014, 1.30pm.

Bernie Ryan  
Assistant Director – Corporate Governance and  
Monitoring Officer  
Level 5  
River Park House  
225 High Road  
Wood Green  
London N22 8HQ

Helen Chapman  
Principal Committee Coordinator  
Level 5  
River Park House  
225 High Road  
Wood Green  
London N22 8HQ

Tel: 020 84892615

Email:

[helen.chapman@haringey.gov.uk](mailto:helen.chapman@haringey.gov.uk)

Monday, 3 February 2014



This page is intentionally left blank

**Membership of the Health and Wellbeing Board**

<b>Organisation</b>		<b>Representation</b>	<b>Role</b>	<b>Name</b>
<b>Local Authority</b>	Elected Representatives	2	Cabinet Member for Health and Adult Services	Cllr Bernice Vanier (Chair)
			Cabinet Member for Children and Young People	Cllr Ann Waters
	Officers' Representatives	3	Director of Adult social Services	Mun Thong Phung
			Interim Director of Children and Young People's Services	Lisa Redfern
			Director of Public Health	Dr Jeanelle de Gruchy
	<b>NHS</b>	Haringey Clinical Commissioning Group (CCG)	4	Chair
GP Board Member				Dr Helen Pelendrides
Chief Officer				Sarah Price
Lay Member				Cathy Herman
<b>Patient and Service User Representative</b>	Healthwatch Haringey	1	Interim Chair	Sharon Grant
<b>Voluntary Sector Representative</b>	HAVCO	1	Interim Chief Executive	Pamela Pemberton

This page is intentionally left blank



**Haringey Council**

Report for:	Health and Wellbeing Board (HWB) on 11 <sup>th</sup> February 2014	Item Number:	
-------------	--	--------------	--

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

Report Authorised by:	<p>Mun Thong Phung, Director of Adult Social Services</p> <p>p.p. <i>B. F. Tarka</i></p> <p>Sarah Price, Chief Operating Officer, Haringey Clinical Commissioning Group</p> <p><i>Sarah Price</i></p>
-----------------------	---

Lead Officers:	<p>Beverley Tarka, Acting Deputy Director, Adult Social Services</p> <p>Jill Shattock, Direct of Commissioning, Haringey Clinical Commissioning Group</p>
----------------	---

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

### 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 Round (26/6/13), HM Treasury

This page is intentionally left blank





**Haringey Council**

- 1.1 This report presents for consideration and approval Haringey's proposed Better Care Fund (BCF) Health and Social Care Integration Plan, hereafter referred to as the 'Integration Plan', prior to its dispatch to NHS England on 14<sup>th</sup> February 2014, for initial scrutiny. If required, a revised final version of this Plan must be submitted for ministerial sign-off no later than 4<sup>th</sup> April 2014.
- 1.2 The Integration Plan – see Appendix 1 - has been jointly produced by the Council (Adult Social Care) and Haringey CCG.

## **2. Cabinet Member introduction**

- 2.1 I am delighted to present this report to the Health and Wellbeing Board, 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-up provision across health and social care and the 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**

It is recommended that Members of the Health and Wellbeing Board:

- 3.1 Approve the Integration Plan, as set out in Appendix 1, in readiness for its submission to NHS England on 14 February 2014.
- 3.2 Note that Haringey Clinical Commissioning Group's Governing Body considered and agreed the Integration Plan as set out at Appendix 1 on 30<sup>th</sup> January 2014.



## Haringey Council

3.3 Note that Cabinet will consider the final Plan as agreed by the Health and Wellbeing Board at its meeting later today (11<sup>th</sup> February 2014).

### 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 a result no alternative option to the Integration Plan is presented. Maintenance of the status quo will perpetuate current inefficiencies in the provision of health and social care, fail to realise value for money gains and not improve people's experience of service provision. Moreover, will place Haringey in breach of an important national policy initiative and result in the loss an exciting opportunity to reshape services through the use of the Fund.

### 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 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



## Haringey Council

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 the preparation of 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.

### Funding The Integration Plan – details of the BCF

- 5.5 The June 2013 Spending Round set out the details of the BCF 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.

- 5.6 It is emphasised that the money invested in the BCF is not new with the majority of the Fund consisting 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 which will have to switch its pattern of investment with some of the funds placed in hospital provision having to be 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 In addition, the national guidance indicates that the BFC is to be subject to ringfencing to cover the new duties and associated costs imposed on local



## Haringey Council

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. 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.

- 5.8 However, the BCF cannot be characterised as a prop for social care. It, more accurately, 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 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:

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

- 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 pool early in 2014/15, to ensure that these are in place when required. Before the Council can enter into any Section 75 agreements, Cabinet agreement will be required.

### Our Approach to Integration - Stakeholder Engagement

- 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



## Haringey Council

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. Further details on the engagement exercise can be found in the Integration Plan at Appendix 1.

### **Our Approach to Integration – building on what we have achieved**

- 5.14 In addition, the Integration Plan reflects a commitment to build on the integrated services Haringey already has in place, schemes worth approximately £5.91m which are making a valuable contribution to health and wellbeing in the Borough. However, while the 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 Plan is cognisant of the outputs from the CCGs Value Based Commissioning work which is designed to place the outcomes people value most at the heart of the commissioning process.

## **6. The Integration Plan**

- 6.1 The presentation of the Integration Plan is restricted by the limitations imposed by the NHS England templates which must be used for its completion. The following synopsis of the Plan is provided in terms of the main headings of these templates.

### **Scope - The Service User and Patient Cohort**

- 6.2 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 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**



## Haringey Council

- 6.3 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)

- 6.4 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 interrelated objectives.

### Aims and Objectives

- 6.5 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.
- 6.6 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 ambitions and to make its vision a reality.



## Haringey Council

6.7 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



## Haringey Council

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.

### Cultural Change and Challenge

- 6.8 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.
- 6.9 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

- 6.10 The vision underpinning the Integration Plan is about nothing less than a systems wide transformation of health and social care in Haringey and the changes described are 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.
- 6.11 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,





### **Haringey Council**

preventing dependency and maintaining independence and improving individuals' experience of services.

- 6.12 Furthermore, Haringey is able to base transformation on the solid bedrock of experience that 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 journey that starts out by recognising where we are today, and where we will be in 2014/15 and 2015/16. These matters are considered in the next three sub-sections.

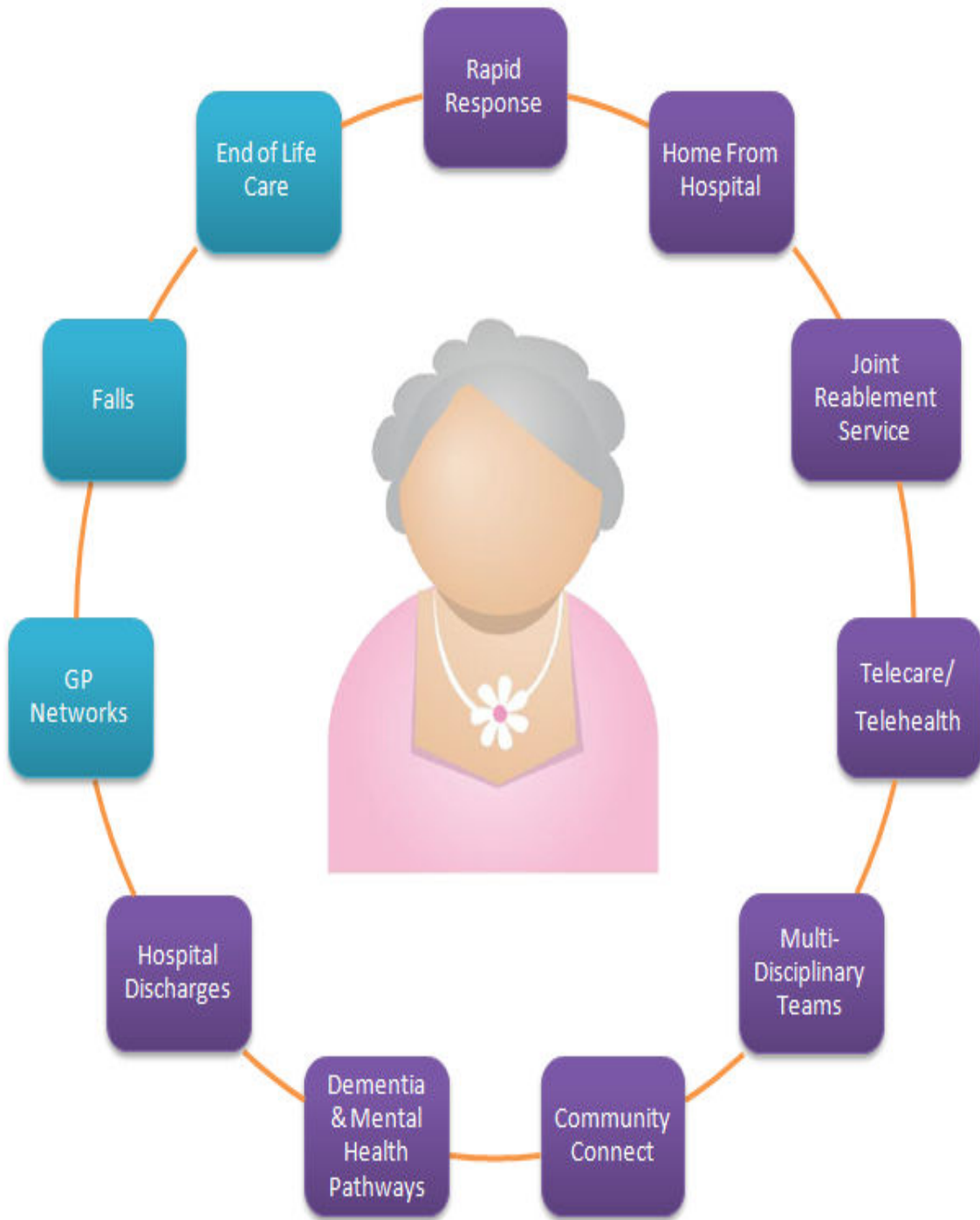
#### **Building On What We Have achieved - where we are today**

- 6.13 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.

#### **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 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.

**Figure 1.** Example of Services That Are Already Integrated



= Horizontally integrated services across health and social care



= Vertically integrated services within health care

**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 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 at Figure 1 and below at 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.

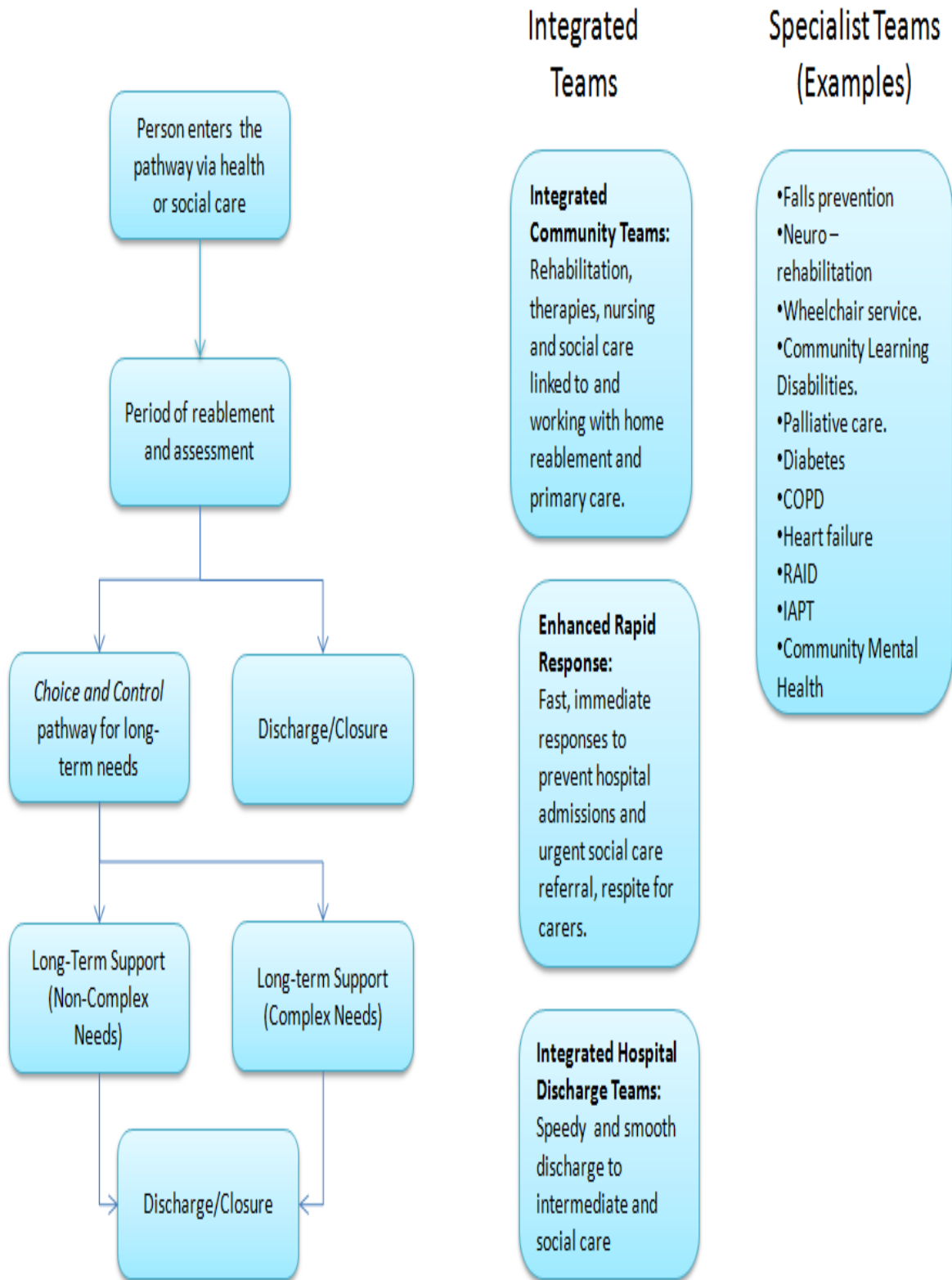
### **Establishing Ways of Working That Support Transformation – the enablers**

- 6.17 Alongside the development of new services will be the development of new ways of work which will 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.



**Haringey Council**

**Figure 2. What the Proposed Model Looks Like.**



**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 intentions.
- 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).



## Haringey Council

- 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.

### 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



## Haringey Council

(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.

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 PMO 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 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. Ultimate responsibility for the delivery of this Integration Plan rests with the Health and Wellbeing Board which has, in line with



**Haringey Council**

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.** Governance Structure

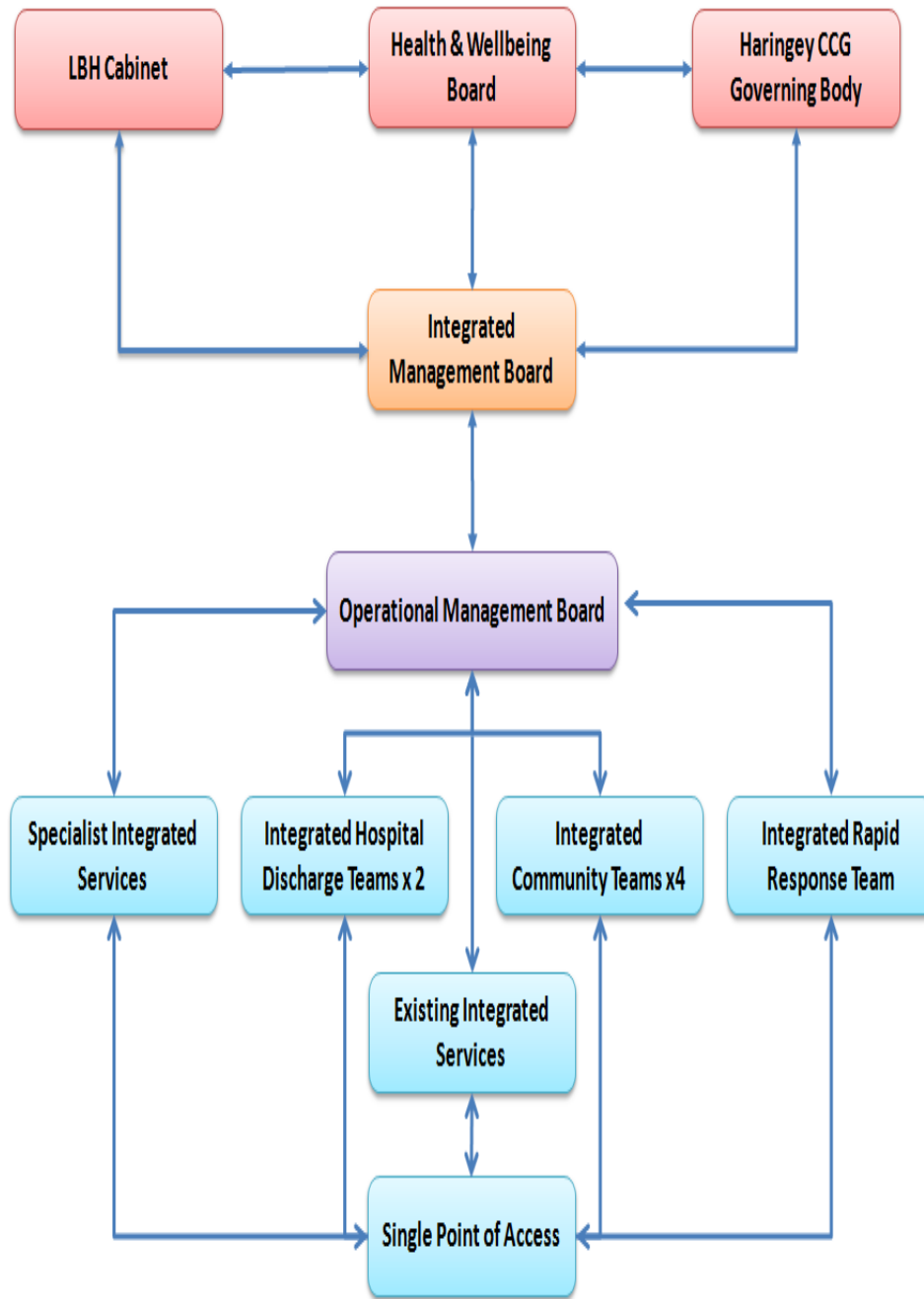




Haringey Council

Performance Management

Reference Groups



- Executive oversight and policy direction
- Strategic oversight and commissioning.
- Operational oversight
- Business units



**Haringey Council**

- 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 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.

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 prerequisite 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 Plan has been prepared by officers of the Council and the CCG and must be 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



**Haringey Council**

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 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 Plan.

### **Outcomes and Metrics**

- 6.34 The Integration Plan template sets out the metrics that will be used monitor impact of the Plan. 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:



## Haringey Council

- 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 at part 2 of the Plan. Attention here is drawn to the summary of proposed expenditure of the BCF, provided in Tables 1.

6.37 Table 1 provides an overview, by scheme and year of the planned 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, including the Council, wish to make.

6.38 Approximately 25% of the BCF in 2015/16 is paid for improving outcomes. If the 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 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.

**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/activation, 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	
<b>Total</b>		<b>6,322,497</b>	<b>225,000</b>	<b>21,740,923</b>	<b>335,000</b>
Note: benefits are put against the main contributor, but all schemes benefit					

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



**Haringey Council**

<b>Contingency plan:</b>		<b>2015/16</b>	<b>Ongoing</b>
<b>Outcome 1</b> 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
<b>Outcome 2</b> 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
<b>Outcome 3</b> 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
<b>Outcome 4</b> 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
<b>Outcome 5</b> Patient / service user experience	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
<b>Outcome 6</b> 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.

6.39 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.

## **Making Integration and Whole Systems Transformation Happen**



## Haringey Council

- 6.40 This report and the Integration Plan outline an exciting but very challenging, large and complex programme of change. Whole systems change 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.
- 6.41 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 that has all party support).
- 6.42. 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 be:
- a) the establishment of the governance structure;
  - b) the development and agreement of a comprehensive programme plan;
  - c) the agreement of a method by which to deliver better information sharing with all technical and information governance issues solved;
  - d) the review of existing integrated services – see Figure 1;
  - e) the completion of plans to in place integrated teams – see Figure 2 - and launch of the single point of access;
  - f) the agreement of a joint commissioning strategy;
  - g) 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;
  - h) the ongoing engagement with all stakeholders, but especially service users and patients and their carers and NHS and social care providers.
- 6.43 In addition to the above priority areas of change health and social care partners in Haringey will commit to working on and developing other areas over the next 2 to 3 years.
- 6.44 Accompanying the integration of health and social care will be 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.

## 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

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	Amber (Low)	We will bring diverse staff groups together to build a new integrated professional identity reinforced by physical collocation, joint





**Haringey Council**

seamless.		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)	<ul style="list-style-type: none"> <li>• Our current plans are based on engagement with providers who are, broadly, supportive of the proposals to integrate health and social care in Haringey.</li> <li>• 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.</li> </ul>
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)	<ul style="list-style-type: none"> <li>• 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</li> <li>• We believe there will be potential benefits that come out of this process, as well as potential risks.</li> </ul>
IF we fail to achieve the level of performance against the metrics	Amber (Medium)	We will invest in business analyst capacity to ensure that the performance of all



**Haringey Council**

<p>contained in the BCF Plan THEN part payment of the BCF will be withheld.</p>		<p>BCF funded schemes is robustly monitored allowing under-performance to be identified and proactively managed.</p>
---	--	--

## **7 Comments of the Chief Finance Officer and financial implications**

- 7.1 The Better Care Fund was announced by the Chancellor in the Autumn Statement and indicative allocations to Local Authorities 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 Head of Legal Services and legal implications**

**Haringey Council**

- 8.1 This report seeks the Health and Wellbeing Board's agreement to the Integration Plan for the Better Care Fund, in readiness for its submission to NHS England by 14 February 2014.
- 8.2 In formulating the Plan, certain conditions must be met including the requirement to have regard to the Joint Strategic Needs Assessment for the local population and existing commissioning plans for both health and social care. Further, there are national conditions which must be met as set out at paragraph 6.33 of this report; and both national and local metrics for measuring success which will result in the release of further funding in 2015/16.
- 8.3 The Plan must be able to demonstrate patient service user, public and service provider engagement and how this consultation has taken place. A summary of the consultation that has been undertaken is provided at paragraph 5.12 of this report. An equalities screening tool has been undertaken on the proposals addressed within the Plan which has concluded that there was no requirement for a full equalities impact assessment to be undertaken.
- 8.4 Funding in 2014/15 will take the form of a 'Section 256 transfer' from Haringey CCG to the Local Authority. Section 256 National Health Service Act 2006 permits NHS England to make payments to local authorities towards expenditure incurred or to be incurred by it in connection with any social services functions. The funding transfer is subject to a written agreement between the Council and the NHS England which is referred to as a Section 256 Agreement. 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.
- 8.5 NHS England has set out that funding in 2015/16 will be by way of 'Section 75' pooled budgets. Section 75 National Health Service Act 2006 permits NHS bodies and local authorities to establish pooled funds for the provision of health-related functions. This funding transfer will be subject to further written agreement(s) between the Council and the NHS England, referred to as a Section 75 Agreement. These 'Section 75' pooled fund arrangements will require the approval of the Cabinet. These matters will be brought to the Cabinet for decision in advance of the 2015/16 tranche of funding.
- 8.6 The use of all funds provided under the Better Care Fund must meet the requirements of the guidance from the Department of Health to NHS England of 19 December 2012 (Gateway Reference: 18568). This includes the condition that the local authority agree with its local health partners how the funding is best used within social care and the outcomes expected from this investment, through a jointly agreed Plan. It is indicated that the Health and Wellbeing Board is the natural place for these discussions. This is further supplemented in guidance issued by NHS England and the Local



## Haringey Council

Government Association dated 17 October 2013 which states that, “Each upper tier Health and Wellbeing Board will sign off the plan for its constituent local authorities and CCGs.” As such, the Health and Wellbeing Board is being asked to agree the Plan, and the Cabinet will be asked to endorse the same at its meeting of even date (11 February 2014).

- 8.7 The CCG and the Council are free to extend the scope of their pooled budget funds beyond the allocation from NHS England.

## 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. 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”*



**Haringey Council**

## 10 Head of Procurement Comments

10.1 There are no current procurement issues within 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](#)
- 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 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;



**Haringey Council**

Appendix 2:

Appendix 3:

'I' and 'We' Statements; and

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

##### b) Authorisation and signoff

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

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

<b>Signed on behalf of the Health and Wellbeing Board</b>	
<b>By Chair of Health and Wellbeing Board</b>	Councillor Bernice Vanier
<b>Date</b>	<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
<p><b>LB Haringey (2012), “<i>Joint Strategic Needs Assessment (JSNA)</i>”.</b>  <a href="http://www.haringey.gov.uk/index/social_care_and_health/health/jsna.htm">http://www.haringey.gov.uk/index/social_care_and_health/health/jsna.htm</a></p>	<p>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.</p>
<p><b>LB Haringey (2012), “<i>Joint Health &amp; Wellbeing Strategy (JHWS)</i>”</b>  <a href="http://www.haringey.gov.uk/hwbstrategy">http://www.haringey.gov.uk/hwbstrategy</a></p>	<p>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.</p>
<p><b>LB Haringey (2013), “<i>GP Collaborative Profiles.</i>”</b></p>	<p>Public Health analyses of the populations and their health needs of each of Haringey’s four GP Collaboratives.</p>
<p><b>Barnet, Enfield and Haringey CCGs (2013), “<i>Barnet, Enfield and Haringey Clinical Strategy.</i>”</b>  <a href="http://www.barnetccg.nhs.uk/about-us/beh-clinical-strategy.htm">http://www.barnetccg.nhs.uk/about-us/beh-clinical-strategy.htm</a></p>	<p>Describes the planned changes to local healthcare services with emphasis on the future of hospital services.</p>
<p><b>LB Haringey (2011), “<i>Haringey Ward Profiles</i>”</b>  <a href="http://www.haringey.gov.uk/index/council/how_the_council_works/fact_file/wardprofiles.htm">http://www.haringey.gov.uk/index/council/how_the_council_works/fact_file/wardprofiles.htm</a></p>	<p>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.</p>
<p><b>A Khaladi (undated), “<i>A Question of Behaviours,</i>”</b>  <b>iMPOWER</b></p>	<p>A report which addresses the increasing dependency on</p>

<p><a href="http://www.impower.co.uk/en/a-question-of-behaviours-the-latest-report-from-impower-453.html">http://www.impower.co.uk/en/a-question-of-behaviours-the-latest-report-from-impower-453.html</a></p>	<p>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.</p>
<p><b>London Borough of Haringey (2013), “2013/14 Commissioning Plan – Section 256 Social Care Funding.”</b></p>	<p>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.</p>
<p><b>National Collaboration for Integrated Care and Support (May 2013) “Integrated Care and Support: Our Shared Commitment”</b> <a href="https://www.gov.uk/government/publications/integrated-care">https://www.gov.uk/government/publications/integrated-care</a></p>	<p>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.</p>
<p><b>NHSE (July, 2013), “The NHS belongs To The People: A Call To Action”</b> <a href="http://www.england.nhs.uk/2013/07/11/call-to-action/">http://www.england.nhs.uk/2013/07/11/call-to-action/</a></p>	<p>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.</p>
<p><b>LB Haringey and Haringey CCG (2014), “Dementia Joint Commissioning Strategy and Delivery Plan”</b></p>	<p>Maps existing and future demand for dementia</p>

	<p>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.</p>
--	---

## 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:

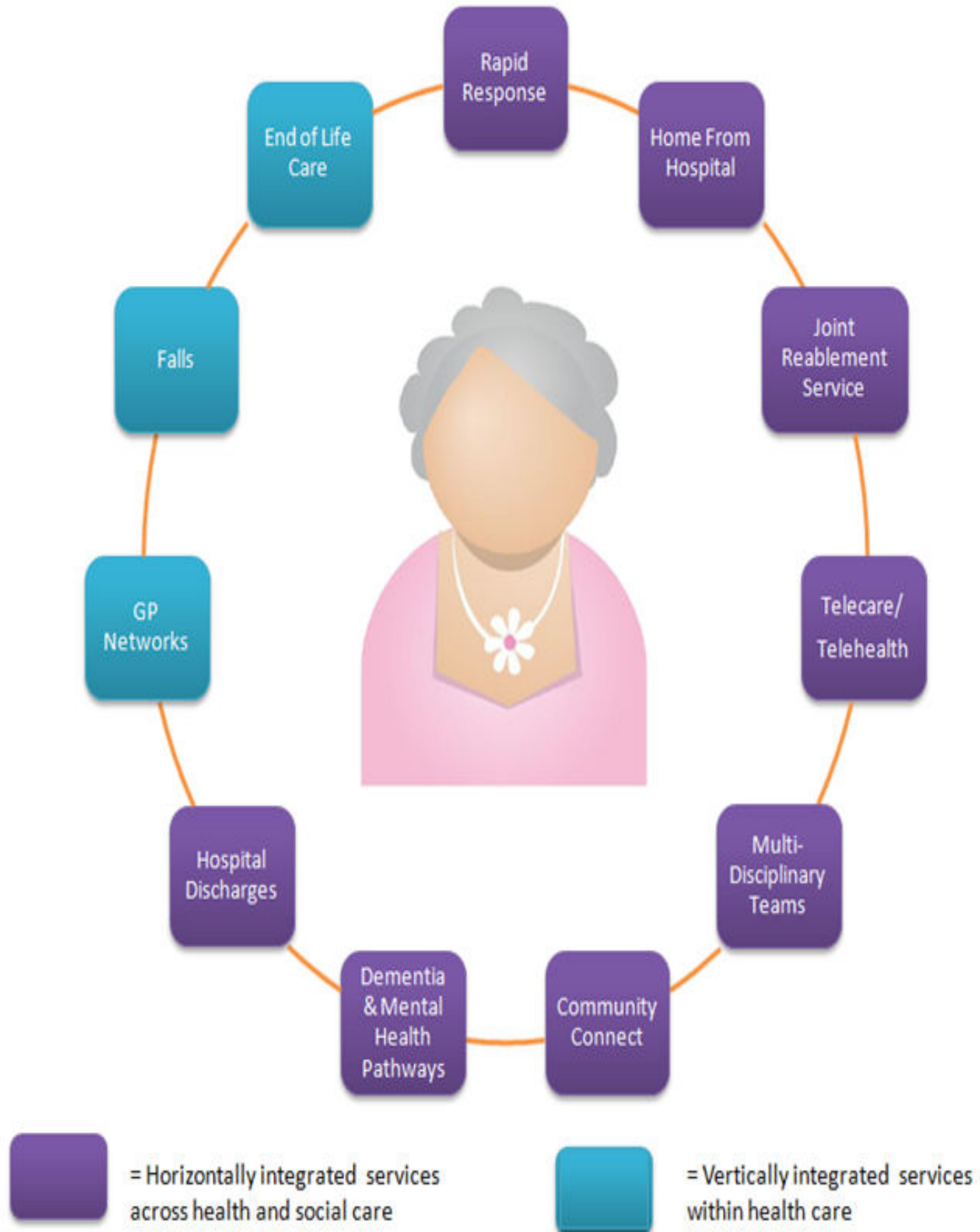
- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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.

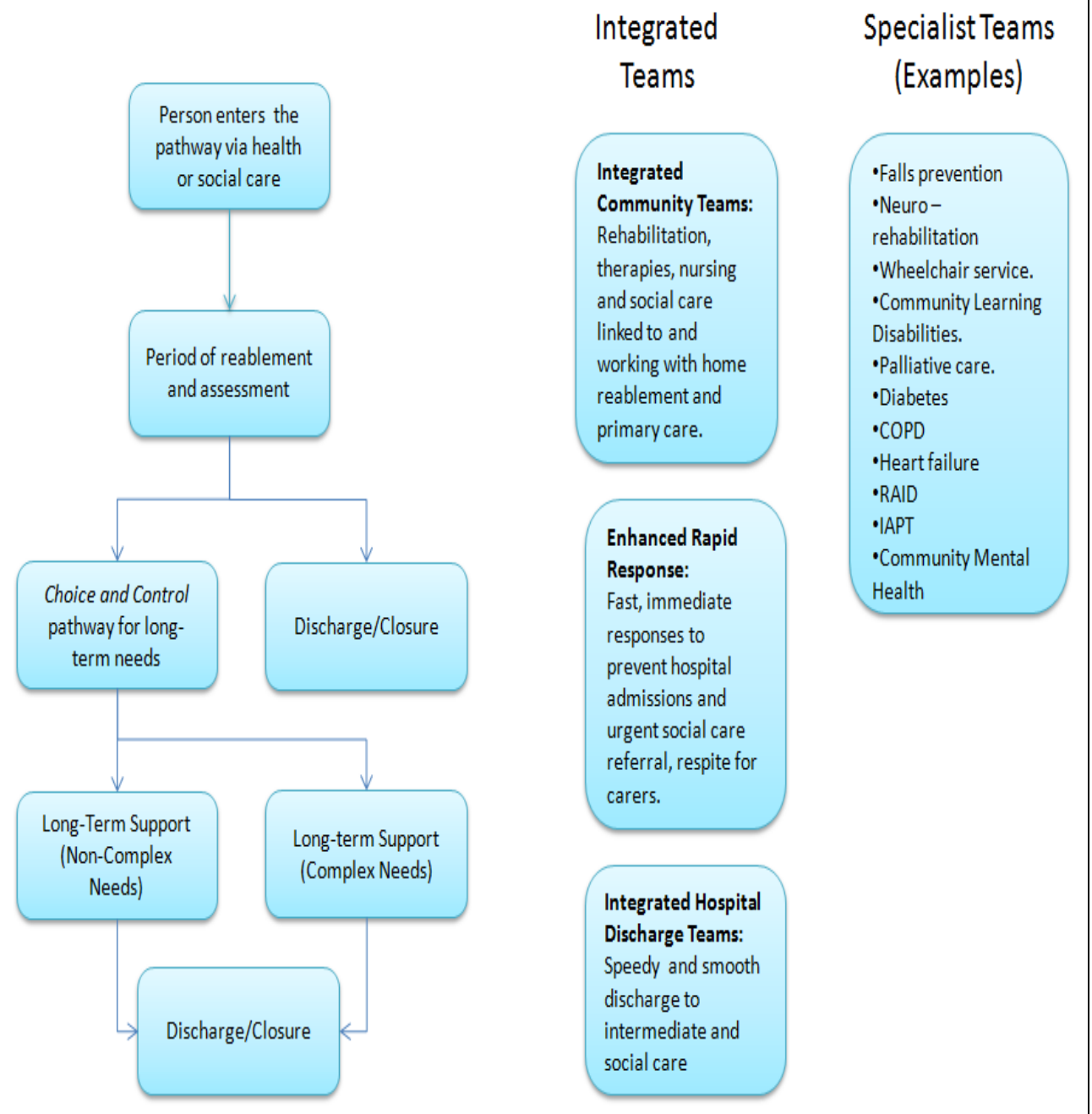
### **Building On What We Have Achieved - Where We Will Be Tomorrow, 2015/16**

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 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 intentions.
- 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 people'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 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

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<sup>1</sup> 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.

---

<sup>1</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf](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 from 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**

<b>Risk Level</b>	<b>Over 65 With an LTC (one or more)</b>	<b>Over 65 Without an LTC</b>	<b>Total over 65</b>	<b>% of patients 65 and over with one or more LTC</b>	<b>% of patient 65 and over without LTC</b>
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 3<sup>rd</sup> 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)	<ul style="list-style-type: none"> <li>• Our current plans are based on engagement with providers who are, broadly, supportive of the proposals to integrate health and social care in Haringey.</li> <li>• 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.</li> </ul>
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)	<ul style="list-style-type: none"> <li>• 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</li> <li>• We believe there will be potential benefits that come out of this process, as well as potential risks.</li> </ul>



This page is intentionally left blank

## 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
<b>BCF Total</b>		<b>6,437,430</b>	<b>18,061,000</b>	<b>22,075,923</b>

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
<b>Outcome 1</b> 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
<b>Outcome 2</b> 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
<b>Outcome 3</b> 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
<b>Outcome 4</b> 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
<b>Outcome 5</b> Patient / service user experience	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
<b>Outcome 6</b> 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

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/COG	195,000				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/COG		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	
Reablement	London Borough of Haringey	625,000							
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	2,450,000		88,738				177,476	
GP Case Management and 7 day access	London Borough of Haringey	150,000				3,857,904		94,110	
Integrated End of Life Care Service	COG	1,371,430		58,580		1,371,430		206,141	
Additional Third Sector Investment	Whittington Health	26,067		158,178		1,378,399			
Promotion of self management, measurement of patient engagement/activity, community development (Community Development Workers and Good Neighbours)	London Borough of Haringey					75,000			
Community Capacity Grant Schemes	London Borough of Haringey	120,000		131,966		770,000		263,931	
Promoting independence for people with disabilities	London Borough of Haringey					638,000			
<b>Total</b>		<b>6,322,497</b>	<b>225,000</b>	<b>788,635</b>	<b>0</b>	<b>21,740,923</b>	<b>335,000</b>	<b>1,272,960</b>	<b>0</b>

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

### 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

In line with advice received this section provides details of how Haringey's BCF plans will enable it to achieve the target attached to each metric, and how their attainment will be measured.

#### 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 able to address the health and social care needs of individuals in the round (holistic provision). 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 invest in falls prevention which will make a particularly significant contribution to reducing the permanent admissions of older people as falls are a primary cause of these admissions. To monitor the benefits of these schemes all will be performance managed and work to SMART outcome orientated service specifications.

For the purposes of measuring overall 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.

**Adult Social Care Outcomes framework** <http://www.hscic.gov.uk/article/2021/Website-Search?q=Measures+from+the+Adult+Social+Care+Outcomes+Framework&go=Go&area=both>  
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Haringey's BCF Plan proposes a significant additional investment in our successful integrated reablement services. This will play an important role in equipping people with the skills and providing them with the confidence to manage independently, within their own homes, following a period of illness and/or hospitalisation. 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. 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.

The same approach will be taken to measuring outcomes as that described above and the following algorithm will be applied:

- **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.

Adult Social Care Outcomes framework (HSCIC: <http://www.hscic.gov.uk/article/2021/Website-Search?q=Measures+from+the+Adult+Social+Care+Outcomes+Framework&go=Go&area=both>)

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

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

- For each metric the same assurance process applies. This is designed to deliver high achievement and performance through the use of the BCF 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 CCG and the Health and Wellbeing Board.
  4. The lessons arising from examination of the performance data will be learnt with under-performance being addressed with providers and good practice shared across the provider community. We want to use the assurance process as a learning, as well as, a performance tool.

We believe that the steps outlined above give confidence that Haringey's approach to assuring the process underpinning the agreements of the performance plans is both robust and accountable.

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	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				
Injures due to falls in people aged 65 and over				
Injures due to falls in people aged 65 and over	Metric Value	461	446.0	431.0
	Numerator	38.4		35.9
	Denominator	27765		27765
		(April 2012 - March 2013)		(April 2014 - March 2015)

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

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

This page is intentionally left blank





**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.

<b>Theme 1. Information</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• I want) good high quality signposting.</li> </ul>	<ul style="list-style-type: none"> <li>• (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')</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) information that is regularly updated and remains current.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) be informative about services available for service users.</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) the people who provide support have access to good information.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) ensure we have access to up-to-date information on local services.</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) information the enables choice.</li> </ul>	
<ul style="list-style-type: none"> <li>• I want information on what services are available for people</li> </ul>	
<ul style="list-style-type: none"> <li>• I want clear pathways.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) good information about eligibility.</li> </ul>	
<ul style="list-style-type: none"> <li>• I want clear governance and accountability – good information about who is responsible for what.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) my information to be shared when it needs to be and protected when it needs to be.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) to be supplied with contact numbers.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) clear information available as and when needed.</li> </ul>	
<b>Theme 2. Control</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• I want to have professional to have in-depth knowledge of my needs and future and to work with me.</li> </ul>	
<ul style="list-style-type: none"> <li>• I want to be given the confidence to cope with my situation, not to be</li> </ul>	



**Haringey Council**

harassed and for somebody to be there when I need them.	
<b>Theme 3. Services That Work Together As One Team</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• (I want) a system that really works with everyone who is part of it all working together.</li> </ul>	<ul style="list-style-type: none"> <li>• We will give) care co-ordination a high priority.</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) better communication between agencies.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) employ suitably qualified managers who have a collective vision of what integration means.</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) a common assessment.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) have one computer system.</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) a clinical team that listens to the provider.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) to have confidence that my care team is well managed.</li> </ul>	
<ul style="list-style-type: none"> <li>• <i>(I want) people to speak to each other – “pick-up the old telephone instead of unnecessary paperwork”.</i></li> </ul>	
<b>Theme 4. Continuity</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• (I want) single responsible person managing my care plan.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) ensure that that one person is responsible for each service user (e.g. a keyworker).</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) continuity of care.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) provide continuity of care.</li> </ul>
	<ul style="list-style-type: none"> <li>• (We will) have one person to do assessments.</li> </ul>
<b>Theme 5. Accessible Services</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• I want) easy access (to services).</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) a single point of access.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want ) clearer pathways.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) access to good quality services (e.g. new social workers visits every 2 weeks and another never seen).</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) someone to help me navigate my way.</li> </ul>	
<b>Theme 6. Wellbeing</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• I want) befriending.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) to see people, to have companionship, to have someone to talk to.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) to live in a safe environment – a home I know and understand.</li> </ul>	



**Haringey Council**

• (I want) drop-in centres.	
• (I want) to meet others.	
• (I want) to be socially included.	
<b>Theme 7. A Clearly Defined Service</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
• (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.
<b>Theme 8. A Personalised Service That Respects Dignity And Promotes Choice And Control</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
• (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 <i>'tick boxes'</i>
• (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 <i>'equal'</i> , 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	



**Haringey Council**

needs and maintain my dignity.	
<ul style="list-style-type: none"> <li>• (I want) to be treated with compassion and dignity.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) my care to feel personal.</li> </ul>	
<ul style="list-style-type: none"> <li>• (I want) to feel satisfied and keep happy, safe and worthy.</li> </ul>	
<b>Theme 9. Advocacy</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• 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.</li> </ul>	
<b>Theme 10. Prevention</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• (I want) preventative services.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) invest in prevention.</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) timely help to avoid crises.</li> </ul>	
<b>Theme 10. Competence</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• (I want) social workers who really know what they are doing and who are sufficiently qualified.</li> </ul>	<ul style="list-style-type: none"> <li>• We will) learn from failure</li> </ul>
<ul style="list-style-type: none"> <li>• (I want ) good managers/training.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) work harder and be dedicated.</li> </ul>
<ul style="list-style-type: none"> <li>• (I want people to) stop, reflect and take stock of who we are and where we are going.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) employ suitably qualified managers who have a collective vision of what integration means.</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) robust monitoring and review processes in place to follow the tendering and commissioning stage.</li> </ul>	<ul style="list-style-type: none"> <li>• (We will) stop and take stock of where we are and where going. Frontline staff are overwhelmed by the pace of change.</li> </ul>
<b>Other</b>	
<b>'I' Statements</b>	<b>'We' Statements</b>
<ul style="list-style-type: none"> <li>• (I want) transport as part of integration</li> </ul>	<ul style="list-style-type: none"> <li>• (We will give) Adult Safeguarding the importance it deserves.</li> </ul>
<ul style="list-style-type: none"> <li>• (I want) better use of telecare and telehealth I want better use of telecare and telehealth.</li> </ul>	

### APPENDIX 3. The Relationship Between Proposed Investments and the Delivery of Outcomes

	<b>Outcome 1</b> Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	<b>Outcome 2</b> Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	<b>Outcome 3</b> Delayed transfers of care from hospital per 100,000 population (average per month)	<b>Outcome 4</b> Avoidable emergency admissions (composite measure)	<b>Outcome 5</b> Patient / service user experience	<b>Outcome 6.</b> 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, Social Workers based in Hospitals 7 days/wk)			X		X	
Integrated End of					X	

Life Care Service						
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
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
Community Development Workers + expansion of Good Neighbours scheme	X	X		X	X	
Home From Hospital			X		X	
Information Technology &	X	X		X	X	

Better Data Sharing						
Single Point of Access				X	X	

The matrix 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.

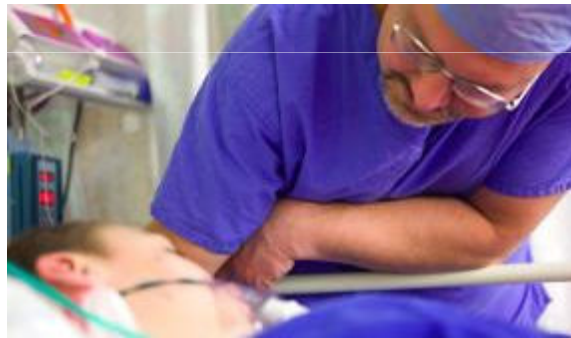
This page is intentionally left blank



# Primary Care Commissioning

## Quality & Safety in Primary Care

### London Region



February 2014



Contracts & Value

**Medical**

**1516 contracts**

**Value £ 1.063b**

1322 Registered GP providers with CQC  
(including out of Hours services)

## Background

- GPs are independent contractors, not employees of the NHS
- They must be included in the Performers' List and registered with the CQC to deliver services
- Performer List Regulations set out a regulatory framework for applying conditions to a GP's inclusion or continued inclusion
- NHSE decisions about inclusion or removal can be appealed via the First Tier Tribunal
- Important to differentiate practice Vs individual, but these can be blurred
- In order to be registered practices need to put in an application to the CQC for all regulated activity. The application has to prove the organisation is meeting specific standards.

## Managing GP Performance

There will continue to be two aspects of **performance management** in primary care for which NHS England is responsible:

- Contractual – managed by the Head of Primary Care
- Individual Performer – managed by the Medical Director.

The two will often overlap and so close working relationships are essential.

CCGs are responsible for **improvement** of clinical quality of primary care with NHS England and the Area Team will hold CCGs to account for delivery of this function.

The lines between performance management and improvement are fluid and NHSE and CCGs need to work closely together to ensure a fair and consistent approach is applied.

## How do we identify poor performance?

Although the new structure means we have lost our close relationship with practices we continue to make use of a range of information from different sources to inform our understanding of performance:

- National, London and local data to inform, compare and challenge
- Local intelligence from peers, other contractors/performers, CCG colleagues are key
- Information from Regulators, Regulatory Bodies and other statutory/non statutory organisations (e.g. CQC and GMC)
- Information from complaints, other providers, surveys, press/TV
- Direct patient feedback
- Whistleblowers
- Commissioned reviews

We take initial concerns to the Performance Screening Group (PSG) and consider outcomes and possible sanctions via a performance “Decision Making Group” (DMG)

## New national arrangements being developed ...

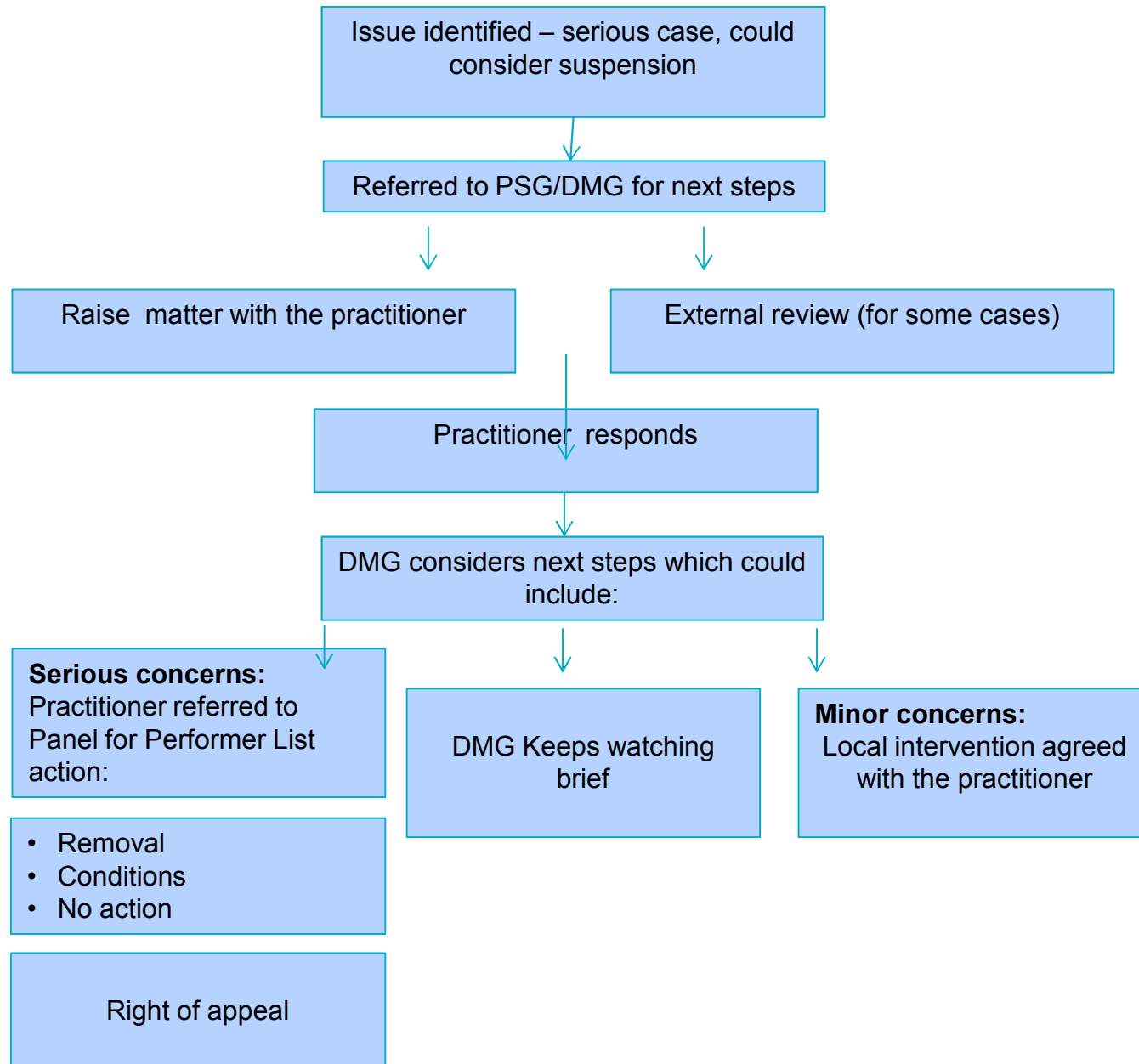
### **Contractual –**

- The range of national standards practices will be expected to meet
- The weighting/tolerances/triggers etc. to be applied
- The national process for handling poor contractual performance

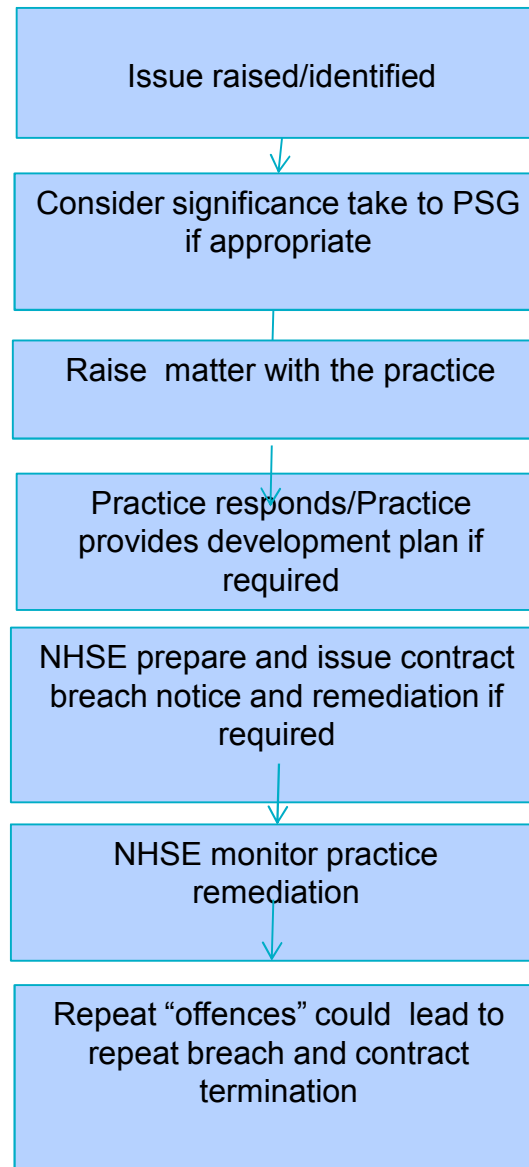
### **Individual performer –**

- The new National Performer List and associated regulations
- The national process for handling poor individual performance, including arrangements for Panel consideration etc.
- Appraisal & Revalidation

# Individual Performance



## Contractual or Practice matter





# CQC

- CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care
- There are three types of inspections – Scheduled, Responsive, Themed
- Referral to CQC via several routes – NCSC, website, LA, NHS services or in person by service users, relatives or staff.
- Regular programme of engagement with NHS England, CCG's, Healthwatch, Local Authorities and providers forums.
- Re-inspect services not meeting standards and take proportionate enforcement action against those accountable.

## Changes between old and new systems

- Processes essentially the same
- Different teams operating them
- More defined split between performer and contract
- New relationships required between NHSE and LAs, CCGs and Public Health England so that concerns they have in their commissioning of primary care services can be shared and locked into NHSE processes
- CQC Inspection has become a key source
- Liaison meetings to pull together intelligence across all factors. (Mini risk summit) in three areas

## The Revalidation of London's GPs

- Revalidation is the process by which the General Medical Council (GMC) confirms the continuation of a doctor's license to practice. It provides assurance that a doctor is both up to date and fit to practice. All Doctors are to be revalidated April 2016. Each Area Team's Medical Director is the Responsible Officer, RO, for GP Revalidation. They are responsible over the next 3 years for making sure all GPs are ready for Revalidation. It's the RO who makes the recommendation but GMC who decides whether a GP should be Revalidated or not. Not being revalidated means the GP loses their licence to practice. Being properly appraised is a key part of showing that a GP can be ready for Revalidation.
- Each team has a process for managing revalidation recommendations in its area. Where there are concerns about a GPs performance that arise from the Revalidation process then these cases are taken to PSG for consideration.
- In the first year of revalidation, 2013-14, the area teams must make revalidation recommendation for at least 20% of their GPs. In the following two years they will need to make recommendations for the remaining 80%. See <http://www.england.nhs.uk/ourwork/qual-clin-lead/revalidation>

## GP Appraisal in London

- Each Area Medical Team is responsible for managing the GP appraisal system within its part of London. Having an annual appraisal is a requirement of both the Performers List Regulations and the GP contracts. It's also an essential part of Revalidation.
- Appraisal provides a GP with the opportunity to reflect on their practice, agree a personal development plan and ensure they are up to date with all their mandatory training.
- Appraisals are conducted by an experienced GP employed by NHS England.
- In 2012/13, over 95% of London's GPs were appraised and we can account for the 5% who were not appraised.
- For the NHS England Appraisal Policy see <http://www.england.nhs.uk/wp-content/uploads/2013/03/medical-app-policy.pdf>