Haringey Council

Health and Wellbeing Board

TUESDAY, 30TH SEPTEMBER, 2014 at 18:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Please see membership list below

AGENDA

1. WELCOME AND INTRODUCTIONS

2. APOLOGIES

To receive any apologies for absence.

3. MINUTES (PAGES 3 - 10)

To consider and agree the minutes of the meeting of the Board held on 1 July 2014 as a correct record.

4. 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 13).

5. 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.

6. QUESTIONS, DEPUTATIONS, PETITIONS

To consider any requests received in accordance with Part 4, Section B, Paragraph 29 of the Council's Constitution.

7. FIVE BOROUGH FIVE YEAR PLAN 2014/15 - 2018/19 - BARNET, ENFIELD, HARINGEY, CAMDEN AND ISLINGTON CLINICAL COMMISSIONING GROUPS (CCGS) (PAGES 11 - 18)

8. HEALTH AND CARE INTEGRATION (PAGES 19 - 150)

9. GP SERVICES IN HARINGEY (PAGES 151 - 200)

10. GP ACCESS IN TOTTENHAM HALE: CAPACITY STUDY (PAGES 201 - 206)

The appendix to this report has been circulated separately as it was too large to include within the agenda pack.

11. ANNUAL PUBLIC HEALTH REPORT (PAGES 207 - 212)

12. PHARMACEUTICAL NEEDS ASSESSMENT (PAGES 213 - 224)

13. NEW ITEMS OF URGENT BUSINESS

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

14. 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:

- 13 January 2015
- 21 April 2015

Bernie Ryan
Assistant Director – Corporate Governance and Monitoring Officer
Level 5
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Xanthe Barker
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Agenda Item 1

Membership of the Health and Wellbeing Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	Leader of the Council	Cllr Claire Kober
			Cabinet Member for Children and Young People	Cllr Ann Waters
			Cabinet Member for Health and Wellbeing	Cllr Peter Morton
	Officers' Representatives	3	Director of Adult Social Services	Beverly Tarka
			Interim Director of Children and Young People's Services	Lisa Redfern
			Director of Public Health	Dr Jeanelle de Gruchy
NHS	Haringey Clinical Commissioning Group (CCG)	4	Chair	Dr Sherry Tang
			GP Board Member	Dr Helen Pelendrides
			Chief Officer	Sarah Price
			Lay Member	Cathy Herman
Patient and Service User Representative	Healthwatch Haringey	1	Interim Chair	Sharon Grant
Voluntary Sector Representative	HAVCO	1	Interim Representative	Gill Hawken

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Agenda Item 3

MINUTES OF THE HEALTH AND WELLBEING BOARD
TUESDAY, 1 JULY 2014

Board Members Present: Councillor Claire Kober (Chair and Leader of the Council) Gill Hawken (Interim CE HAVCO), Sir Paul Ennals (Chair of Haringey LSCB),Zina Etheridge (Deputy Chief Executive LBH), Dr Jeanelle de Gruchy (Director of Public Health, LBH), Sharon Grant (Chair, Healthwatch Haringey), Cathy Herman (Lay Member, Haringey CCG), Charlotte Pomery (Assistant Director Commissioning LBH), Sarah Price (Chief Officer, Haringey CCG), Beverley Tarka (Director of Adult Services LBH), Dr Sherry Tang (GP Board Member, Haringey CCG), and Councillor Ann Waters (Cabinet Member for Families).

In Attendance: Xanthe Barker (Principal Committee Officer LBH), Sarah Hart (Senior Commissioner Public Health, LBH), Andy James (DAAT Programme Manger LBH), Stephen Lawrence-Orumwense (Assistant Head of Legal Services LBH), Sanjay Mackintosh (Corporate Delivery Unit LBH), Liz Marnham (Senior Policy Officer LBH).

MINUTE NO.	SUBJECT/DECISION	ACTION BY
CNCL86.	**WELCOME AND INTRODUCTIONS** The Chair welcomed those present to the meeting	
CNCL87.	**APOLOGIES** Apologies for absence were received from the following: Councillor Peter Morton Dr Helen Pelendrides Lisa Redfern (substituted by Charlotte Pomery)	
CNCL88.	**URGENT BUSINESS** There were no items of urgent business.	
CNCL89.	**DECLARATIONS OF INTEREST** There were no declarations of interest made.	
CNCL90.	**QUESTIONS, DEPUTATIONS, PETITIONS** A deputation was taken from Mr Rod Wells of the group Haringey Needs St Ann's Hospital (HaNSAH) in relation to St Ann's Hospital and the Barnet, Enfield and Haringey Mental Health Trust's (BEH MHT) proposed plans for redeveloping the site. Mr Wells began by advising that HaNSAH had been formed in order to campaign for improved and integrated healthcare facilities at the St Ann's Hospital site. The main contention of the group was that rather than reducing	

the services currently delivered from the site, there should be a review of health needs in the east of the Borough, particularly in light of the projected ten thousand new homes expected in the area, and that the St Ann's site should be used to meet the additional demands that this would create.

Mr Wells noted that BEH MHT had now put forward a planning application for the site and contended that as designated NHS land, the Council and Clinical Commissioning Group (CCG) should support HaNSAH's call for a healthcare needs assessment to be undertaken before the planning application was considered. The group considered that this was essential in order to assess the potential increase in health care needs as a result of the anticipated increase in population in the east of the Borough.

Mr Wells noted that the Community Reference Group (CRG), which had been established as part of BEH MHTs consultation process on the redevelopment of the St Ann's site, had requested that information regarding the use of health services was used to inform the planning application and that consideration should be given to including plans for a walk in centre or minor injuries unit within the planning application. It had also been requested that a formal Healthcare Needs Assessment was undertaken by the Director of Public Health to inform the planning application in order to determine what healthcare provision was needed.

In summary there were three key questions that HaNSAH considered should be taken into account before plans for the redevelopment of the site were considered; how integrated services and care pathways could be developed on the site; the benefits for patients from the development of the site and; how the development of the site might contribute to reducing health inequalities between the east and the west of the borough. Mr Wells noted that HaNSAH had begun its own healthcare needs assessment, based on publically available data and that, in the group's view, this demonstrated a need for improved mental health services, an integrated child health centre and an urgent care centre on the St Ann's site.

In conclusion Mr Wells noted that in its role of promoting and coordinating integrated provision between the NHS, social care and public health services in Haringey, the Health and Wellbeing Board (HWB) should request that the Haringey Infrastructure Plan (HIP) was updated and that the Director of Public Health should undertake a Health Care Needs Assessment for the east of the borough before the outline planning application for the St Ann's site was considered.

The Chair thanked Mr Wells for his deputation and responded to the points raised. She began by noting that BEH MHT had now submitted a planning application for the St Ann's site and that there was a process that the application would now be subject to before it was determined by the Planning Committee. As part of this process there would be the opportunity for people to comment on the application at the Development Management Forum and at the Planning Committee meeting itself. In terms of the content of the

	planning application the Chair noted that of the existing sixteen acres that the site covered the application proposed that almost ten acres would be retained and could be used for clinical space in the future if required. With regard to the group's calls for a Healthcare Needs Assessment to be undertaken by the Director of Public Health, the Chair noted that the Joint Strategic Needs Assessment set out the health care needs of the borough and that the commissioners of health and social care used the information contained within this to commission services. In response to the assertion that the HIP should be reviewed, due to the large number of new homes that were likely to be built in Tottenham, the Chair noted that the HIP was a high level overarching plan covering the period 2011 – 2026 and that this would not be reviewed. The Council and NHS would continue to work together to monitor growth trends and the corresponding need in terms of needs as part of the Core Strategy and the Community Infrastructure Plan and other health plans. In conclusion the Chair thanked Mr Wells again for his deputation and noted that he and other members of the deputation were welcome to remain for the duration of the meeting.	
CNCL91.	**MINUTES** **RESOLVED:** That, subject to the inclusion of Gill Hawken in the list of those present, the minutes of the meeting held on 8 April 2014 be confirmed as a correct record.	
CNCL92.	**HEALTH AND WELLBEING STRATEGY OUTCOME 1 DELIVERY UPDATE** The Board considered a report, previously circulated, which provided an update with regard to the progress made by the Delivery Group for Outcome 1 of the HWB Strategy (2012-15). The Board discussed the report and it was noted that the terms 'early years' and 'early help' referred to different areas of focus and that these should not be used interchangeably. In response to a question around provision for children aged 0 to 4 years of age and whether specific reference would be made to this within the universal Healthy Child Programme (HCP), the Board was advised that it would. Ensuring that all children in the borough received a healthy start in life was a key driver for the strategy. There was agreement that the Board should receive more detail with respect to the provision being made for children aged 0 to 4 years of age as the HCP was developed. It was noted that although the recent Big Lottery Fund bid had not been successful, the data and the analysis work that had been done would be utilised across a range of projects including the creation of an operating model for early years provision.	AD Commissioning / Dir Children's Services

	RESOLVED: That the content of the report and the proposed direction of travel for the Early Years Strategy be noted.	
CNCL93.	**PERFORMANCE ON CHILDHOOD OBESITY: PUBLIC HEALTH UPDATE** The HWB received a presentation, previously circulated as part of the agenda pack, which provided an update on analysis work being undertaken by the Public Health team in relation to childhood obesity in the borough. Following this the HWB discussed the work being undertaken and how this might be taken forward. In response to a question as to whether there had been any analysis of the specific issues contributing to the high prevalence of childhood obesity in BME groups, the Director of Public Health advised that this had not been done in Haringey to date. Developing a better understanding around different cultural attitudes to physical activities and sport, particularly in relation to women and girls, would also be useful in tackling should obesity. The HWB was in agreement consideration should be given to undertaking a piece of work analysing the specific issues affecting BME groups order to enable interventions and services to be better targeted. The HWB discussed the use of targeted interventions and examples of this and it was noted that the Mayor's London Health Commission (LHC) was looking at how these might be introduced to tackle a range of public health issues on a pan-London basis. It was noted that in some areas of America there had been a targeted drive by health officials and public organisations to raise awareness of the levels of sugar in soft drinks and to limit the sale of these in schools. There was agreement that the possibility of adopting one or two areas for targeted interventions should be focussed on in a coordinated way by all partners to create behavioural change and that the HWB should discuss this in more depth at a future meeting. **RESOLVED:** That the need for a whole-system approach to tackling childhood obesity be noted.	Dir Public Health Dir Public Health
CNCL94.	**HEALTH AND WELLBEING STRATEGY UPDATE** The HWB considered a report, previously circulated, which provided an update on the current status of the Health and Wellbeing Strategy (2015-18) refresh project and the actions taken to date. It was noted that a refresh steering group had been established and that this met on a monthly basis and that a separate strategy writing team had been formed to write the strategy itself. The membership of the strategy writing	

	team was formed from members of the steering group, the outcome delivery group chairs and the Public Health team. The Board was advised that the Joint Strategic Needs Assessment (JSNA) steering group had met and that the narratives for each chapter were due to be completed by 30 June. In order to ensure that the JSNA fed into the refresh the Chair of the JSNA refresh sat on both the strategy refresh steering group and the strategy writing team. A presentation was being developed that would be taken to stakeholder meetings in order to capture views on how the pervious strategy had worked, the key challenges for the future and how success might be measured. A workshop session for the HWB was also being arranged for August to discuss the strategy refresh and this would provide the opportunity for the HWB to focus solely on this. There was agreement that as part of this the HWB would need to consider the provision of primary health care in the east of the borough. **RESOLVED:** i. That the actions taken to date be noted. ii. That the list of Health and Wellbeing stakeholders whose views would be captured as part of the strategy refresh be noted.	Dir Public Health
CNCL95.	**LONDON BOROUGH OF HARINGEY CORPORATE PLAN** A presentation was given setting out how the Council's new Corporate Plan was being devised. The HWB was advised that the new three year Corporate Plan (CP) would run from 2014/15 to 2017/18 and that it was being prepared in consultation with Members and partners. The CP was being prepared in light of the new Administration's manifesto commitments and resident feedback and would be aligned to the Council's Medium Term Financial Strategy (MTFS), Workforce Plan, Performance Management Framework and Commissioning Framework. A workshop session had been held to look at Priority 6 'Reducing health inequalities and improving wellbeing for all' at which the Director of Public Health had set out the following vision and six outcome focussed objectives: <u>Vision</u> 'All residents live healthy, fulfilling lives for longer' <u>Objectives</u> ➢ Haringey is a place where the healthy choice is the easier choice ➢ All children have a healthy start in life ➢ Young people and adults have improved reproductive and sexual health	

	➢ More people with severe health problems have good physical health ➢ More people with health and social care needs are living full, independent lives within the community ➢ All residents in Haringey can expect to have long, healthy lives The Board discussed the vision and objectives set out above and it was noted that alignment between the Health and Wellbeing Strategy, the Corporate Plan and CCG commissioning plans, would be crucial in ensuring that each was effective as possible and that the best possible use of resources was achieved. There was agreement that the HWS workshop session in August would provide a useful opportunity to discuss the objectives in more detail. **RESOLVED:** That the plans with respect to the new Corporate Plan for 2015/16 to 2018/19, as outlined in the presentation, be noted.	
CNCL96.	**HEALTH AND WELLBEING - NATIONAL AND LONDON DEVELOPMENTS UPDATE** The HWB received a report, for noting, that provided an update on a number of national and pan-London developments in relation to health and wellbeing including the Mayor's London Health Commission, the London Health Board and Public Health England's Health and Wellbeing Framework. **RESOLVED:** That the implications for Haringey and of the National and London developments described in the report be noted.	
CNCL97.	**HOMELESSNESS HEALTH NEEDS ASSESSMENT TASK AND FINISH GROUP REPORT** The HWB considered a report, previously circulated, which set out proposals for establishing a homelessness health pathway. The HWB had established a Task and Finish Group to consider how six key issues, identified by the Homelessness Health Needs Assessment, should be addressed. The group was comprised of members from Haringey CCG, Public Health and the Council's Housing Team had met on four occasions. It was noted that the group's fourth meeting had been attended by representatives from Healthwatch and the group 'All People All Places'. The Board discussed the Task and Finish Group's findings with regard to GP registration, models of primary care, customer service advice delivered from Apex House and hospital discharge. With regard to GP registration and the requirement for photo identification to be provided, there was agreement that consistency was needed and confirmation from the Department of Health's Equalities Unit that this was not required was welcomed. It was suggested that this and issues with regard to hospital discharge should be raised with North	CCG Chief Officer

	East London NHS. The Chair of Healthwatch Haringey echoed points highlighted in the report with regard to the difficulties homeless people experienced accessing housing services at Apex House and noted that ongoing engagement with Healthwatch would be welcomed on this. There was agreement that a multi partnership workshop to help develop a homelessness pathway would be a good way of bringing partners together and that following this the HWB should receive a report setting out the conclusions of this and how the work would be taken forward. **RESOLVED:** That the proposals set out in paragraph 4 of the report be noted.	Senior Commissioning Manager Housing Related Support
CNCL98.	**THE NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST FOUNDATION STATUS UPDATE** The HWB considered a report, previously circulated, from the Deputy Chief Executive of North Middlesex University NHS Trust, on the progress in relation to its application for foundation trust status. It was noted that the hospital was making good progress in its application for Foundation Trust (FT) status. The application was now in its second of the three stages 'Development and Assurance' and these were assessed by the NHS Trust Development Authority (TDA). As part of this a twelve week public consultation had commenced on 27 May and would include a number of public events. There was also an online questionnaire that people could complete on the hospital's website. The Board was advised that in order for the application to progress, letters of support from key commissioners (Enfield and Haringey CCGs) were required. The need to demonstrate that the hospital's plans were broadly in line with the commissioning intentions of each CCG would be important and it was noted that there would be discussions at the relevant CCG governing bodies in September. The Board discussed the update and it was requested that there was engagement with Healthwatch outside the meeting to discuss the implications for patients that FT status might bring. It was also noted that demonstrating how patient and other stakeholders' views were being responded to would be a very important piece of follow up work after the consultation period had ended. People that responded to questionnaires and consultation attended events often felt dissatisfied when they did not receive a response to their concerns. The Chair thanked the Deputy Chief Executive of the North Middlesex University NHS Trust for attending and for providing the update.	Healthwatch / Deputy CE North Middlesex

	RESOLVED: That the update be noted.	
CNCL99.	**NEW ITEMS OF URGENT BUSINESS** There were no new items if urgent business.	
CNCL100	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** The Chair noted it was important that the HWB had strategic discussions that shaped policy and there was agreement that in addition to a smaller number of formal reports there should be themed discussions at each meeting. The Director of PH was asked to discuss possible themes with partners outside the meeting. Given the concerns raised around the provision of primary care services in the east of the borough, as part the deputation received and concerns raised by residents at the difficulty of registering with a GP, this would be a good theme for discussion at the September meeting. The Director of PH also noted that Integration should be discussed at the next meeting.	Dir Public Health

The meeting closed at 3.40pm.

Councillor Claire Kober

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Chair

Agenda Item 7

Haringey Council

Report for:	**Health and Wellbeing Board – 30 September 2014**	**Item Number:**	

Title:	**Five borough 5 year plan 2014/15 – 2018/19** **Barnet, Enfield, Haringey, Camden and Islington Clinical Commissioning Groups (CCGs)**

Report Authorised by:	**Sarah Price, Chief Officer, Haringey CCG**

Lead Officer:	**Dee Parker, Interim Head of Strategy and Performance, Haringey CCG**

Ward(s) affected: All	**Report for Key/Non Key Decisions:** **N/A**

1. Describe the issue under consideration

1.1. This report provides the Haringey Health and Wellbeing Board (HWB) with an update on NHS strategic planning and progress towards the next submission of the North Central London (NCL) Strategic Planning Group (SPG) Five Year Plan which aligns the plans across Barnet, Camden, Enfield, Haringey and Islington CCGs, Public Health, and NHS England (primary care and specialised services). This submission is due to NHS England (NHSE) in late October 2014.

1.2 In February 2014 the Health and Wellbeing Board (HWB) was asked to review and support Haringey Clinical Commissioning Group's (CCG) 2 year operating plan which formed the first two years of a wider five year strategic plan. Subsequent to this update, the five North Central London CCGs have been working together as a Strategic Planning Group (SPG) to develop an overarching five-year strategic plan. The rationale of the five borough approach being a stronger platform for collaborative working that will drive innovation and better health service design for our population.

1.3 Haringey CCG is now seeking to:
- inform the HWB of progress with the NCL CCGs' five year strategy

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- demonstrate how it incorporates and builds on the existing work of the Haringey CCG local five year strategic plan
- clarify the impact of the NCL five year plan for the population of the borough of Haringey
- secure the support of HWB for the NCL plan.

1.4 An early draft of the NCL strategy was submitted to NHS England (London) in June. The NCL SPG is currently working towards the next submission of the NCL 5 year plan which is due in late October 2014.

2. Recommendations

2.1 The HWB members are asked to **NOTE** the contents of this paper, progress to date and the next steps.

2.2 The HWB members are asked to **SUPPORT** the NCL plan.

3. Background

3.1. North central London (NCL) comprises Barnet, Camden, Enfield, Haringey and Islington CCGs, each of which works both individually and collaboratively to meet the challenges of delivering high-quality, patient-focused health care services to their local populations.

3.2 The NCL CCGs and NHSE (London) are responsible for planning and commissioning NHS services across north central London. Together they are working in partnership with local authorities, local providers and other key stakeholders to define a five-year strategy for health and integrated care services across north central London.

3.3 The NCL Strategic Planning Group (SPG) was formed earlier this year to respond to the NHSE request for a five year strategic plan across the five boroughs for the period 2014-2019. The SPG membership includes Directors of Commissioning, Strategic Planning and others representing CCG planning functions. Local authority, provider organisations and other strategic partners are invited to attend sessions regularly on topics important to the development and shared delivery of commissioners' five year vision.

3.4 The vision and values of North Central London Strategic Planning Group

3.4.1 The vision across NCL is to develop **an integrated care network between organisations (supported by current technology to share clinical records) that is focused on outcomes for and shaped by patients**. There is also a need to support patients in having a more independent role in looking after their own health needs which will be achieved through greater patient participation in shaping local healthcare. Seven day working underpinned by the implementation of the Better

Haringey Council

Care Fund is seen as key to providing the infrastructure to deliver better access and services closer to home.

3.4.2 NCL CCGs have agreed the core values on which this vision is built. This reinforces the intention to deliver high quality care for patients, in the most efficient, and cost effective way. NCL is pioneering a value-based approach to commissioning as it is believed that commissioning for better health outcomes is fundamental to creating a better health service and healthier population.

3.4.3 Our vision will be achieved when the north central London health system demonstrates the following characteristics which are in line with HWB strategies:

3.4.3.1 A systematic approach to prevention including earlier diagnosis of disease
3.4.3.2 Reducing inequalities in health outcomes by targeting vulnerable groups
3.4.3.3 Individuals encouraged and supported to take greater responsibility for their health
3.4.3.4 Integrated, compassionate, high quality, effective and efficient care pathways that are shaped by patients
3.4.3.5 Easy access to services delivered in ways and places convenient to patients
3.4.3.6 Financial sustainability though a clinically driven focus on quality of services.

3.5 Developing stronger partnerships across North Central London

3.5.1 In order to develop a collective five year plan amongst the many diverse organisations in NCL it is fundamental to establish a shared understanding of key challenges and ascertain where stronger partnership working would enhance the health and wellbeing of local people. Collaboration does not only mean all five CCGs working together. There will be occasions when two or more CCGs collaborate. There will also be occasions when the collaboration involves working with local authorities or other organisations from outside the area.

3.5.2 Our shared aims and objectives for collaboration are to:

3.5.2.1 Achieve clinical improvements and better health outcomes for local people across NCL
3.5.2.2 Deliver other tangible benefits for patients, for example, reduction in waiting times, easier access to services, smoother care pathways etc
3.5.2.3 Ensure efficiencies in service delivery including better value for money and associated savings through improved leverage with providers
3.5.2.4 Achieve greater resilience and better risk management within organisations and across the health and care economy as a whole
3.5.2.5 Bring in and share additional knowledge and expertise
3.5.2.6 Declutter workloads and avoid duplication of effort
3.5.2.7 Reduce fragmentation and inconsistency of delivery across the five boroughs
3.5.2.8 Strengthen and build a sustainable health economy within the context of an agreed vision.

Haringey Council

3.5.3 Working with local authorities is a priority to ensure the delivery of the NCL vision and truly integrated services which respond to what patients tell us about their experience of health and care. Our vision for integration extends beyond achieving more joined up health and social care services and includes an enhanced role for voluntary sector organisations.

3.6 Key challenges for North Central London

3.6.1 The challenges can be summarised as follows:

3.6.1.1 Population and Demand – the health of the population continues to improve but inequalities still persist

3.6.1.2 Quality and Outcomes - our health services have many strengths but quality remains unacceptably variable

3.6.1.3 Finance and Sustainability - the 'do nothing' scenario is unsustainable and will deliver a financial gap of £463m in 2019.

3.6.2 Many of the clinical priorities and issues facing the five boroughs in north central London are similar. Common factors relate to management of long-term conditions, the balance between primary, community and secondary care, access to unscheduled care, population changes, variation in quality, activity and patient experience, and the challenges of addressing significant financial challenges.

3.6.3 System challenges include a lack of integration between organisations resulting in fragmented services for patients that cross organisational and local authority boundaries. System-wide changes enabled by the Better Care Fund and collaboration between providers are necessary to deliver seamless services and optimal outcomes for patients. There is also a significant challenge to educate the local population on the most appropriate access to care, and for each individual to be supported to start to take ownership for their own self-management.

3.7 Alignment with local plans and HWB strategies

3.7.1 The CCGs' current plans and commissioning intentions are based on JSNA data and are aligned with HWB strategies. Haringey CCG is closely involved with the refresh of the Haringey HWB strategy.

3.7.2 The NCL plan is also closely aligned to the Haringey CCG five-year plan in making primary care and care closer to home really work for all Haringey residents by:

3.7.2.1 Moving from buying healthcare to buying improved outcomes as defined by our residents

3.7.2.2 Moving to a population centred approach to commissioning – fitting in with people's lives, improving access

3.7.2.3 Specifically promoting and supporting self care where appropriate – the public empowered in their own care.

Haringey Council

3.8 **Risks for Haringey**

3.8.1 There is a risk that Haringey CCG's plans for the local population will be overshadowed as the NCL plans evolve. This has been partially mitigated by ensuring that Haringey's strategic plans are embedded into the NCL overarching strategy. Haringey's focus will be on continuing to translate these plans into high quality local services that address local health needs. Where wider collaboration adds value to our population, we will work closely with our partners to develop seamless pathways of integrated care, simplifying access to specialist care with patients returning home for further care and support. The development of the NCL strategy will continue to pose a degree of risk to Haringey.

3.8.2 The pace and scale of implementing transformational change across many organisations and stakeholders poses a further risk for Haringey and its partners. To mitigate this risk Haringey CCG will build on the extensive local communications and engagement we have carried out to develop the Haringey vision and the Haringey CCG five year plan. We will continue to offer people in Haringey the opportunity to inform the development of our plans and shape and improve the quality of services, in line with our local engagement strategy. This will be achieved through many conversations with different stakeholders, including the workforce and at public meetings, engagement visits, Network meetings and stakeholder events.

3.9 **Next Steps**

3.9.1 Next submission of the NCL Five Year Strategic Plan to NHS England is due in late October 2014.

4. **Comments of the Chief Finance Officer and financial implications**

4.1 This report provides an update on the progress of the five year strategic plan for North Central London. The activity and plans mentioned in this strategy are funded by the NHS. With the exception of some areas of joint work with Local Authorities, there is little impact on Council budgets. Any potential impact as a result of changing the way that healthcare is delivered locally is difficult to define at this stage. This risk will continue to be managed through the development of the Better Care Fund and the integration and joint working that will grow as a result of this initiative.

5. **Comments of the Assistant Director of Corporate Governance and legal implications**

5.1 The Assistant Director Corporate Governance has been consulted about this report. There are no legal issues arising for the Board

6. **Equalities and Community Cohesion Comments**

Haringey Council

6.1 The public sector equality duty consists of a general equality duty, which is set out in section 149 of the Equality Act 2010 itself, and the specific duties which came into law on the 10th September 2011. In summary, those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The Act also states that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status.

6.2 All the statutory agencies involved in the collaboration – NHS Barnet, Camden, Enfield, Haringey and Islington constituting North Central London – are all public bodies within the meaning of the Equality Act 2010 and as such subject to the general equality duty as set out above.

6.3 The NCL five year strategy takes account of this duty by setting out its plans and actions over the next five years to reduce health inequalities for the population of north central London. The plan takes into account the diversity of populations across the five boroughs of NCL with a people centred and integrated approach to commissioning which will contribute to improved access and health outcomes for all NCL residents.

7. Policy Implication

Haringey Council

7.1 The NCL five year plan has been developed in partnership with commissioning leads and with reference to the Joint Strategic Needs Assessment (JSNA) and is closely aligned to the Joint Health and Wellbeing Strategy

8. **Use of Appendices**

8.1 None

9. Local Government (Access to Information) Act 1985

N/A

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Agenda Item 8

Haringey Council

Report for:	**Health and Wellbeing Board – 30 September 2014**	**Item Number:**	

Title:	Health and Care Integration

Report Authorised by:	Zina Etheridge – Deputy Chief Executive

Lead Officer:	Zina Etheridge – Deputy Chief Executive, Haringey Council and Sarah Price – Chief Officer, Haringey CCG

Ward(s) affected: All	**Report for Key/Non Key Decisions:** For consideration and information

1. Describe the issue under consideration

1.1. This paper sets out a proposal to establish a Health and Care Integration Programme, which will enable the Council and the Clinical Commissioning Group (CCG) to jointly achieve better outcomes for local residents, improve the user experience and to deliver efficiencies and value for money. This proposal will also consider how existing collaboration and integration initiatives will be incorporated within this Programme.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to:

(i) Note the proposal for the Health and Care Integration Programme, as set out in the presentation, attached in Appendix 1.

(ii) Note that some of the existing integration initiatives will be incorporated into this Programme – updates for key integration initiatives currently in progress are included in the Appendices 2 to 6 and will be presented as part of this session

Haringey Council

(iii) Agree that the Health and Wellbeing Board provides strategic oversight of the programme, although key decisions will need to be made through the Council or CCG decision making structures

(iv) Agree that a follow up presentation / paper will be submitted for the next meeting, which will also include a proposal of how the Health and Wellbeing Board will be involved in this Programme

3. Background information

3.1. Changes in the system, legislation and policy place an increasing emphasis for integrating and joining up services. There are a limited number of projects and initiatives where the Council and CCG collaborate to develop integrated services. There is a need for a more formal and structured approach for this collaboration and integration.

3.2. The presentation, embedded in the previous section 2, provides further information.

3.3. As part of this session, updates and further information are provided for a number of Integration initiatives and projects, including:

(i) Value Based Commissioning Older People with Frailty

(ii) Mental Health Framework

(iii) Better Care Fund re-submission

(iv) Scrutiny Reports

4. Comments of the Chief Finance Officer and financial implications

4.1. Not applicable at this stage. As a next step further work will be completed to scope the Programme and associated projects, as well as to determine any financial implications. This scope and financial implications will be discussed and agreed with the appropriate stakeholders in the respective organisations.

4.2. The result of this scoping work with any comments from the Chief Finance Officer(s) will be included in the follow up presentation/ paper for the next meeting.

5. Comments of the Assistant Director of Corporate Governance and legal implications

5.1. The recommendation to set up a Health and Care Integration Programme is conducive to the Council's and the CCG's statutory powers to promote integrated commissioning and provision of services in health and social care. These powers in

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particular those relating to the Council, are set out in Sections 75 of the National Health Services Act 2006 (as amended) (arrangements between NHS bodies and local authorities for the delegation of functions), Sections 25 and 26 of the Children and families Act 2014 (Education, health and care provision: integration and joint commissioning) and Section 3 of the Care Act 2014 (Promoting integration of care and support with health services etc).

6. Equalities and Community Cohesion Comments

6.1. The proposed Health and Care Integration Programme is designed to provide health and social care services that produce better outcomes 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.

7. Policy Implication

7.1. There are no direct policy implications arising out of this report however national policy is a key driver of integration especially from the Better Care Fund and Care Act Implementation and this programme of work will complement and add value to work under this remit.

8. Use of Appendices

8.1. The following Appendices have been submitted with this paper:

Appendix 1 – Health and Care Integration Programme (presentation)

Appendix 2 – Value Based Commissioning Older People with Frailty (paper)

Appendix 3 – Mental Health Framework (paper)

Appendix 4 – Better Care Fund re-submission (paper for information)

Appendix 5 – Scrutiny review and Response Report

9. Local Government (Access to Information) Act 1985

9.1. No applicable

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DRAFT

HARINGEY INTEGRATION PROGRAMME

Vision and scope

September 2014

Desired outcome – achieving Haringey's vision for Integrated Care

With changes in the system, legislation and policy, an increasing emphasis for integrating and joining up services.

Haringey's shared vision for Integrated Care is the key outcome for an Integration Programme:

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 be centred on their needs, supporting their independence
and provided locally wherever possible.

This means:

- The patient's perspective is at the heart of any discussions about integrated care.
- When planning and providing integrated care services **the patient's perspective should be the organising principle of service delivery**

To meet Haringey's vision for Integrated Care, there is a need for more integration and collaboration between the Council and the CCG.

Need for change

- A number of individual projects already underway
  - Focused on integrated health and social care
  - With collaboration across the CCG and the Council (and providers), where
- Proposal to establish a Health and Care Integration Programme
  - A more focussed and co-ordinated approach to integration projects
  - Establishing the conditions and environment where Integration is ingrained into day-to-day operation
- Incorporating existing projects, including:
  - Better Care Fund Programme
  - Value Based Commissioning
  - Haringey Learning Disabilities Partnership
  - Mental Health Framework
  - Implementation of SEND reforms / Children & Families Act, and Care Act
- Ensuring other transformation programmes, particularly in the Council, support the aims of integration and any interdependencies are managed
- Integration will help in addressing the financial challenges facing the CCG and the Council
  - but acknowledged that it will not fully resolve these challenges

Principles for Collaboration / Integration Programme

- Collaborate based on trust – open, honest and transparent
- Leadership at all levels
  - Each project has a senior sponsor who has an organisational stake in the integration of health and social care services in Haringey
- Integration Programme covers both commissioning and provision of services (i.e. delivery models)
- Governance model allows for quick decision making as long as within the agreed principles and scope of the Programme
- All agreed and approved integration initiatives are delivered and managed as a project
  - Adoptions of best practice, such as Haringey Council's Programme Management Framework
- Cost reduction would not be the overriding criteria for Integration
  - Cost savings will be identified and tracked where possible
- The model and degree of integration will be determined and agreed for each project
  - Best approach for the situation
  - Considering approaches tested and used in other projects

Initial scope align with the priorities in Health and Wellbeing Strategy

- Frail and elderly people

  Initial focus on:

  – Better Care Fund Programme (scope of 2014/15)
  – Value Based Commissioning Project
  – Some work to assure alignment between these two projects

- Children 0-25

  Initial priorities to include:

  – SEND reforms
  – Integration with Early Help models
  – Integrated service offerings for “Conception to 5”

- Mental Health (and Wellbeing)

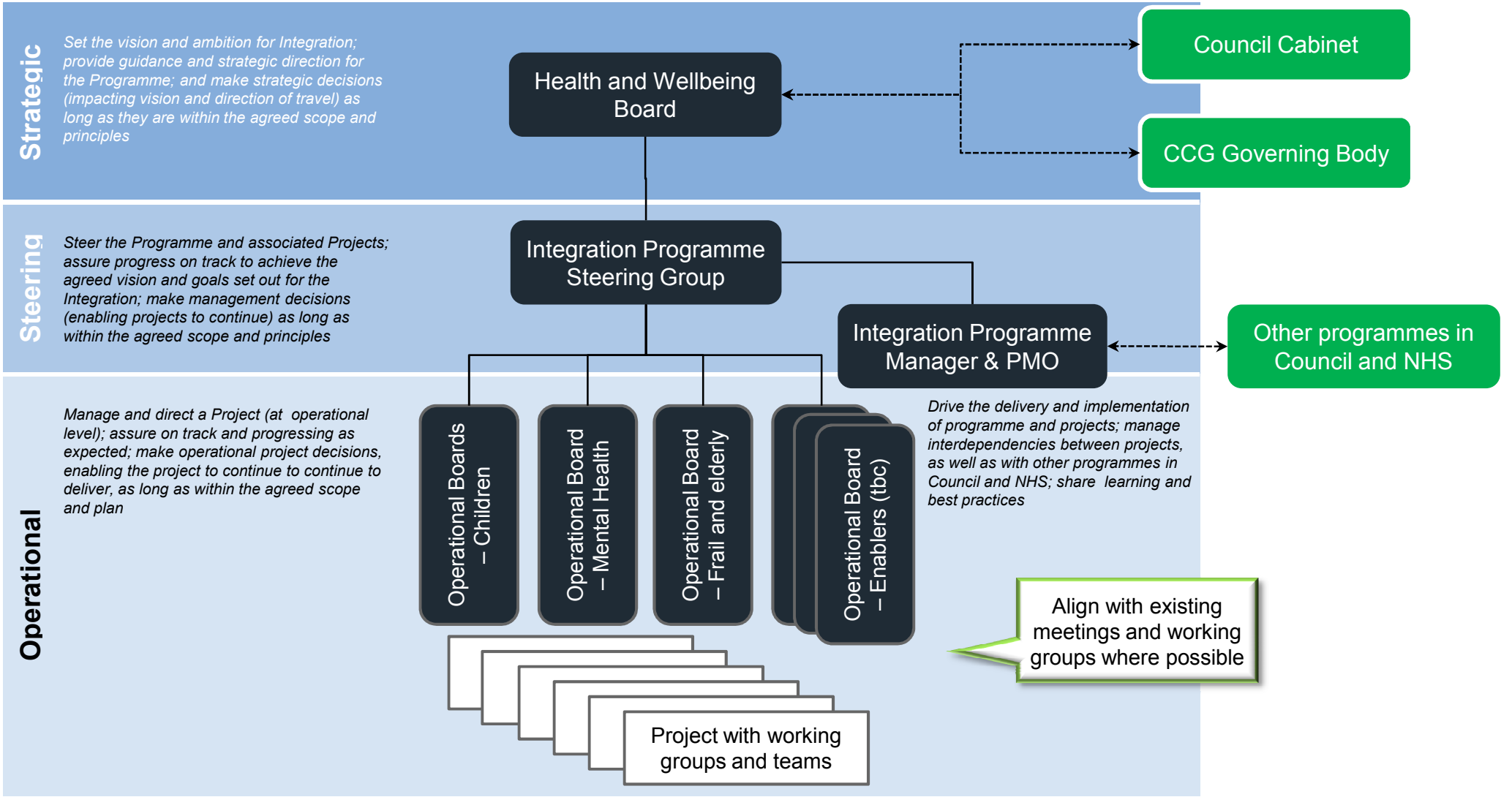
  Initially covering:

  – Mental Health Framework
  – Better Care Fund Programme (scope for 2015/16)
  – CAHMS services – integration and improvements
  – Early help pathway – both children and adults
  – Specialist mental health services (Tier 4)

Potential key risks and issues

- Differences in organisational cultures
- Existing controls and systems in the various organisations
  - Significant differences and complexity - specific to organisations
  - Not supporting collaboration and integration
- Pressures to deliver credible and ambitious plans quickly
- Financial pressures the CCG and the Council are facing
  - Significant cut in budgets
- Organisational barriers
  - Organisational boundaries and separate teams both between and within an organisation
  - Infrastructure limitations – IT, data sharing
- Effective Clinical Leadership and Political Leadership
- Involvement and management of other NHS organisations
  - NHS England, neighbouring CCGs, health providers – both key stakeholders and contributors to the Programme
- Locally no control or influence on centrally driven changes in organisational structures and policies, in particular in health

Governance for Integration Programme



Next steps

- Define and scope the Health and Social Care Integration Programme
  - Overall programme – plan and other programme documents
  - Initial focus areas / themes / priorities
  - Existing / (potentially) new projects
- Define and document the governance model in further detail
  - ToR for Integration Programme Steering Group
  - Role and responsibilities for Integration Programme Manager and PMO
- Define and agree (extend) role and responsibilities for Health and Wellbeing Board
- Establish Operational Boards and structure
  - Work streams and projects
  - Align with existing meetings and working groups, where possible

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APPENDIX 2

Report for:	**Health and Wellbeing Board - September 2014**	**Item Number:**	

Title:	**Discussion Paper on Value Based Commissioning – Older People with Frailty**

Report Authorised by:	**Sarah Price** Haringey Clinical Commissioning Group sarah.price@haringeyccg.nhs.uk

Lead Officer:	**Rachel Lissauer** Haringey Clinical Commissioning Group Rachel.Lissauer@haringeyccg.nhs.uk

Ward(s) affected: N/A	**Report for Key/Non Key Decisions: N/A**

1. Describe the issue under consideration

1.1 This paper provides an update on progress in developing an outline business case for Value Based Commissioning (VBC).

1.2 VBC is an important part of delivering integrated care and the Better Care Fund programme (which are the subject of separate reports on this agenda). VBC for older people with frailty has been the subject of discussion between health and social care commissioners and with providers.

1.3 The London Borough of Haringey would be required to approve any commitment of local authority funding for value based commissioning. This paper comes to the Health and Wellbeing Board to promote discussion in advance of any such decision-making process.

2. Recommendations

2.1 It is recommended that the Health and Wellbeing Board:
(a) Consider and discuss the proposals set out in the discussion paper; and
(b) Provide feedback that will influence the development of the Outline Business Case.

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3. Background information

3.1 Within healthcare, we traditionally commission by paying for episodes of care (such as individual appointments or hospital admissions) rather than paying for achievement of agreed outcomes. We also have block contracts for community health services. Within social care there are separate processes of carrying out assessments and putting into place individual packages of care or placements, funded either through personal budgets or direct payments.

3.2 The different approaches to how payment for care is organised can contribute towards client's experiences of health and social care being fragmented. Commissioners will not have an understanding of the whole package of health and social care meaning it may not be built around a patient's whole needs. In addition, individuals often need to navigate their own way through a complex web of services, commissioned and funded in different ways.

3.3 As commissioners of health and social care, it is difficult to understand the total cost of health and care for a particular person or for a particular cohort of the population. Patients and clients may be required to meet a certain threshold of need in order to trigger a service. This can mean that services are focused on treatment and a reactive response rather than prevention. Different services and organisations have different ways of measuring performance. Often these measures tell us about the number of people who have been reviewed, visited or admitted rather than telling us about the outcome of a service or intervention for the person and the impact it had on their health and wellbeing overall.

3.4 The value based commissioning programme (VBC) is an ambitious attempt to move towards contracting for an entire system or pathway of care with a strong focus around outcomes. It describes a move to commission for outcomes of care, as defined by the public, patients and professionals. Such outcomes could include:

- Being able to plan one's own care with joined up provision;
- Feeling in control of the health and care someone is receiving; and
- Feeling listened to and treated with respect by all.

3.5 Measuring 'value' means measuring the outcomes achieved by the total cost of care for a patient/client or population cohort. There are a number of different options for how such an approach could be introduced in Haringey and these are currently being explored.

3.6 Haringey CCG has been leading a project across both Haringey and Enfield, looking at how VBC can be implemented for the over 75s who are already frail or at risk of becoming frail. Considerable work has been carried out with members of the public and front-line staff to identify the outcomes that they prioritise and that are important to them. The CCG and Local Authority have also both submitted

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information so that we have the first stage of baseline costs for this cohort of our population, across health and social care.

3.7 Local Authority officers have participated and influenced the project as part of the Steering Group and the North Middlesex Hospital Transformation Board, both of which have had frequent updates on project progress.

3.8 The CCG is now approaching the stage of issuing Commissioning Intentions to acute and community health providers and of drafting an Outline Business Case (OBC) to explore the implications of moving towards this commissioning approach. The Governing Bodies of Enfield and Haringey CCGs will then be asked to make a decision about whether to move towards VBC from April 2015. This paper sets out the implications of moving towards VBC and explores the line of argument that will be developed within the Outline Business Case.

3.9 Whilst the Local Authority will continue to participate in discussions about VBC a decision about financial or other resource contributions is not being sought at this time.

3.10 This paper is provided as background and context ahead of decision-making. The Health and Wellbeing Board is asked to consider its perspective on value based commissioning so that comments or concerns can be reflected and addressed in the Outline Business Case.

4. Implications

4.1 The introduction of an approach based on value based commissioning to the health and care economy of Haringey raises a number of issues some of which are set out briefly below. These would need to be worked through in developing the Outline Business Case and in order to inform the production of a Full Business Case. There is commitment and opportunity to explore these issues further and to ensure the implications are well understood across the system as we move forward.

- Unlike the CCG, the Council has a role as both commissioner and provider.
- The Council and the CCG procure and contract differently and are subject to different rules currently.
- Personalisation is a fundamental approach underpinning social care delivery and the impact on resident choice and personalised packages of care and support would need to be understood in the context of the options being appraised for value based commissioning.
- The risks of market failure and how commissioners would respond have yet to be addressed.

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- The emphasis on partnership and consortium approaches across providers will require developmental work with the provider market.

- Ensuring benefits flow back into the whole system rather than remaining in one part of the system is necessary to ensure improved outcomes benefit all partners.

5. Comments of the Chief Finance Officer and financial implications

5.1 The proposal under discussion is for a proportion of the CCG current spend on care for people aged over 75yrs to be separated out from standard contracts and made contingent on outcome delivery.

5.2 In order for this proposal to be developed and approved, an Outline Business Case will be submitted to the CCG for approval and will then be developed into a Full Business Case in November 2014.

5.3 The Council may wish to participate as part of the network of providers without committing financial resource to value based commissioning. The Council may decide to take a proposal to Cabinet for a decision about the commitment of resource to Value Based Commissioning. The timescale for this would be defined by the Council.

6. Comments of the Assistant Director of Corporate Governance and legal implications

6.1 The Assistant Director of Corporate Governance has been consulted about this report. Although there are no legal implications arising from the report, the issue raised (i.e. VBC) is important in the context of the Board's strategic role in health and social care provision and integration.

7. Equalities and Community Cohesion Comments

7.1 An equalities and community cohesion report is being undertaken as part of the OBC.

8. Policy Implication

8.1 Close links to Integrated Care agenda for Local Authority and CCG. Value Based Commissioning aims to create incentives that will support the delivery of integrated, locality teams being pursued as part of the implementation of the Better Care Fund.

9. Use of Appendices

9.1 N/A

10. Local Government (Access to Information) Act 1985

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10.1 N/A.

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APPENDIX 3 a

Report for:	Health and Wellbeing Board	Item Number:	

Title:	Mental Health and Wellbeing Framework

Report Authorised by:	Jeanelle De Gruchy, Director of Public Health

Lead Officer:	Tamara Djuretic, Assistant Director of Public Health

Ward(s) affected: All	Report for Information

1. Describe the issue under consideration

1.1 There is a need locally to bring together all of the existing strategies and articulate a clear vision for improving mental health and wellbeing of Haringey's residents from early years throughout adulthood and older age. Our existing Health and Wellbeing Strategy started to set the direction of travel and strengthen partnership working. We now need to scale up our ambition and develop the Framework to strengthen this priority and clearly articulate our strategic integrated commissioning plans for future years.

1.2 Health and Wellbeing Board (HWB) Outcome 3 Delivery Group: Improving mental health and wellbeing agreed to initiate development of joint Haringey CCG and Haringey Council Mental Health and Wellbeing Framework that will feed into refresh of HWB Strategy 2015-2019. Public Health Directorate is providing strategic leadership, jointly with the CCG in development of the Framework.

2. Cabinet Member introduction

2.1 Haringey has a high level of mental illness and that can impact on any sphere of life: family, employment, education, social interactions. Tackling this issue is a priority for the Council and therefore I welcome partnership approach to developing the Framework.

2.2 Recent years have seen some significant improvements in supporting people to have good mental health, in particular, our investment in a range of public mental

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health interventions. However, we do need to be more ambitious and aspire to commission and deliver the best mental health services for our communities in partnership with the CCG, voluntary sector and service users.

3. Recommendations

3.1 The HWB is asked to note Mental Health and Wellbeing Framework scoping document and approve the process for developing the Framework.

3.2 Draft Framework to be presented to the Health and Wellbeing Board in April 2015.

4. Alternative options considered

4.1 N/A

5. Background information

5.1 Mental ill health represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability. Nearly 11% of England's annual secondary care health budget is spent on mental health. Estimates have suggested that the cost of treating mental health problems could double over the next 20 years. More than £2 billion is spent annually on social care for people with mental health problems. In Haringey, there is a high level of mental health need. An estimated 3,160 children have mental health problems in the borough and this is predicted to rise. Estimated 34,000 adults locally live with anxiety and depression and over 3, 000 suffer from severe mental illness. Haringey's suicide rates are higher than London and England, especially in men 30 to 45 years of age.

5.2 'No Health without Mental Health: The cross government mental health outcomes strategy for people of all ages' published in 2011 sets out clear objectives for improving mental health and wellbeing and emphasises the importance of mental health being 'everyone's business'. It goes on to say that mental wellbeing is crucial for individuals and the country's social and economic status, identifying good mental health and resilience as "fundamental to our physical health, our relationships, our education, our training, our work and achieving our potential" and stated that "our objectives for employment, education, training, safety and crime reduction, reducing drug and alcohol dependence and homelessness cannot be achieved without improvements in mental health.

5.3 Our current local offer of services for people with mental health problems focuses on highly specialised hospitalised services, few beds for recovery and rehabilitation and a high cost supported accommodation. This offer creates a community that is highly dependent on the services and is seldom supported to move on and have fulfilling, independent life.

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5.4 Furthermore, current emphasis on the treatment at the severe end of illness results in costly and inefficient commissioning of services that are often reactive and have limited impact on health outcomes. Current economic climate that is resulting in reduced budget in public services and also has an impact on individual's mental wellbeing; and increasing local mental health needs due to population growth; is making the current approach and model of service that both, Haringey Clinical Commissioning Group (CCG) and Haringey Council commission and/or provide, simply not sustainable. It is therefore an imperative to work in partnership across local health and social care economy and the third sector to design good quality and efficient service offer designed around service users and carers. This can only be achieved if we work closely with those who know what they need most.

5.5 Proposed Framework (Appendix I) will bring together a range of stakeholders and experts (Reference Group) across local health and social care economy who will first start developing a high level joint vision and ambition for mental health and wellbeing state of Haringey and work towards developing a set of outcomes and specific priorities that would underpin implementation of the vision. The Framework will have delivery plan with a set of outcomes that will be regularly monitored.

5.6 Reference Group had its first workshop in mid-September where draft vision and priorities started to emerge. Initial suggestions for priorities were around scaling up prevention and early help offer in a more integrated way and also focusing on delivering integrated pathways for recovery. Recovery, as defined by the reference group, is about providing flexible and personalised support to enable people with mental ill health to live and fulfil their potential as an equal member of local community.

5.7 More details on the scope of the Framework and process for developing the Framework are described in Appendix I.

6. Comments of the Chief Finance Officer and financial implications

6.1 There is no additional funding for the delivery of this strategy although as the report shows there is already substantial investment across the local authority and the NHS in Mental Health services including £9.3m of Adults Services budget. All work arising out of the development of this framework will need to be funded from within these existing budgets.

7. Comments of the Assistant Director of Corporate Governance and legal implications

7.1 The Assistant Director of Corporate Governance has been consulted about this report. There are no legal implications arising from the report.

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8. Equalities and Community Cohesion Comments

8.1 The public sector equality duty consists of a general equality duty, which is set out in section 149 of the Equality Act 2010 itself, and the specific duties which came into law on the 10th September 2011. In summary, those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The Act also states that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status.

8.2 As part of the development of the framework, an impact assessment should be undertaken to identify any issues and put into place an action plan as necessary.

9. Head of Procurement Comments

N/A

10. Policy Implication

10.1 Mental Health and Wellbeing is one of the Health and Wellbeing Strategy 2012-15 Outcome and is articulated as a priority in the Corporate Plan.

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11. Use of Appendices

Appendix A: Mental Health and Wellbeing Framework – scoping document.

12. Local Government (Access to Information) Act 1985

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NHS

Haringey Clinical Commissioning Group

Haringey Council

Producing the Joint Mental Health and Wellbeing Framework for Haringey

GET INVOLVED

Haringey Clinical Commissioning Group

Haringey Council

1. WHY ARE WE DEVELOPING THE FRAMEWORK?

1.1 There is a need locally to bring together all of the existing strategies and articulate a clear vision for improving mental health and wellbeing of Haringey's residents from early years throughout adulthood and older age. Our existing Health and Wellbeing Strategy started to set the direction of travel and strengthen partnership working. We now need to scale up our ambition and develop the Framework to strengthen this priority and clearly articulate our strategic commissioning plans for future years.

1.2 We hope that the Framework will set out our ambition for transforming mental health services locally. This will require cross-partnership response which seeks to address the causes of poor mental health, tackle stigma and discrimination, offer early help and engage fully with those affected by mental illness, their families and communities. There needs to be a greater focus on shifting the care from inpatient settings to provision of integrated services in the community.

1.3 Over the last few years we have seen some real improvements locally on how we support people with mental illness to access adequate interventions and treatment and we now need to reach more people and scale up our offer for recovery. By recovery, we mean providing support to people to live independently (wherever possible) and to have meaningful social relationships, maintain good quality housing, get back to work and live a satisfying life, even if there are some limitations caused by their condition.

2. WHAT ARE THE NATIONAL AND LOCAL DRIVERS FOR CHANGE?

National drivers

2.1 Mental ill health represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability. Nearly 11% of England's annual secondary care health budget is spent on mental health. Estimates have suggested that the cost of treating mental health problems could double over the next 20 years. More than £2 billion is spent annually on social care for people with mental health problems.

2.2 'No Health without Mental Health: The cross government mental health outcomes strategy for people of all ages' published in 2011 sets out clear objectives for improving mental health and wellbeing:

1) More people will have good mental health
2) More people with mental health problems will recover
3) More people with mental health problems will have good physical health
4) More people will have a positive experience of care and support
5) Fewer people will suffer avoidable harm
6) Fewer people will experience stigma and discrimination

2.3 The strategy emphasised the importance of mental health being 'everyone's business' and that mental wellbeing is crucial for individuals and the country's social and economic status, identifying good mental health and resilience as "fundamental to our physical health, our relationships, our education, our training, our work and achieving our potential" and stated that "our objectives for employment, education, training, safety and crime reduction, reducing drug and alcohol dependence and homelessness cannot be achieved without improvements in mental health."

Local drivers

2.4 In Haringey, there is a high level of mental health need. An estimated 3,160 children have mental health problems in the borough and this is predicted to rise.

2.5 Estimated 34,000 adults locally live with anxiety and depression and over 3, 000 suffer from severe mental illness.

2.6 Haringey's suicide rates are higher than London and England, especially in men 30 to 45 years of age.

2.7 Our current local offer of services for people with mental health problems focuses on highly specialised hospitalised services, few beds for recovery and rehabilitation and a high cost supported accommodation. This offer creates a community that is highly dependent on the services and is seldom supported to move on and have fulfilling, independent life.

2.8 Furthermore, current emphasis on the treatment at the severe end of illness results in costly and inefficient commissioning of services that are often reactive and have limited impact on health outcomes. Current economic climate that is resulting in reduced budget in public services and also has an impact on individual's mental wellbeing; and increasing local mental health needs due to population growth; is making the current approach and model of service that both, Haringey Clinical Commissioning Group (CCG) and Haringey Council commission and/or provide, simply not sustainable. It is therefore an imperative to work in partnership across local health and social care economy and the third sector to design good quality and efficient service offer designed around service users and carers. This can only be achieved if we work closely with those who know what they need most.

3. HEALTH AND WELLBEING STRATEGY 2012-2015

3.1 One of the three outcomes of the current Health and Wellbeing Strategy is to improve mental health and wellbeing in Haringey and the current vision is:

> 'We want all residents to enjoy the best possible mental health and wellbeing and have a good quality of life – a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.'

3.2 During development of the Framework, we would like to review this vision together with the wide range of stakeholders and the public to ensure that it is ambitious, achievable and owned across local communities, primary and community services and other health and social care services.

3.2 As we start developing the Framework, it is important to reflect on the current Strategy, evaluate its progress and identify further challenges. Here are some of the main achievements of the HWB Strategy: Improving mental health and wellbeing, ongoing concerns and issues for consideration:

Achievements

- Implemented all primary school approach to emotional wellbeing run by Young Minds;
- There has been a reduction in the number of young people not in education, employment or training (NEET)
- Recorded crime is down by 40%
- 320 adults and 100 young people have been helped to find job; of those one third sustained jobs after six months;
- The Clarendon Recovery College has been established as has a community based initiative which, working with the third sector, is designed to break down the social isolation of people aged 50 years and over.
- Welfare hubs (Citizen Advice Bureaus) set up in four general practices across the borough;
- Delivered Mental Health First Aid Training to over 150 staff working in Haringey including police, housing association, Council officers, primary care and Councillors;
- Additional capacity provided to the BEH MHT to support smoking cessation
- Housing Related Support re-commissioned 185 mental health units;
- Nine projects commissioned under anti-stigma campaign/public mental health umbrella and early evaluation and feedbacks on the individual projects are encouraging.
- Drugs and alcohol services re-commissioned to ensure they meet needs of the local population.
- Three Overview and Scrutiny reviews recently completed focused on mental health and physical health, mental health and accommodation and mental health and community safety. Recommendations of these reviews can be found at http://www.minutes.haringey.gov.uk/ieListDocuments.aspx?CId=128&MId=6266

Issues for further consideration

- Attainment is low in the early years and, developmentally, many children are not ready for school
- High numbers of children have behavioural problems
- Depression is under-detected in primary care but over-represented in acute settings; levels of severe mental illness are significantly higher than other places, and disproportionately based in the east of the borough
- Over 30% of offenders have mental health problems
- A low number of people with a severe mental health problem are in employment or settled accommodation

4. DEVELOPING THE FRAMEWORK

Process

4.1 The Framework will set out the strategic vision for Haringey CCG and Haringey Council, describe current service provision and funding streams, define outcomes deliverable across the partnership and produce a set of key actions underpinning the outcomes. The outcomes will be measured regularly to monitor progress on the Framework implementation over the next four years (2015-2018).

4.2 The local framework will incorporate the following papers: a) Adult and older people mental health services in Barnet, Enfield and Haringey Commissioning Strategy 2013-15, b) Haringey's Overview and Scrutiny Reviews on mental health and physical health, mental health and accommodation and mental health and community safety; c) Health and Wellbeing Strategy Outcome 3 Delivery Plan; d) LBH service mapping; e) Housing Related Support Commissioning Plan 2012-17 and e) 2014 JSNAs.

4.3 The Framework will reflect 2015/16 commissioning intentions for BEH Mental Health Trust and wider mental health services that will be developed between September 2014 and January 2015. It is envisaged for the expert reference group to be involved in informing high level commissioning intentions at an early stage.

4.4 Details of the governance and process for the framework development is set out in Appendix I.

4.5 We envisage starting the wider engagement on the Framework in November 2014.

4.6 It is proposed to develop a Framework Delivery Plan that will underpin a refreshed Health and Wellbeing Strategy. Governance for monitoring the Framework will be via the Outcome 3 Delivery Group alongside both, Children's and Adults Partnership Board and the governance structure beneath that (including expert reference groups).

Scope

4.7 It is envisaged for the Framework to cover the following:

- Emphasise the importance of wellbeing and assets in the community

- Life course approach to mental health (from early years to older age) including children's mental health and relevant services, transition from child and adolescent mental health services (CAMHS) to adult services and transition from adult services to services for older adults who are physically frail and/or for those with organic illness.

- Cohort of people with dual diagnoses needs such us those with mental health problems who also have dementia, substance misuse, learning disabilities or autism.

- Focus on developing integrated pathways covering prevention and early intervention, primary and community services, hospital and social care and support for independent living in the community.

- Services and interventions to be co-produced with service users: Having control over own life is associated with better physical and mental health. This also means ensuring that people with mental health problems are able to plan their own route to

recovery, supported by professional staff who can help them identify and achieve the outcomes that matter to them and their families and carers, at the centre of their care by listening to what they want, giving them information, involving them in planning and decision-making, treating them with dignity and respect, and enabling them to have choice and control over their lives and the services they receive.

- Value-based commissioning of evidence based services: Including North Central London work on value-based commissioning focusing on outcomes defined by service users. This approach will facilitate commissioning of integrated services with physical and mental health and mental health recovery.

- Specialised, tertiary services commissioned by the NHS Specialised Commissioning Group.

4.8 Due to specific complex needs that require a separate strategic and commissioning approach, the following groups of people and services they require will be excluded from the Framework on Mental Health and Wellbeing:

- Older people with dementia and frailty;
- People with learning disabilities;
- Adults with autism.

4.9 Proposed sections of the Framework are:

a) Vision
b) Executive summary
c) National and local policy context
d) Case for change (including needs assessment)
e) Service mapping
f) Funding and resources
g) Outcomes and priorities for action
h) Implementation plan and monitoring arrangements
i) Appendices

Outcomes

4.10 It is envisaged that local outcomes defined in the framework will be aligned with the national mental health strategy's outcomes (see 2.2). Each of these outcomes will need to be underpinned by a set of priorities that are tailored to local needs. These priorities will be identified during the engagement process with various stakeholders and expert reference group.

5. HOW CAN YOU GET INVOLVED

5.1 We would like to hear your views on the proposed process for developing the Framework, and to invite you to shape the Framework by either expressing your interest to be part of the Expert reference group or wider consultation planned for autumn 2014.

Haringey Clinical Commissioning Group

Haringey Council

Appendix I: Development process and governance framework

This paper sets out the process for developing the Mental Health and Wellbeing Framework and how the process will be governed. The final framework will be approved by the Health and Well Being (HWB) Board which has senior representation from the council, Clinical Commissioning Group (CCG), Healthwatch and the voluntary sector. Before the final framework is sent to the Health and Well Being Board, we are planning the following process:

1. A draft framework will be co-produced by an **expert reference group**. The expert group will consist of one or two representatives from the following groups:

- Users of mental health service and carers of people with mental health needs (representatives drawn from the Adult Partnership Board and its sub-groups).
- Local voluntary sector organisations that specialise in mental health care
- Clinicians from the Barnet, Enfield and Haringey Mental Health Trust
- GPs or other primary care practitioners as providers of primary care and GPs as commissioners
- Public health
- Senior council officers managing social workers in the Mental Health Teams
- Commissioning managers from the council
- Commissioning managers from the CCG

The expert group is expected to meet 2-3 times to develop the draft framework.

2. The draft framework will then be **consulted on more widely** in the following ways:

- Commissioners will write to all local providers of mental health services and other services commonly used by people with mental health needs and ask them to comment on the framework.
- Commissioners will meet with wider groups of carers and service users to get their comments.
- The draft framework will be taken to the CCG's Governing Body and Cabinet Member for Health and Adult Services for agreement that the document can be taken to Adults and Health Overview and Scrutiny Committee
- The draft framework will then be discussed at Scrutiny before being sent to the HWB Board for final approval.

3. The process will be overseen by a Council and CCG officers' group (called the Health and Well Being Outcome Three Group) chaired by the Director of Commissioning at the CCG. The role of this group is to:
    - Ensure that the process described above is followed.
    - Review the draft framework to ensure that it is aligned with existing council and CCG strategic priorities and deliverable within available resources.

    The process and governance is shown as a diagram below:

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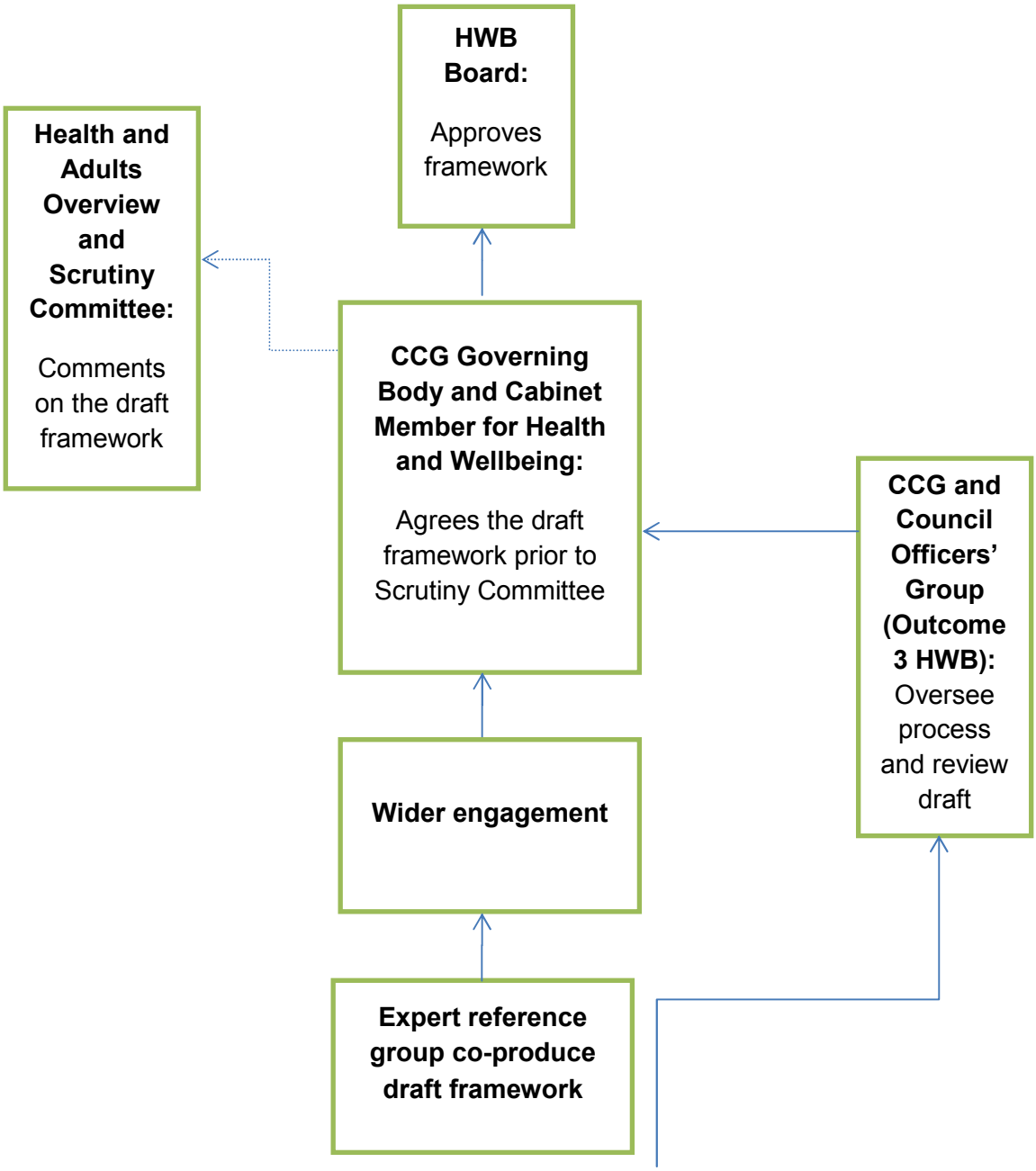
Figure 1: Governance of the development of the Haringey Mental Health and Wellbeing Framework



Haringey Council

APPENDIX 4a

Report for:	**Health and Wellbeing Board 30th September 2014**	**Item Number:**	

Title:	**Haringey Better Care Fund (BCF) Plan**

Report Authorised by:	**Charlotte Pomery, Assistant Director of Commissioning**

Lead Officer:	**Marco Inzani, Commissioning Lead: Better Care Fund**

Ward(s) affected: All	**Report for Key Decision**

1. Describe the issue under consideration

1.1 The Better Care Fund is a single pooled budget to support health and social care services to work more closely together in local areas, introduced in the Comprehensive Spending Review in June 2013.

1.2 In August 2014, NHS England asked all local authorities and Clinical Commissioning Groups to resubmit their Better Care Fund (BCF) Plan templates by 19th September 2014. The stated purpose of the resubmission was to give the Local Government Association and NHS England greater assurance that plans will deliver the required activity and outcomes for the integration of health and social care for Haringey and to achieve the priority target for reducing emergency admissions.

1.3 As required by NHS England, the Health and Wellbeing Board is being asked to endorse the revised Plan which was submitted on 19th September as a vision to improve the health, wellbeing and independence of Haringey people through the delivery of integrated health and social care services. The report will be taken to Cabinet in October 2014 which will be asked to note the revised BCF Plan.

Haringey Council

2. Cabinet Member introduction

2.1 The BCF in Haringey supports greater integration of health and social care for local residents, focusing in its first year on older people with frailty and in its second year on people with mental health needs. It builds on work already underway to improve outcomes for people with health and care needs and to join up services so that they are easier to access and to use.

2.2 Whilst the target to be achieved through the BCF Plan has been revised to include a reduction in all emergency admissions by 3.5%, the initiatives and schemes being implemented across health and social care are those already in development. The schemes are designed to prevent a need for admission by building greater independence, to avoid hospital stays by ensuring there are services available in the community and to improve responses following a hospital stay. The integration of services outlined in the BCF is important to improving people's experiences and to reducing the fragmentation of services currently in place.

3. Recommendations

3.1 The Health and Wellbeing Board is asked to:

a. endorse the revised BCF Plan submitted on 19th September 2014 as a vision to improve the health, wellbeing and independence of Haringey people through the delivery of integrated health and social care services. The BCF Plan is attached at Appendix 1 and 2.

b. note the revisions made to the Plan as required by NHS England. A summary of changes made to the Plan is attached at Appendix 3.

4. Alternative options considered

4.1 The BCF Plan is part of a national programme to ensure integration of health and social care. It builds on work locally to integrate services to improve the user experience and to achieve better outcomes.

5. Background information

5.1 The vision for the Better Care Fund is "By April 2019, 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."

5.2 The original Haringey Better Care Fund (BCF) was submitted in April 2014 and the vision has not changed since then. The Council and Haringey Clinical Commissioning Group (CCG) have started the process of implementation to ensure that integrated services are in place by April 2015.

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5.3 In July 2014, NHS England and the Local Government Association (LGA) announced a change in policy for the BCF with a requirement to meet a reduction in all emergency hospital admissions by a minimum of 3.5%, with a proportion of the BCF budget being linked to performance on the metric. Guidance and revised templates were released in August 2014 that required all Health and Wellbeing Board (HWB) areas to resubmit plans by Friday 19th September 2014 to meet the revised policy direction and to give greater assurance that BCF plans would deliver the required performance. Due to the timing of the Haringey HWB, it has not been possible to meet as a Board in advance of the submission.

5.4 The new requirements from NHS England include an imperative to meet a reduction in all emergency hospital admissions by a minimum of 3.5%, with a proportion of the BCF budget being linked to performance on that metric. A 3.5% reduction in admissions target is no longer based on avoidable admissions for older people but on all emergency admissions. Achievement of the target will result in 705 fewer admissions to hospital with a potential saving of £1.2m. The focus on this target for performance related incentives above all others is a new feature of the revised Plan. There was no discretion for local areas to negotiate a different indicator and the level of target was set with reference to recent performance trajectories and those of peer areas.

5.5 It has been agreed that if total emergency admissions are not reduced by 3.5%, NHS funding will be used to fund the extra acute activity in line with strengthened principles on the protection of Adult Social Care. There will therefore be no financial impact for the Council should the performance target not be achieved.

5.6 The changes that have been made to the Plan, set out in Appendix 2, compared to the April 2014 submission, are otherwise not substantive and require greater assurance to be given that the performance and other targets would be achieved.

5.7 To meet the target of a 3.5% reduction in emergency admissions, and based on national and local evidence, the following schemes have been proposed:

- **Scheme 1: Admissions Avoidance.** The Admission Avoidance Scheme identifies people most at risk of an emergency admission to hospital and via a Care Co-ordinator based in an Integrated Primary Care Locality Team develops a care plan containing the support needed, either from self-care or from safe and effective services (including the Dementia Day Centre and the Mental Health Recovery College), to keep them well and independent and prevent an admission. When there is an acute risk of a hospital admission a Rapid Response Team will deliver this service within a few hours of being called.

- **Scheme 2: Effective Hospital Discharge.** The Effective Hospital Discharge Scheme delivers three key services: step down care via a non-acute facility to enable people to convalesce prior to returning home; a volunteer led

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befriending and home visiting service for people aged over 50 prior to hospital discharge; and a Multi-Disciplinary Team reablement package to patients following a hospital discharge. The reablement package includes personal care and support that encourages service users to carry out activities themselves in order to restore independence.

- **Scheme 3: Promoting Independence.** The Promoting Independence Scheme delivers a range of community development interventions to support self-management of health conditions and reduce social isolation. The Scheme also encompassed an integrated service to support palliative care.

- **Scheme 4: Integration Enablers.** The Integration Enablers Scheme includes a number of different services that support the delivery of the other BCF schemes including: Interoperable systems of IT across health and social care; Single Point of Access to a range of services; Seven Day Working in Services; and the Care Act responsibilities of both the Council and the CCG.

6. Comments of the Chief Finance Officer and financial implications

6.1 The financial implications for the BCF in Haringey are that a 3.5% reduction in emergency hospital admissions will result in 705 fewer admissions with a potential saving of £1.2M to the wider health economy. To deliver this, the Haringey CCG minimum contribution to the pooled fund of the BCF in 2015/16 is £16.5M and the Council is making a further contribution of £5.6M. Mapping the expected activity and savings generated by the relevant services in each scheme, and in particular: Rapid Response; Reablement; integrated Locality Teams (Care Co-ordination to avoid hospital admissions); integrated Palliative Care; and Neighbourhood Connects (third sector programme to support self-management and reduce social isolation) demonstrates that the expected activity across these services should reduce emergency hospital admissions by 711 in 2015/16 and therefore meet the expected activity for the BCF. If the target is not met then £1.2M will be made available for Haringey CCG to use to meet the over performance in acute activity. As a contingency the BCF plan includes assurances that NHS funding will be used to fund over-performance in acute, in line with the protection of social care.

6.2 The following funding sources (**Error! Reference source not found.Error! Reference source not found.Error! Reference source not found.**) have been identified across LBH and Haringey CCG:

Organisation	Funding Stream	14/15	15/16
LBH	Base Budget	£0	£ 5,601,200
CCG	Section 256	£ 5,071,067	£ 5,261,067
CCG	Transformation	£ 513,000	£ 1,540,504
CCG	Readmissions	£0	£1,000,000
CCG	Over 75s Case Management	£ 1,371,430	£ 1,371,430

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Organisation	Funding Stream	14/15	15/16
CCG	Community Healthcare	£0	£ 7,300,000
	TOTAL	£ 6,925,497	£ 22,074,201

6.3 The following table (**Error! Reference source not found.Error! Reference source not found.Error! Reference source not found.**) identifies the budget for the different BCF Schemes, according to the source and the potential provider:

Scheme Name	Area of Spend	Commissioner	Provider	Source of Funding	2014/15 (£000)	2015/16 (£000)
1. Admissions Avoidance	Social Care	Local Authority	Local Authority	Local Authority Social Services	-	4,013
	Social Care	CCG	Local Authority	CCG Minimum Contribution	576	620
	Mental Health	CCG	NHS Mental Health Provider	CCG Minimum Contribution	1,095	1,095
	Community Health	CCG	NHS Community Provider	CCG Minimum Contribution	-	7,839
	Community Health	CCG	Primary Care	CCG Minimum Contribution	1,371	1,371
2. Effective Hospital Discharge	Social Care	CCG	Local Authority	CCG Minimum Contribution	3,225	3,225
	Community Health	CCG	NHS Community Provider	CCG Minimum Contribution	48	693
3. Promoting Independence	Social Care	CCG	Charity/Voluntary Sector	CCG Minimum Contribution	146	336
	Community Health	CCG	NHS Community Provider	CCG Minimum Contribution	121	300
4. Integration Enablers	Social Care	Local Authority	Local Authority	Local Authority Social Services	-	1,588
	Social Care	Local	Local	CCG	235	475

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Scheme Name	Area of Spend	Commissioner	Provider	Source of Funding	2014/15 (£000)	2015/16 (£000)
		Authority	Authority	Minimum Contribution		
	Community Health	CCG	NHS Community Provider	CCG Minimum Contribution	-	169
	Primary Care	CCG	CCG	CCG Minimum Contribution	108	350
				TOTAL	6,925	22,074

7. Assistant Director of Corporate Governance Comments and legal implications

7.1 The Assistant Director of Corporate Governance has been consulted on this Report.

7.2 The NHS England Better Care Fund Revised Planning Guidance July 2014 requires the Health and Wellbeing Board to approve the revised BCF Plan.

7.3 The Board is also required to agree a target reduction in total hospital emergency admissions and the minimum target for all areas is 3.5% unless an area can make a credible case as to why it should be lower. The Guidance provides that "if a Health and Wellbeing Board area fails to deliver the agreed ambition to reduce total emergency admissions only a portion of the locally agreed performance money will be automatically released to be spent on the planned activities. The amount released will be linked to the level of performance achieved e.g. achieving 70% of the target reduction will secure 70% of the performance payment. However, "the remaining performance money will not leave the local area, and it will remain within the CCG, intended for use to compensate for unplanned acute activity or spend on NHS commissioned services, in consultation with partners on the Health and Wellbeing Board" (Paragraphs 23 - 24).

8. Equalities and Community Cohesion Comments

8.1 Data from the JSNA and GP practice profiles will target the BCF on vulnerable groups with protected characteristics including: Frail Older People; People with Dementia; and Adults with mental health needs. A brief equality screening was undertaken with the North and East London (NEL) NHS Commissioning Support Unit (CSU) Equalities lead who noted: the commitments to accessing various communities through a variety of channels; workforce training and development to include issues facing protected characteristics; services will be personalised and

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focused on individuals' needs; and incorporating equalities monitoring in service redevelopments.

9. Head of Procurement Comments

9.1 N/A

10. Policy Implication

10.1 A Section 75 National Health Service Act 2006 health and social care agreement will be developed following the resubmission of the BCF so that the key principles and processes for any budget changes and decisions are clearly outlined. This ensures that both partners are fully involved in and sighted on any decisions that affect integrated services.

11. Reasons for Decision

11.1 Formal acknowledgement of the Haringey BCF resubmission.

12. Use of Appendices

12.1 Summary of Changes to Haringey Better Care Fund (BCF) Plan

12.2 Better Care Fund – Haringey Planning Template (Part 1)

12.3 Better Care Fund – Haringey Planning Template (Part 2)

13. Local Government (Access to Information) Act 1985

N/A

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Haringey

Better Care Fund Plan

Part One

2014-16

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Contents

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Better Care Fund planning template – Part 1

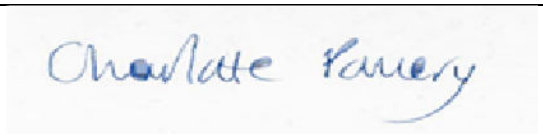
1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Haringey Local Authority**
Clinical Commissioning Groups	**Haringey CCG**
Boundary Differences	**N/A**
Date agreed at Health and Well-Being Board:	**19/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£0**
2015/16	**£16,473,000**
Total agreed value of pooled budget: 2014/15	**£6,925,000**
2015/16	**£22,074,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	 Haringey CCG
By	Sarah Price
Position	Chief Officer
Date	19/09/14

Signed on behalf of the Council	 Haringey Council
By	Charlotte Pomery
Position	Assistant Director of Commissioning
Date	19/09/14

Signed on behalf of the Health and Wellbeing Board	TBC Haringey Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Claire Kober
Date	19/09/14

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c) 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.

Document or information title	Synopsis and links
LB Haringey "Joint Strategic Needs Assessment (JSNA)" 2012	Information on the health and wellbeing of people in Haringey. http://www.haringey.gov.uk/index/social_care_and_health/health/jsna.htm
LB Haringey "Joint Health & Wellbeing Strategy (JHWS)" 2012	Plan to improve the health and wellbeing of people in Haringey, based on three outcomes: 1. Every child has the best start in life 2. A reduced gap in life expectancy 3. Improved mental health and wellbeing http://www.haringey.gov.uk/hwbstrategy
LB Haringey "GP Collaborative Profiles." 2013	49 GP Practices in Haringey are organised into four Collaboratives: Northeast; Southeast; West and Central. The Profiles provide information on the demography and health and wellbeing for each collaborative.
NHS North Central London "Primary Care Strategy: Transforming the Primary Care Landscape in North Central London" January 2012	Strategy to improve the quality and capacity of primary care in North Central London. http://www.haringeyccg.nhs.uk/about-us/strategies-and-publications.htm
LB Haringey "Haringey Borough Profile" 2011	Detailed demographic and socio-economic profile of Haringey. http://www.haringey.gov.uk/index/council/how_the_council_works/fact_file/boroughprofile.htm
LB Haringey "Haringey Ward Profiles" 2011	Detailed demographic and socio-economic profile of the 19 Haringey wards. http://www.haringey.gov.uk/index/council/howthe_council_works/fact_file/wardprofiles.htm
London Borough of Haringey "2013/14 Commissioning Plan – Section 256 Social Care Funding." 2013	Plan for the use of health funding for social care services that produce positive health outcomes in Haringey.
Haringey CCG "Commissioning Strategy 2014/15 – 2018/19" 2014	Five year strategy for the commissioning of health services in Haringey.
Haringey CCG "Operating Plan 2014/15 – 2015/16" 2014	Two year plan on how national and local health priorities will be achieved in Haringey.

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2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Haringey Better Care Fund Vision

ENABLING INDEPENDENCE THROUGH INTEGRATION

"By April 2019, 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."
London Borough of Haringey/Haringey Clinical Commissioning Group

Haringey is the fourth most deprived borough in London. The population of Haringey is younger than the national average but, following the national trend, the proportion of over 65s within the population is rising fast. The Haringey Joint Strategic Needs Assessment (JSNA) demonstrates that there is a nine year gap in life expectancy, for both men and women, between the west and the east of the borough. The east of the borough has the lowest life expectancy and contains Tottenham, one of the most deprived areas in the country.

The Haringey Health and Wellbeing Strategy (HWBS) builds on this evidence and identifies three key priorities:

a) Giving every child the best start in life
b) Tackling the life expectancy gap
c) Improving mental health and wellbeing

In line with the priorities of the HWBS, the BCF encompasses actions to tackle health inequalities and the life expectancy gap, through a focus on early interventions in Long Term Conditions, and improve mental health and wellbeing, through a focus on choice, control and empowerment. It is recognised that through the implementation of the BCF over the next few years, opportunities for integrated services for children will be explored further.

Based on evidence from the JSNA, and through consultation with stakeholders, a decision was made to focus the Haringey Better Care Fund (BCF) on frail older people (65+) for the first year of implementation. It is believed that this is the group for whom integration will have the greatest and most immediate impact in Haringey.

In Haringey there are 22,400 adults over the age of 65 years and 2400 over the age of 85 years (Census 2011). An estimated 74% of those over 65 years who are registered with a GP live with one or more long-term conditions (Haringey Health and Wellbeing Strategy).

Patients over 65 years are major users of emergency services and use the majority of hospital beds for unplanned admissions. The Haringey JSNA shows there have been high rates of emergency admissions due to circulatory diseases and this rate has been increasing. Emergency admission rates are significantly higher for men than for women for Coronary Heart Disease (CHD), heart failure and stroke and there is a clear social

gradient for all three conditions especially in deprived populations (JSNA Circulatory Diseases). More than 1 in 20 people in Haringey have diabetes. The standardised rates of emergency hospital admissions due to diabetic ketoacidosis and coma have increased markedly in the last few years and the reasons for this are not clear (JSNA Diabetes).

Older age groups are likely to suffer from poor mental health due to long term and limiting illness. The hospital admission rate for mental health (345 per 100,000 population) in the last three years in Haringey was higher than the London average. The majority of depression related hospital admissions occurred in those over 65 years of age.

Falls are the most common reason for accident and emergency attendance and hospital admission in the elderly. The JSNA shows there is significant upwards trend in older people who fell in the last three years especially in the over 85 years. For all emergency admissions in Haringey of residents aged over 75 years, 6.9% of are related to falls, 15.2% related to respiratory conditions and 19.1% related to cancer.

The use of urgent and emergency care is a clear indicator of the effectiveness of health and social care in supporting people's health and independence. Haringey is committed to implementing evidence based services that will address the over representation of older people in urgent and emergency care. Where possible illness and injury will be prevented and Long Term Conditions and Mental Health will be appropriately managed.

Haringey's BCF is transformational. It calls for the reorientation of health and social care provision away from reactive care, which is provided in acute and institutional settings to proactive care, which is provided in people's homes and community settings. The intention of the BCF is to provide joined up, co-ordinated health and social care services which reduce the need for people to go to hospital. When it is necessary for people to go to hospital they should be treated as quickly and safely as possible so that they can return home and return to independence.

The BCF 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."

Our approach to integration focuses on the assets of people marking a decisive move away from the traditional preoccupation with deficits. We will not define people by their disabilities and needs, but by their abilities, by their potential and by what they can do for themselves, with and without support. People will be helped to remain healthy and independent for long as possible and be supported to build lives beyond illness and disability through reablement and recovery. This approach will ensure that health and social care services in Haringey are person centred, provide great outcomes and positive experiences of care.

We know from our engagement work that this means 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 emphasise speed of response, early intervention, enabling independence, self-management and providing services in people's homes.

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b) What difference will this make to patient and service user outcomes?

Public and Service User Outcomes

Through a series of eight public, patient, service user and carer engagement events in Haringey (with a total of 200 local people) to understand people's experiences of health and social care, a list of local priorities was developed:

i. **Access**: Haringey people lack knowledge of what health and social care services are available and lack clarity about which access points should be used to obtain services.
ii. **Safety**: This theme is related to the confidence people have in both the health and social care services and staff. Comments included "Services should be monitored and take stock of where we are and where we are going" and "Social workers should really know what they are doing and be sufficiently qualified".
iii. **Person Centred**: One respondent summarised this as "being treated decently and with kindness". Haringey people emphasised that their care and support are intensely personal services and the ways in which they are delivered have a direct impact on both the quality of people's experiences and on their general sense of wellbeing.
iv. **Information**: To exercise choice and control Haringey people need high quality up-to-date information which identifies available services and how to access them. They also stressed the need to protect personal information and for it to only be shared with their consent.
v. **Self-Care:** Haringey people are worried about being a 'burden' on carers and do not want services to take-over and do things for them, thereby, creating avoidable dependency. They want to maximise the amount of time they spend in good health and value services that help them to do things for themselves, supporting their independence.
vi. **Team Work**: Haringey people recognise that health and social care services that work together as one team, including the service user/patient, deliver a better experience and outcomes. Communication is seen as central to this: "I want people to speak to each other – pick-up the old telephone instead of unnecessary paperwork".
vii. **Wellbeing**: Older people in particular value services that promote wellbeing and reduce loneliness as expressed by one respondent "I want to see people, to have companionship, to have someone to talk to."

Haringey BCF will address these patient and services user priorities as follows:

a) **Integrated services will be easy to access**, through a single point of access. Health and social care pathways will be clearer and shorter with fewer 'hand-offs' including the use of a single assessment process and care co-ordination.
b) **Integrated services will be well managed** and provided by competent professionals and staff. Interoperable IT will support the work of staff to better manage patient and service user care.
c) **Integrated services will be person centred** and highly personalised to the experiences and views of the people who use them. Services will uphold peoples' sense of self-worth, focusing on peoples' assets and refusing to define people by their disabilities. Services will offer people as much choice and control as possible, which may include personal budgets.
d) **Integrated services will provide good and timely information**, from a variety of sources including the voluntary and community sector. Consent will be sought before any personal information is shared with other services and professionals.

e) **Integrated services will enable individuals to do things for themselves** through prevention of ill health, self-management of existing long term conditions and reablement towards independence when recovering from a period of poor health. Support will also be offered to carers, friends and families of patients and service users so that they can continue to care.
f) **Integrated services will work together as one team**, including the patient/service user, with clear and constant communication. Staff will come from primary, community, social and acute care services, as well as the voluntary and private sector, and include GPs, community matrons, district nurses, therapists and social workers.
g) **Integrated services will promote wellbeing and reduce loneliness** through the building of community capacity and caring networks in partnership with the third sector. Services will better align responses to physical and mental health needs.

These patient outcomes match recent strategic reports and analysis in Haringey which have identified that there is a need to improve communication and care coordination in the health and social care system as well as develop an integrated approach to providing care across the boundaries of primary and secondary care. Focus needs to be targeted on ensuring efficient systems; removing gaps and duplication with existing service provision and providing care in lower-cost settings with an increasing emphasis on primary and secondary prevention. This will enable patients to receive the right care in the right place, so that they are seen by the most appropriate professional to meet their clinical needs.

Population projections and future needs

Future projections demonstrate that based on current trends, clinical needs are expected to grow. In 2035 the population of over 65s (2010 ONS sub-national population projections) will account for 14.5% of the Haringey population (London 14.2%), increased from 11.4% in 2010. In the next ten years, Haringey will see a rise of 50% for the over 85 population. Given the increasing elderly population in the west of Haringey, there will be an expected increase in long-term conditions and associated higher use of community and hospital services

The number of people with more than one health condition such as Coronary Heart Disease (CHD), diabetes, asthma or dementia is set to rise significantly. The Haringey JSNA shows that prevalence of CHD and hypertension is likely to increase but will remain static for stroke. The prevalence for diabetes is estimated to increase to 9.4% by 2030. Approximately half of this increase is due to the changing age and ethnic group structure of the population and about half is due to the projected increase in obesity.

Accident and emergency attendances resulting from a fall have been predicted to double over the next 25 years. Falls are predicted to increase particularly in the age 65-69 age group and in the over 85 years.

To reduce these increasing pressures on acute services, and in particular urgent care and accident and emergency (A&E) departments, the BCF will focus actions that have the potential to halt or reverse their progression as well as planning to ensure future needs are met. The focus of the Haringey BCF on prevention will seek to the prevalence of preventable conditions. The focus on self-management of long term conditions, mental health and falls, initially with older people (65+), will seek to maintain the independence of a growing cohort of those most at risk. The focus on effective

hospital discharge will seek to meet the predicted increase in future needs.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Health and Social Care Service Changes

Integration will transform the way in which health and social care services are delivered in Haringey by April 2019. Services will respond to changes in the expectations, needs and experiences of the local population. **Figure 1** shows the whole BCF service pathway for Integrated Services for Older People, which has been developed with a range of stakeholders including public, patients/service users, carers, providers (including public and voluntary sector) and partners (including CCG and LBH staff).

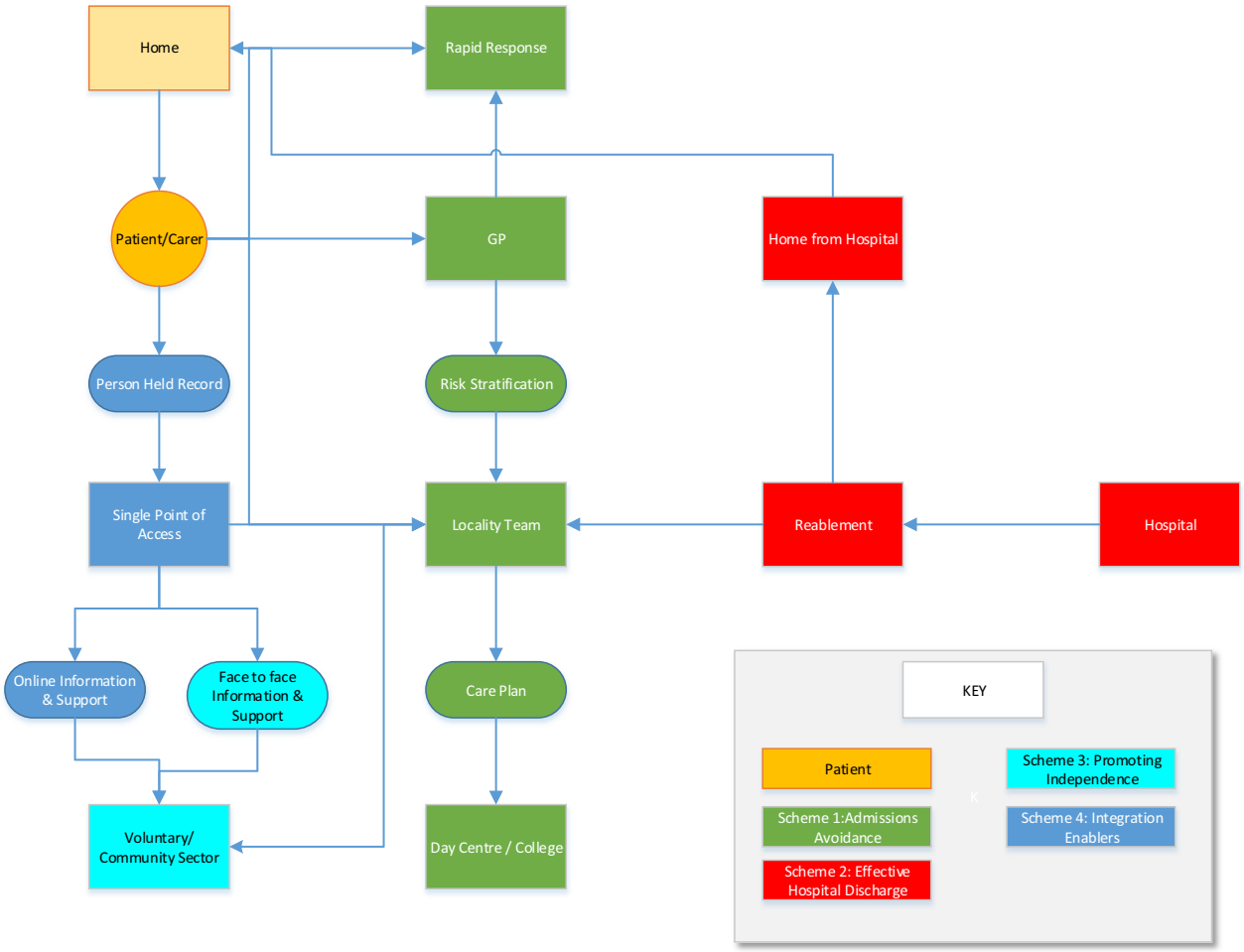

Figure 1: Integrated Services for Older People Pathway Summary

By April 2019, the vision is that there will be a cultural and behavioural shift where people in Haringey will regularly monitor their own health and wellbeing. A person held record which links to a range of data sources will be available for all residents. This will be able to track key indicators for health and wellbeing including physical health, mental health and the broader determinants of health e.g. information on education or benefits. The person held record will be able to flag early warning signs if there are any issues that require attention. The emphasis will be on people maintaining their own health, through using their own abilities, skills and potential and to know where to get support if this is not possible.

The majority of Haringey residents will know where to go for support to enable them to maintain their health and independence. They will be able to access support easily and quickly from a reliable and well maintained web-site 24 hours a day, 7 days a week. The website will provide tools that will assess peoples' needs holistically and then navigate them towards the most appropriate information and advice, which may include links to voluntary and community support services. Most people will be able to navigate this with no further support, but for a small proportion of people who need assistance this will be available via the telephone or face to face in a central hub where staff will have access to a similar set of holistic screening tools and links to a wide variety of services. For the majority of the Haringey population these simple actions will be enough to maintain a healthier and happier life.

For a small proportion of the local population more intense support may be needed to maintain health and independence. As well as providing an early warning to Haringey residents, the person held record (with the appropriate information governance to protect personal and sensitive information) will also provide an early warning to Care Co-ordinators within integrated health and social care Locality Teams. For residents with specific health conditions (e.g. Long Term Conditions (LTCs), Dementia, Mental Health) that make them more at risk of an unplanned admission to hospital, they will have access to a named Care Co-ordinator who will proactively monitor and review the resident's health and wellbeing.

Care co-ordinators will be employed within a variety of providers who can respond to the differing needs of individuals. These providers will be from a range of sectors that support health and social care including traditional NHS and Local Authority services such as Primary Care, Community Health Care, Acute Care, Mental Health, Social Care; and Voluntary, Community, Social Enterprises and Private sector providers. All providers will deliver high quality and safe services as part of a broader integrated pathway.

Care Co-ordinators will be employed by different providers but will work as part of an integrated Locality Team. They will each bring vital specialist medical and social care skills and expertise to help maintain the health and wellbeing of Haringey residents. They will also work generically as part of an integrated team so that they develop and maintain a relationship with their patient/service user, increasing efficiency and reducing duplication. By being within a specialist provider Care Co-ordinators will get the clinical and professional supervision necessary to deliver high quality and effective services. By working in an integrated and multi-disciplinary team Care Co-ordinators will ensure they have quick access to the expertise, skills and support of other professions needed for the care of their patients/service users.

Information from the person held records will also populate a risk stratification tool. This will enable GPs to identify registered patients at risk of an unplanned admission. This will ensure that the right people are assigned to Care Co-ordinators within the Locality Teams. Locality Teams will be based around clusters of GP practices, with every GP knowing the name of the Care Co-ordinators assigned to their patients. Patients/Service Users, GPs and Care Co-ordinators will work together to define and agree goals to improve health and wellbeing, which will be recorded in Care Plans, accessible within person held records.

Information and advice services and Locality Teams will work together to keep the majority of the Haringey population as healthy and independent as possible. Health conditions will be improved or stabilised where possible, maintaining acute services for

when they are needed most. When urgent care is needed, rapid response services will be used, where appropriate, in the first instance to provide care in people's homes. When conditions worsen and necessitate a hospital admission, acute services will be primed to act quickly and efficiently. A patient's discharge will be planned upon admission so that services are ready when needed. Reablement services will be delivered at the earliest opportunity to ensure that patients are returned to independence following a hospital discharge. Reablement services will link to Locality Teams so that patients can be monitored as long as necessary to reduce any risk of a readmission to hospital.

By April 2019 integration will take place at the operational and strategic levels with integrated teams, integrated management, integrated commissioning and integrated governance structures combining to provide local people with high quality, efficient and effective services.

This five year vision for integrated health and social care services in Haringey builds on an existing range of both horizontally integrated (between health and social care providers e.g. reablement services) and vertically integrated services (between different healthcare providers e.g. acute and community healthcare providers at Whittington Health). Existing services include:

- Rapid Response – urgent health and social care support for conditions (e.g. urinary tract infections, respiratory problems) to avoid a hospital admission, or facilitate the early discharge of those admitted.
- Dementia Day Centre – Support for carers of people with dementia e.g. weekend drop-in service
- Mental Health Recovery College – Courses for secondary mental health services users focused on recovery and wellbeing
- Reablement – Personal care and support for people with poor physical and mental health to restore independent functioning
- Step Down Care – Non-acute facility to support the timely discharge from acute hospital
- Home from Hospital Pilot – Short term volunteer led befriending and home visiting service for people aged over 50 who are discharged from hospital
- Neighbourhood Connects – Community development approach to support residents to make positive choices regarding health and well-being and reduce isolation
- Integrated Palliative Care – Five day a week, nurse led service for end of life patients and families, offering both health and social care input.

Monitoring and evaluation of these services provides a local evidence base for effective integration e.g. the Haringey joint reablement service has demonstrated that from March 2013-14 the majority of service users (64%) who complete a short period of intensive reablement support by trained reablement workers and therapy staff are returned to independence (Chart 1).

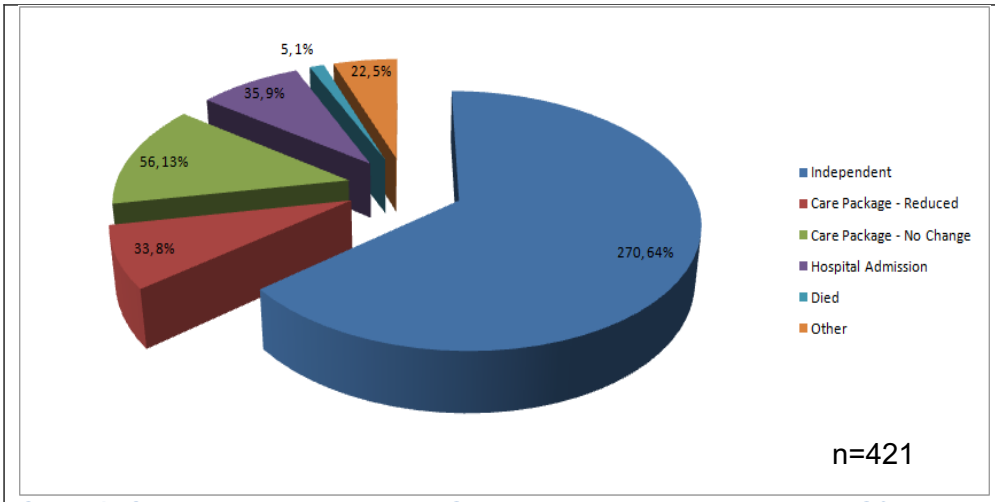

Chart 1: Community Reablement: Outcomes Achieved At The End Of The Reablement Period March 2013 – Feb 2014 (Source, LBH)

The Haringey BCF will review and evaluate all current integrated services to identify good practice and align them with the national evidence base. Services that are shown to be performing well and within current best practice will be expanded (from five days a week to seven days a week) and linked into the proposed BCF Pathway in Figure 1 to facilitate access through a single point of access. Services that do not meet expected performance measures and/or do not match current best practice will be co-designed and re-developed to ensure that they do, before being linked into the pathway.

As well as existing services, the Haringey BCF is proposing a new integrated service 'Locality Teams'. This service is in the process of being co-designed between health and social care agencies, with input from a broad range of stakeholders (including the public). This service will also be based on the national evidence base.

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3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In this section we show through analysis of data how care can be improved by integration, starting first with the data for recent performance in Haringey. In 2011/12 the rate of emergency hospital admissions for all conditions in Haringey was 7,855.82 per 100,000 people (all ages). Table 1 below shows that Haringey was ranked 2nd best out of 10 similar London boroughs for emergency hospital admission rates for all conditions in 2011/12. Of comparable boroughs, Wandsworth performs best, and to match Wandsworth's rate of emergency hospital admissions in 2011/12 Haringey would have required a 3.8% improvement in its emergency hospital admission rates.

Geographical area	Indirectly standardised rate of emergency hospital admissions per 100,000 people per year (2011/12)	Rank
Wandsworth LB	7554.11	1
Haringey LB	**7855.82**	**2**
Greenwich LB	8027.99	3
Islington LB	8708.93	4
Lambeth LB	8973.03	5
Croydon LB	9299.78	6
Southwark LB	9571.50	7
Hammersmith and Fulham LB	9744.62	8
Lewisham LB	9753.01	9
Waltham Forest LB	10257.51	10
ENGLAND	8987.99	Haringey is significantly better that England average
London SHA	7955.43	Haringey is statistically not different from London

Table 1: Rate of emergency hospital admissions for all conditions per 100,000 people in Haringey and comparable boroughs (Source NHS information centre data taken from HES)

Chart 2 below shows the trend in emergency hospital admission rates in Haringey and 9 comparable London boroughs from 2007/08 to 2011/12. Between 2007/08 and 2011/12 the rate of emergency hospital admissions (all conditions and all ages) in Haringey has fluctuated, but has shown a general downward trend, with an average annual fall of 1.8%.

The measure used in this analysis is an overall measure of emergency hospital admission rates for all age groups and all conditions, however there are limitations in this analysis:

- It does not enable a comparison of admission rates in different age groups, or amongst people with different diseases.
- When comparing rates in different geographical areas it does not take into account

the different disease profiles of the areas.

- The most recent data available for comparison is 2011/12 and therefore does not provide a picture of current performance.

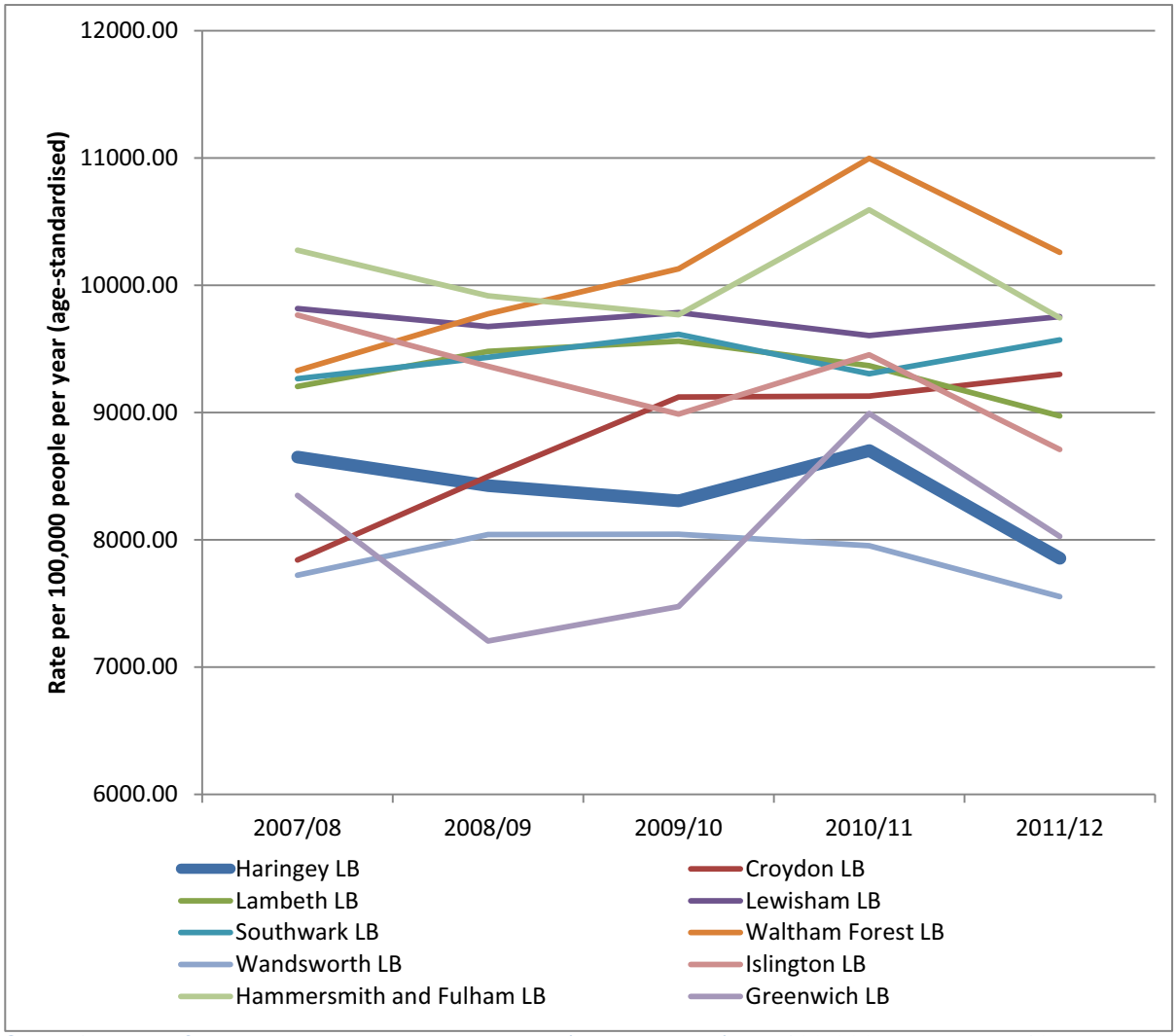


Chart 2: Rate of emergency hospital admissions (all conditions) per 100,000 residents in 10 comparable London boroughs. (Source: Analysis from NHS Information Centre data – taken from HES.)

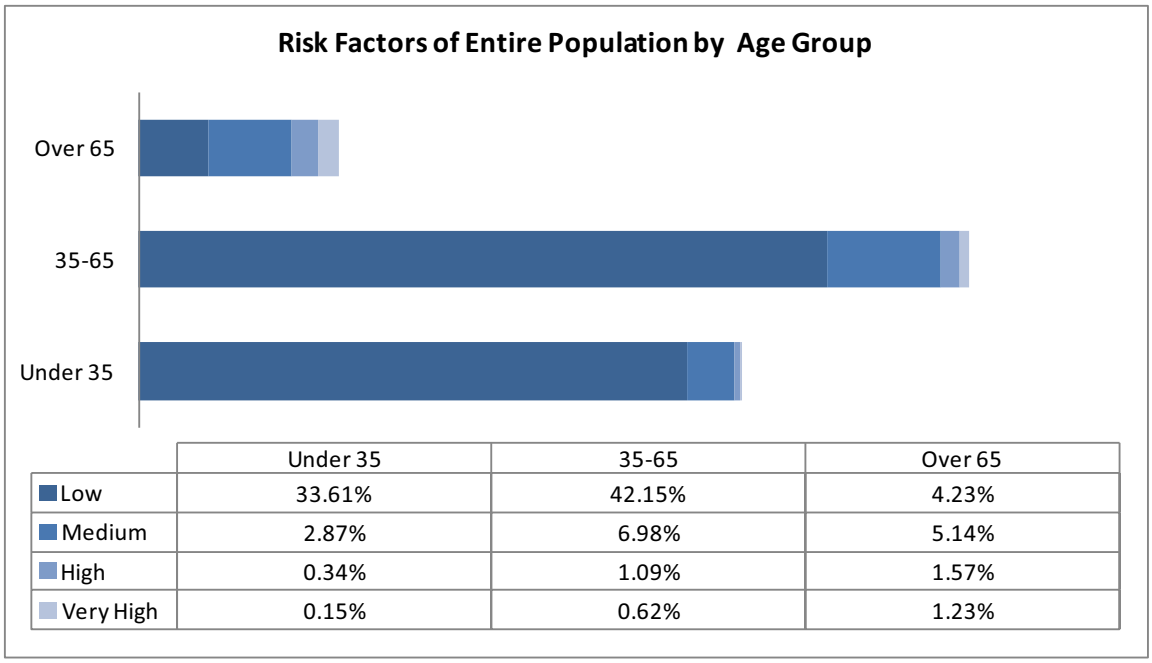
Due to these limitations more recent data from other sources is being used to develop a case for change in Haringey. Haringey CCG commissions the Health Intelligence risk stratification tool which predicts the likelihood of a person having a non-elective hospital admission within the next 12 months based on a number of variables including age, number of Long Term Conditions (LTCs) and number of non-elective admissions in the last 12 months.

Data from the tool was used to risk stratify the whole of the Haringey GP registered population. The age and gender profile of the GP registered and the Haringey resident population (taken from the census) are broadly in line. The largest age band is 25-49 and 13% of the population are over 65. There are 30,162 fewer people in the GP registered population compared to the resident population.

The risk stratification tool has four categories of risk, with the percentage of the GP registered population that are within the category: 2% are very high risk; 3% are high risk; 15% are medium risk; and 80% are low risk. In Haringey (report run on 12th August

2014) 6,745 people are high risk and 4,496 are very high risk, totalling 11,241 people.

Breaking down the risk categories by three broad age groups provides the following analysis (**Chart 3**):



	Under 35	35-65	Over 65
Low	33.61%	42.15%	4.23%
Medium	2.87%	6.98%	5.14%
High	0.34%	1.09%	1.57%
Very High	0.15%	0.62%	1.23%

Chart 3: Risk Factors of Entire Population by Age Group

The chart shows that the over 65s have a higher probability of being in the high and very high risk categories. Further analysis shows that over 65s make up 56% of the High/Very High Risk categories, whilst making up just 13% of the population. In addition of all the over 65s, 23% are in the High/Very High Risk categories. Over 65s are also over represented in terms of acute service usage (specified as outpatients, A&E and emergency admissions) accounting for 26% of activity.

The ethnic profile of those in the High/Very High Risk Category is broadly in line with the profile of the overall GP population, meaning that no group is under or over represented amongst the High/Very High Risk group. However it should be noted that Haringey has a very high ethnic mix with 86% of people coming from an ethnic background other than White British, which includes the two largest categories Mixed Ethnicity (18%) and Black African Caribbean (17%).

Table 2 shows the prevalence of health conditions amongst the Haringey GP registered population. As a proportion of the total GP registered population depression of the most prevelant condition, followed by (in order) diabetes, Chronic Kidney Disease (CKD), Chronic Obstructive Pulmonary Disease (COPD) and finally dementia. Taking these health conditions in total, 44% are attributable to depression.

Condition	Total number	Proportion of GP population	Proportion of Health Conditions
CKD	**4,126**	1.84%	11.32%
COPD	**2,086**	0.93%	5.72%
Dementia	**728**	0.32%	2.00%
Depression	**16,196**	7.21%	44.43%
Diabetes	**13,314**	5.92%	36.53%

Table 2: Prevalence of health conditions amongst the Haringey registered population

Taking these health conditions in total **Chart 4** again shows that the over 65s are over represented with these conditions.

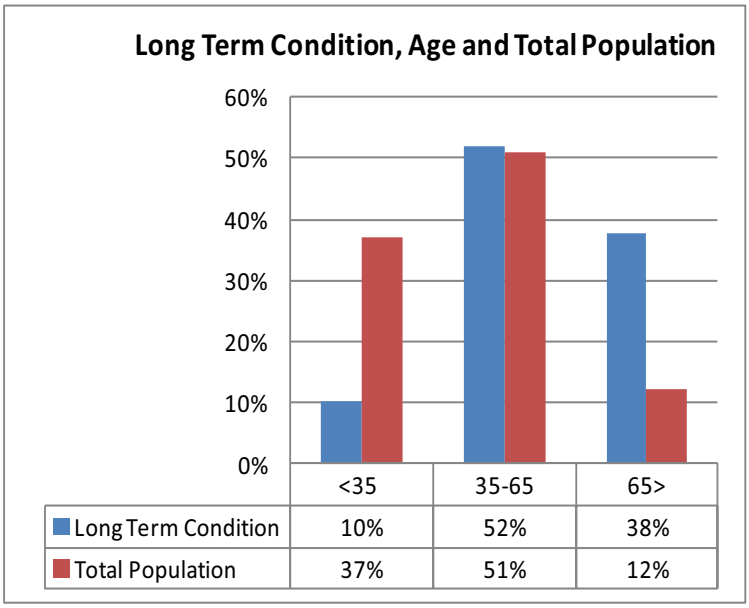


Chart 4: Distribution of Health Conditions by age band.

The risk stratification tool makes a coherent case for targeting the BCF on the over 65 age group in the first instance and for ensuring that mental health is given equal parity of esteem in the development of all schemes.

The focus of the BCF on integration connects with priorities that have a significant impact on the quality and outcomes of patient centred care. Working in a joined up way will improve the patient experience, achieve better outcomes and enable more efficient use of resources across partners. Priorities have been identified through patient and GP feedback of areas of concern, national focus (e.g. pressure ulcer reduction), analysis of reasons for emergency admissions (6 month review of care homes admissions) as well as a review of ensuring awareness of quality issues in Haringey CCG. The following priorities have a particular link to integrated working:

- **Discharge processes.** Ensuring that discharge processes from acute services are as joined up and proactive as possible to facilitate appropriate discharge at the earliest point. This should enable people to return home to independence with appropriate support, ready to be increased or decreased as required.
- **Ensuring robust quality assurance processes for all providers.** These are already robust in most areas but commissioners are also working to ensure that every organisation, including small community organisations, have clear processes for identifying areas for potential improvement and that this is monitored by Haringey CCG. Having a consistent framework for quality assurance across providers will contribute to increased integration and equivalent standards across sectors.
- **Insight and Learning Programme - Listening to feedback of patients, service users, carers and the community.** Ensuring that commissioners listen to, triangulate and investigate further and then learn from insights from patients, service users, carers and the community to drive quality improvements and further integration.
- **Care homes work.** Working with Haringey residential and nursing homes that care for those who are frail and elderly to drive quality improvement and avoid admissions to hospital. Ensuring that care homes operate as part of an integrated system of care for individual patients will maximise their benefit and reduce the risk of hospital

admissions. A number of focus areas have been identified including pressure ulcer management, falls prevention, End of Life Care work and Do Not Resuscitate (DNR) forms, emergency admission reviews and reviews of those cases where residents are frequently attending the hospital or who are living with long term conditions.

- **Pressure ulcer prevention.** Commissioners have initiated joint working across acute, community and care home providers to provide an integrated approach to reducing the prevalence and severity of pressure ulcers, which originate in the community (in peoples' homes or care homes). Colleagues in primary and adult social care will also support this work. Initial data is indicating that the prevalence and severity of pressure ulcers are reducing but further work is needed to target those at most risk including patients who are only known to Primary Care or who are only supported by a carer.

The target reduction of 3.5% of non-elective admissions in 2015/16 would result in 705 fewer admissions. The information detailed within the 'Case for Change' indicates that the majority of this activity will be within the older adult population (65+), targeting people with one or more Health Condition (either mental health and/or Long Term Conditions). Using this analysis, and the evidence base for integration, partners have developed responses based on increasingly joined up care around residents. In order to meet the reduction in admissions, Haringey has based its response on the national evidence base regarding Care Co-ordination; Reablement and Self-Care. Further information on the evidence base is detailed under each of the Scheme Descriptions in Annex 1, with a summary presented here. To meet the reduction in non-elective admissions, the following activity has been modelled, based on this evidence:

- A review of evidence presented in NHS England's BCF technical toolkit reported that a care co-ordination approach could result in a long-term reduction in hospital admissions of 37%. The risk stratification identifies 4500 people as at very high risk of a hospital admission in Haringey. This group accounts for over 5000 acute hospital admissions per year in Haringey. If the care-coordination approach achieves this level of success in Haringey's high risk population, 1665 admissions per year could be prevented in the long-term. Assuming that this effect will be seen in a step-wise progression over 4 years, 460 admissions will be prevented in 2015/16.
- A recent randomised control trial of reablement services which include personal care and support for people with poor physical and mental health to restore independent functioning (Lewin et al, 2014) showed that for every 100 clients, reablement results in 7 less hospital admissions per year compared to usual social care. In Haringey reablement will be expanded to provide to an additional 200 clients in 2015/16 resulting in 14 prevented admissions.
- Clients referred to palliative care services are 30% less likely to require non elective admission in the last 30 days of life (Purdy S, Lasseter G, Griffin T, et al. BMJ Supportive & Palliative Care, Published Online First: doi:10.1136/bmjspcare-2013-000645). In Haringey palliative care services will move from a five day to a seven day service and provided to an extra 200 clients in 2015/16 resulting in 60 prevented admissions.
- Evidence around the effectiveness of falls prevention programmes and self-care (e.g Gillespie et al. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2012) demonstrate a 25% reduction in non-elective admissions. The risk stratification identifies 6,700 people as at high risk of a hospital admission in Haringey. In Haringey the Neighbourhood Connects service will target 2000 people in this cohort by 2019, starting with 1000

people in 2015/16, with self-care including falls prevention and lifestyle and behavioural change. Haringey expect to achieve a reduction of 175 non-elective admissions from this service in 2015/16

The total reductions expected from these key services will be 709 non-elective admissions with improved care through a more integrated approach. Other services will also be developed and strengthened to support the integration agenda and their performance will also be monitored for potential impact on non-elective admissions. These include the development of a Winter Hub, a multi-professional, multi-disciplinary team from health and social care providing intensive, well-coordinated care to expedite reablement and rehabilitation, with earlier discharge to home or the community with the right support over the intensive winter months. The Winter Hub will be overseen by the Systems Resilience Group who will also oversee the Effective Hospital Discharge Scheme and so align learning from implementation of the different services.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Key Milestones

An overview of the overall estimated timeline to be followed by Haringey is provided below.

August 2013 - March 2014 (Achieved)

- BCF programme management approach and governance structure established
- BCF stakeholders including: service users, patients, carers and public; providers; and partners engaged.
- Budget for BCF agreed
- Initial BCF Plan developed and submitted to NHS England/LGA

April 2014 – September 2014 (Achieved)

- Existing Section 256 schemes evaluated and monitored in line with BCF developments
- BCF implementation plan developed, with key work-streams
- Stakeholders engaged in the co-production of integrated services
- GP practices supported to deliver the Unplanned Admissions Enhanced Service
- Revised BCF Plans developed and submitted to NHS England/LGA

October 2014 - March 2015

- Review implementation of support for the Unplanned Admissions Enhanced Service
- Pilot Integrated Locality Teams with selected GP practices
- Develop business cases and service specifications for: Locality Teams; Mental Health Services; Reablement; Home for Hospital; Neighbourhood Connects; Integrated Palliative Care Team; and Interoperable IT.
- Develop and deliver a workforce education and training programme based on local listening events

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April 2015 – September 2015

- Commission: Locality Teams; Mental Health Services; Reablement; Home for Hospital; Neighbourhood Connects; Integrated Palliative Care Team; and Interoperable IT.

October 2015 – March 2016

- Monitor implementation of BCF Schemes
- Evaluate services to inform next stage of integration
- Scope services that would further contribute to the reduction in emergency admissions and would be amenable to integration

b) Please articulate the overarching governance arrangements for integrated care locally

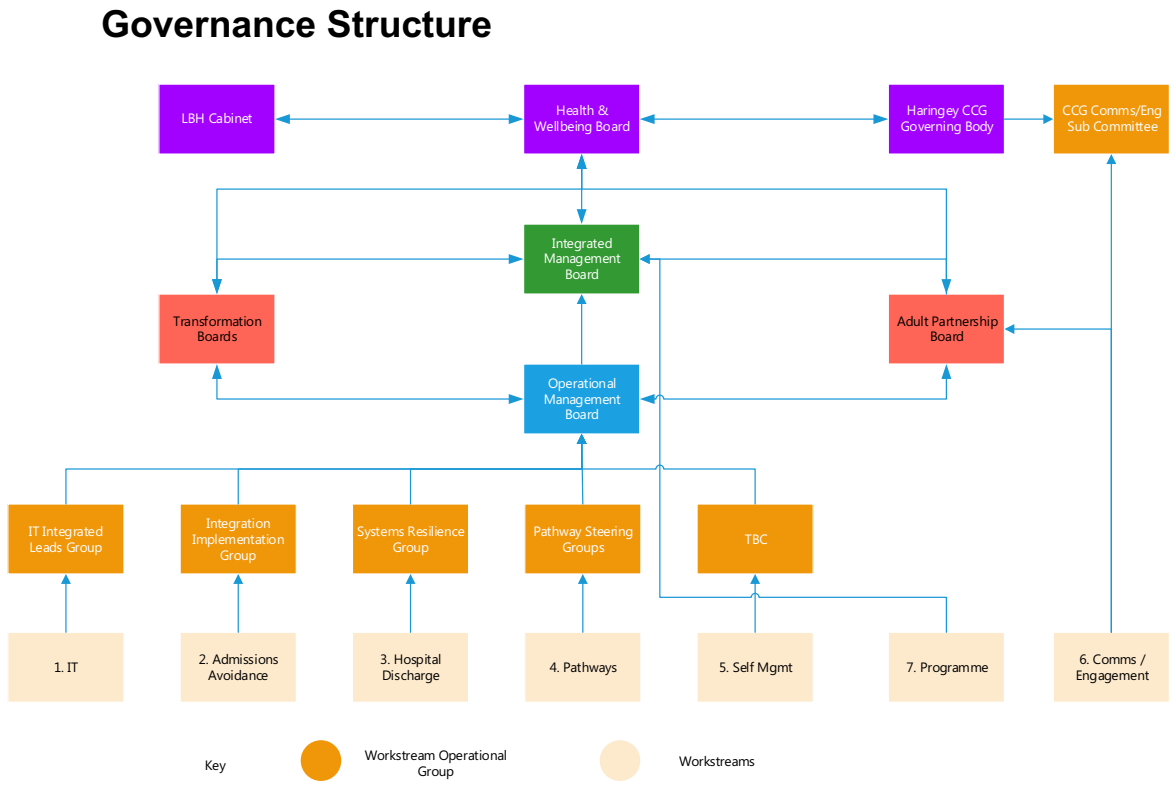

Figure 2: Governance Structure for the Haringey Better Care Fund

Figure 2 describes the governance structure in place to maintain oversight of the BCF and integrated care in Haringey. Haringey has worked hard to integrate governance and develop a shared vision for integration with shared ownership of the target to reduce the number of emergency admissions. The key features of the governance structure are:

Executive oversight and policy direction: This function is the responsibility of the Health and Wellbeing Board, the Governing Body of Haringey Clinical Commissioning Group and the Local Authority Cabinet as the senior executive bodies of the partners responsible for the integration of health and social care. Ultimate responsibility for the delivery of this Integration Plan rests with the Health and Wellbeing Board which has, in line with guidance, been engaged with the BCF. The Chair of the Health and Wellbeing Board will receive briefings with senior managers and the Director of Public Health will assist the Health and Wellbeing Board to discharge its governance responsibilities.

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Strategic oversight: The Integrated Management Board is the senior health and social care commissioning group responsible for maintaining strategic oversight of integration. It will plan spend, set priorities, monitor the delivery of key outcomes, make recommendations to the executive level bodies (the Health and Wellbeing Board, the Cabinet and the CCG's Governing Body) and take ownership of the risk log. It is also the forum to which any serious operational problems can be escalated for solution. The Integrated Management Board will meet on a monthly basis, receive regular monitoring reports and be co-chaired by the Chief Officer of Haringey CCG and Haringey Council's Director of Adult Social Care.

Operational oversight and change management: The Operational Management Board will be responsible for implementing the BCF programme and supporting service transformation. It will work with providers to identify and trouble shoot problems, ensure consistency of practice, promote learning and progress service plans.

Opinions, guidance and advice: It is important that the governance of our BCF is informed by, and benefits from, the wisdom and experience of associated groups. The following two groups will be used to engage and consult on plans and issues that result from integration:

a) Adult Partnership Board: The membership of the Adult Partnership Board is made up from service user, patient and public representatives and organisations including Haringey Healthwatch.
b) Transformation Boards: The Transformation Boards are health provider and commissioner leadership groups centred on the Whittington and North Middlesex Hospitals.

Work-streams: Seven work-streams have been established to help implement the BCF. Each of these work-streams will be aligned to existing working groups, where possible. Each working group will be responsible for supporting the implementation of their specific element of the BCF. Each working group will link to the overarching Operational Management Board.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Management and Oversight

The governance structure described above oversees the strategic and operational management of the BCF Plan, with the focus of day to day management lying with the Integration Management Board. A joint commissioning post between Haringey Council and Haringey CCG (titled Commissioning Lead: Better Care Fund) has been appointed to take responsibility for the programme management of the BCF. The Commissioning Lead is matrix managed across the two organisations, embedding integration within commissioning structures. The Commissioning Lead closely links with commissioners in both organisations.

To implement the BCF the Commissioning Lead has key responsibilities for producing reports that highlight progress and that monitor performance. Another joint post (titled Data Analyst: Better Care Fund) has been appointed to oversee the monitoring and evaluation of all BCF schemes. A task and finish group working across Public Health;

and Commissioning and Finance in both Haringey CCG and Haringey Council was established to look in more detail at the evaluation of all integrated services and schemes and to develop a performance dashboard for the BCF outcomes. All service teams will be responsible for collecting their own monitoring data, which the Data Analyst will collate and report to both the Operational Management Board and the Integration Management Board. The data will be used to both inform commissioning decision making and support the proactive management of integration.

d) **List of planned BCF schemes**

List of Schemes

Please list below the individual projects or changes that you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	**Admissions Avoidance:** The Admissions Avoidance Scheme identifies people most at risk of an emergency hospital admission and via a Care Co-ordinator within a Locality Team develops a care plan setting out the integrated support needed, either from self-care or from safe and effective services, to keep them well and independent and prevent an admission.
2	**Effective Hospital Discharge:** The Effective Hospital Discharge Scheme delivers three key services: step down care via a non-acute facility to enable people to convalesce prior to returning home; a volunteer led befriending and home visiting service for people aged over 50 prior to hospital discharge; and a Multi-Disciplinary Team reablement package to patients, for up to 6 weeks, following a hospital discharge. The reablement package includes personal care and support that encourages and equips service users to carry out activities themselves in order to restore independence.
3	**Promoting Independence:** The Promoting Independence Scheme delivers a range of community development interventions to prevent ill-health arising, to support self-management of health conditions and to reduce social isolation. The focus of this scheme is to build community capacity to respond positively to episodes of need. The Scheme also encompasses an integrated service to support palliative care.
4	**Integration Enablers:** The Integration Enablers Scheme includes a number of different and critically important strands that enable the delivery of the other BCF schemes including: Interoperable IT; Single Point of Access; Seven Day Working in Services; Workforce development and implementation of Care Act responsibilities.

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise? [1]	Potential impact [2]	Overall risk factor [3]	Mitigating Actions
1. Unplanned admissions to acute and institutional settings will not be reduced	3	5 £1.2M savings not met Key business objectives not met No funding for investments	**15**	• Develop detailed financial modelling (including saving, investments and contingency plans) and a performance dashboard to track progress on outcomes and funding by September 2014. • Develop an evaluation framework to determine appropriate measures and outcomes for BCF services, based on national and local best practice, by December 2014. • Engage acute trusts in understanding the integration case for change and the need to change behaviour by September 2014.
2. Milestones are missed due to the complexity and scale of	3	4 Not meet statutory requirements and targets	**12**	• Health and Social Care Integration Management Board established September 2013. • Joint LBH/HCCG Commissioning Lead: BCF appointed to provide programme management appointed April

[1] *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*

[2] *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact and if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*

[3] *Likelihood *Potential impact*

There is a risk that:	How likely is the risk to materialise? [1]	Potential impact [2]	Overall risk factor [3]	Mitigating Actions
change				2014. • BCF Implementation Plan developed with full engagement of HWBB, LBH Cabinet and HCCG Governing Body.
3. There is limited service capacity to deliver the scale of change needed	3	4 £1.2M savings not met Key business objectives not met No funding for investments	**12**	• Develop detailed capacity and service planning with local providers linked to BCF outcomes by November 2014 • Develop business case for investment required to deliver savings by December 2014
4. Services will be implemented when incomplete in development	3	4 Providers destabilised Patient/service user safety compromised due to service changes Complaints due to service changes Disinvestment in service before new services up to capacity	**12**	• Develop business cases, with appropriate commissioning and contracting models, for planned services before they are implemented by April 2015. • Develop an evaluation framework to determine appropriate measures and outcomes for BCF services, based on national and local best practice, by December 2014. • Implement an integrated workforce training and education plan across all providers as part of the LETB bid by April 2015.
5. IT systems will not be effectively interoperable	3	4 Information security compromised across agencies	**12**	• Engage Information Governance, IT leads and Service Leads in the development of all IT solutions by September 2014.
6. Funding is reduced by	3	4 Reduced health and	**12**	• Develop detailed financial modelling (including saving, investments and contingency plans) and a performance

There is a risk that:	How likely is the risk to materialise? [1]	Potential impact [2]	Overall risk factor [3]	Mitigating Actions
financial challenges within the CCG and LA		social care investment in integration £1.2M savings not met Key business objectives not met		dashboard to track progress on outcomes and funding by September 2014. • Section 75 agreement to be developed by December 2014.
7. Stakeholders, including public and staff, are not engaged effectively	2	5 Adverse publicity Block of service changes Staff disengage from process	**10**	• Develop a Communication and Engagement Strategy to develop plans, co-design services and to influence behaviour change by September 2014. • Implement an integrated workforce training and education plan across all providers as part of the LETB bid by April 2015.
8. The Care Act is not aligned to the BCF	3	3 Reduced social care resources for integration	**9**	• Ensure Care Act priorities are reflected in the BCF refresh by September 2014. • Section 75 agreement to be developed by December 2014.

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b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The following funding sources have been identified across LBH and Haringey CCG (**Table 3**):

Organisation	Funding Stream	14/15	15/16
LBH	Base Budget	£0	£ 5,601,200
LBH	Section 256	£ 5,041,067	£0
CCG	Section 256	£0	£ 5,261,067
CCG	Transformation	£ 513,000	£ 1,540,504
CCG	Readmissions	£0	£1,000,000
CCG	Over 75s Case Management	£ 1,371,430	£ 1,371,430
CCG	Community Healthcare	£0	£ 7,300,000
	TOTAL	£ 6,925,497	£ 22,074,201

Table 3: Funding Sources for Haringey BCF, 2014-16

The Transformation Fund is a non-recurrent fund created by Haringey CCG following national guidance to reduce hospital activity.

The minimum contribution for the BCF in 2015/16 is £16,473,000. LBH have agreed to voluntarily include £5,601,200 from their base budget as it aligns to BCF principles, bringing the total BCF budget higher than the minimum contribution.

A Section 75 agreement will be developed following the resubmission of the BCF so that the key principles and processes for any budget changes and decisions are clearly outlined. This ensures that both partners are fully involved in and sighted on any decisions that affect integrated services.

The target reduction of non-elective admissions is 3.5%, which translates to a reduction of 705 admissions and will generate savings of £1,247,850. Negotiations are being held with the two main acute providers to reduce activity.

Haringey is working with the principle that social care funding will be protected. There is currently little flex in budgets to meet a rising demand in acute care.

To manage the risk of failing to reduce non-elective admissions it has been agreed that £1,247,850 will be held in reserve from Haringey CCG Transformation Funding and Readmission Funding. The Integration Management Board will agree how this money is used following progress reports on the BCF outcomes.

Table 4 shows the activity expected per service in each scheme. 2015/16 will be the first year of implementation of these schemes, which are closely aligned with the longer-term vision of both the CCG and the council.

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SCHEME	SERVICE	Baseline	Activity				
		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
ADMISSIONS AVOIDANCE	Locality Team	0	0	1150	2300	3450	4500
	Rapid Response	352	352	352	352	352	352
	Dementia Day Centre	460	460	460	460	460	460
	MH Recovery College	900	900	900	900	900	900
EFFECTIVE DISCHARGE	Reablement	633	600	600	600	600	600
	Step Down	68	60	60	60	60	60
	Home from Hospital	280	280	280	280	280	280
PROMOTING INDEPENDENCE	Neighbourhood Connects	500 (1 Quarter)	500	1000	1500	2000	2500
	Palliative Care	400	400	400	400	400	400
INTEGRATION ENABLERS	Safeguarding	625	625	625	625	625	625
	Carers	820	800	800	800	800	800

Table 4: Activity Expected per BCF service over first three years of implementation.

As integrated services become more established they will be able to meet the needs of local people more efficiently and effectively. This allows them to better identify and respond to currently unmet need and to increase activity and savings. Specific performance indicators will be developed and closely monitored.

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6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Care and Support Initiatives

There are currently two main care initiatives in Haringey related to care and support that link to the integration of health and social care.

Haringey Council Corporate Customer Services Transformation Programme

Haringey Council's Corporate Customer Services are undergoing transformational change. Customer Services is the main point of contact for all social care queries for Haringey residents and stakeholders.

The Council's vision for customer services is to be a trusted organisation where customers have confidence that their current and future needs will be met in an efficient and effective way. There is a focus on more digital solutions for customer service, encouraging self-service. Bringing together different council services with more activity at the start of the customer service process will enable more customer transactions to be completed more efficiently. Separating less complex from more complex customer facing transactions will deliver the most appropriate and effective response to customers.

There are important interdependencies between the Customer Services Transformation Programme and the Integration of Health and Social Care as well as with the Care Act Implementation Programmes. Specifically these are around the establishment of a Single Point of Access for Health and Social Care as well as the duties in the Care Act for Local Authorities to provide advice and information. A corporate approach is being taken reflecting a commitment to one-Council working and has resulted in improved data analysis. Customer Services daily and monthly reports now include Adult Social Care Activity supporting improved planning for developing the Health and Social Care Single Point of Access. It has also been agreed that Customer Services will link to NHS Choices for information on local health services.

A customer pathway is in a high level draft form which starts to describe the journey that customers travel through from Customer Services into integrated Health and Social Care services. The pathway, when finalised, will inform both interoperable IT system developments and customer service specifications, ensuring systems can link well together.

Restructure of Learning Disability Community Team

Haringey Community Learning Disabilities Team is an integrated team bringing together health and social care staff, under a Section 75 agreement, from: Whittington Health; Haringey Council; and Barnet, Enfield and Haringey Mental Health Trust. The Team is managed by a joint appointed Head of Service and Service Manager.

Over the past 18 months changes to pathways, processes and structures throughout the customer journey have taken place in the team to ensure integration between the disciplines. Some of the initiatives have included:

- Developing Multi-Disciplinary Team (MDT) pathways for entry and eligibility into the service, with robust MDT discussion on all referrals and joint health and social care initial assessments. This has reduced the time that people referred into the service wait for assessment and has also meant that the team have been able to assess those transitioning from childhood to adulthood earlier.
- The establishment of cross discipline service user allocation via weekly MDT waiting list meetings rather than the previous system of separate waiting lists and internal referral for each discipline.
- The early identification of a "lead worker" who acts as a single point of contact for the service user and/or carer and ensures care is co-ordinated.
- Integrated MDT processes for complex care situations such as Child Protection, Winterbourne Reviews and Continuing Health Care assessments.
- Working with IT locally to ensure the social care database used by all staff supports the needs of the health partners in terms of clinical work and performance monitoring. This has resulted in health care staff being far more engaged with the social care IT system with a significant improvement in recording information which supports care planning and service developments.

Learning from the integrated Learning Disability Community Team is being used to inform the integration of wider adult services, particularly around joint assessment, MDT pathways, care co-ordination and interoperable IT.

The dependencies of the customer service transformation programme and the BCF will be tracked via the IT Integrated Leads Group which will oversee the development of interoperable IT and the link to the single point of access. The Learning Disability Community Team will link into the development of the Locality Teams and will be tracked via the Integrated Implementation Group.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Strategic and Operating Plans

For successful delivery the BCF needs to be strategically aligned both to Haringey Council's strategic programme and to Haringey CCG's 5 year strategic plan and operating plan.

London Borough of Haringey's Corporate Plan 2013-15 'One Borough, One Future' sets out the council's strategic direction. One of the key principles of the plan is working in partnership so more can be achieved by working together. This principle clearly links to integration and underpins the council's priorities. The Corporate Plan sets four key outcomes, two of which clearly link to the BCF:

- Safety and Wellbeing for all. A place where everyone feels safe and has a good quality of life. This has a focus of reducing health inequalities and improving well-being, which is also a focus for the BCF.
- A Better Council. Delivering responsive, high quality services and encouraging residents who are able to help themselves to do so. This has a focus of customer services and value for money. The BCF is looking to develop a single point of access which will become integrated with the customer service transformation. The BCF will also seek to deliver services in the most cost effective and sustainable way.

The BCF fits within the 5 year vision for Haringey CCG (Strategic Plan, 2014-19) to 'enable the people of Haringey to live long and healthy lives with access to safe, well-co-ordinated and high quality services'. Specifically, this will be achieved by:

- Strengthening and extending partnership working across the whole Haringey community.
- Implementing a model which works for everyone including those who would prefer to self-care and/or want more independence and choice.
- Developing a joined up model which offers a range of prevention, early intervention and support (not just health) delivered by a variety of providers, including the community and voluntary sector) working together in different ways to support people and families more effectively.
- Engaging communities in new and more innovative ways to build capacity for populations to enhance their own health and wellbeing through enhancing existing strengths and resources.
- Developing the role of GP practices in prevention and community interventions e.g. delivery of prevention services and navigation to other Local Authority services.

Haringey CCG has undertaken extensive local consultation on our 5 year plan. The emphasis on working closely with a broad spectrum of local authority services, not only social care and public health, was acknowledged and welcomed by the local authority. Prevention is a strong theme in Haringey CCG's vision and plans delivered through closer integration of primary, community and mental health services. This approach will in time reduce the reliance of our local population on hospital based services and firmly aligns to the BCF.

Haringey BCF plan is also strongly aligned with those of the 5 North Central London (NCL) CCGs of Barnet, Enfield, Haringey, Camden and Islington which make up the NCL Strategic Planning Group (SPG). The SPG is finalising the NCL SPG 5 year plan which is underpinned by the BCF plans.

Haringey CCG has been successful in securing over £190k Health Education North Central and East London (HENCEL) funding to support the delivery of better integrated patient care including a specific focus on the End of Life Care pathway and supported self-management. Working with: the HENCEL; Tavistock & Portman Trust; Barnet Enfield and Haringey Mental Health Trust; Barnet CCG; and Enfield CCG, Haringey is leading work to improve integration in perinatal mental health services and outcomes.

The Haringey CCG Operating Plan and BCF previously both referenced the metric of reducing avoidable hospital admissions and despite the targets being derived from different population denominators the percentage reduction was similar. Included in the operating plan was the aim to achieve an ambitious 5% reduction in avoidable hospital admissions for 2014/15. This has since been reviewed and the target has remained unchanged. However, the alignment with the BCF target has widened due to a change in criteria used for the BCF. The BCF target now includes reducing admissions by 3.5% across all non-elective general and acute admissions whereas the operating plan continues to include a reduction in avoidable admissions associated with ambulatory care sensitive conditions in adults and children. It is not yet known if the operating plan criteria will change in line with the BCF criteria.

Two other ambitions included in the operating plan are reducing the number of years of

life lost for people with treatable mental and physical conditions by 3.2% and improving the health-related quality of life for people with long term conditions by 1%. Key strategies behind the successful achievement of these outcomes will be through the delivery of better care closer to home and promotion of self-management of long term conditions which are closely aligned to the BCF.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Primary Co-commissioning

Haringey CCG has expressed an interest, along with the four other North Central London CCGs, to NHS England for primary care co-commissioning. Plans are currently at a stage of agreeing the mechanisms rather than the subject matter for co-commissioning.

Primary Care has been engaged in the delivery of the Unplanned Admissions Enhanced Service, which has been used in Haringey as a pre-cursor for the development of integrated Locality Teams.

Recent developments with the transformation of Primary Care in Haringey that align with the BCF include:

- GP practices 'working together at scale' plans for the investment of the Primary Care Strategy Fund of £0.5M to enable GP practices to work together in federations or networks. These planned networks mirror the geography for the Locality Team developments to aid integrated working.
- In order to enable GPs to work at scale, GP IT software is being purchased to enable sharing of patient records, with appropriate consent and Information Governance, between practices and with social care and community healthcare teams.
- A local format has been developed for an integrated care plan housed on the GP IT system that can be viewed and updated by health and social care providers.
- Assigned a small budget (from the over 75s GP Case Management Fund) to each GP collaborative group (the division of all GP practices into four clusters across Haringey) to increase GP engagement in the development of Locality Teams and support care co-ordination.
- Plans for the training and development of all primary care staff in integrated health and social care working.

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7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i. Please outline your agreed local definition of protecting adult social care services (not spending)

Local Definition

Haringey CCG and Council have agreed to use the Department of Health (2012) definition[4] on funding transfers from NHS to social care for the protection of social care services "The funding must be used to support adult social care services in each local authority, which also has a health benefit".

This definition describes the services that have been funded through a Section 256 agreement, including:

- Intensive social care reablement services that promote independence, reduce reliance on health services and the need for long-term social care support.
- Step-up and step-down care home placements.
- Rapid response services to promote hospital discharge and prevent avoidable admissions.
- Community development for initiatives that promote health and well-being, reduce isolation and support self-management of existing health conditions

To guide future decisions on which social care services are eligible for protection, the following principles will be used:

- The service must clearly link to one of the BCF Schemes: Admissions Avoidance; Effective Hospital Discharge; Promoting Independence; or Integration Enablers
- The service must be able to deliver one or more of the BCF Outcome Measures
- Within 2015/16 the service must target older people (65+)
- The service must link to healthcare providers
- The service must deliver safe and effective services in line with quality standards and current evidence of good practice

Using these principles the following services will also be protected in 2015/16:

- Social work capacity linked to integrated Locality Teams.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

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

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BCF Commitment to Protect Social Care

The principles agreed above include a criterion that for social care services to be eligible for protection they must link to one of the BCF Schemes. The Schemes have been chosen based on national and local evidence of best practice for integrated services to reduce the number of unplanned admissions. Social Care are seen as key provider to deliver the services within each of these schemes. These Schemes have been agreed by the Integration Management Board and the Health and Well-being Board as part of the BCF Governance. This demonstrates a commitment from both Haringey CCG and Haringey Council to protect social care as a key provider in the delivery of the BCF.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

Social Care Funding

		Haringey's Allocation
Personalisation	Create greater incentives for employment for disabled adults in residential care.	£14,000
Carers	Put carers on a par with users for assessment.	£79,000
	Introduce a new duty to provide support for carers.	£158,000
Information , advice & support	Link LA information portals to national portal.	£0
	Advice and support to access and plan care, including right to advocacy.	£119,000
Quality	Provider quality profiles	£24,000
Safeguarding	Implement statutory Safeguarding Adults Boards	£39,000
Assessment & Eligibility	Set national minimum eligibility threshold at substantial	£191,000
	Ensure councils provide continuity of care for people moving into their areas until reassessment	£21,000
	Clarify responsibility for assessment and provision of social care in prisons	£31,000
Veterans	Disregard of armed forces GIPs from financial assessments	£12,000
Law reform	Training social care staff in the new legal framework	£22,000
	Savings from staff time and reduced complaints and litigation	-£65,000
Total		***£645,000***
IT	Capital investment fund including IT systems (£50m nationally)	£239,000
Grand Total		***£884,000***

Table 5: Haringey Care Bill Implementation Funding in the BCF (Source. lgfinance@local.gov.uk)

In 2015/16 Haringey Council is expected to take £884,000 from its BCF allocation to cover new duties and associated costs imposed on local authorities by the Care Act (**Table 5**).

The Assessment and Eligibility responsibilities, including support for carers, will link to the

Admissions Avoidance and Effective Hospital Discharge Schemes. Haringey Social Care currently sets its eligibility criteria at the 'significant' level and will move towards the 'substantial' threshold. Service users in this category will also be within the risk group for an unplanned admission and so will be targeted for support by Locality Teams, which will include social care provision.

Personalisation; and Information, advice and support both link to the Promoting Independence Scheme through delivery of services within the community and voluntary sector that support prevention and self-management of existing health conditions.

Responsibilities for: Quality; Safeguarding; Veterans; Law Reform; and capital investments in IT will all be linked to the Integration Enablers Scheme by establishing the systems and processes that will support the delivery of the other BCF schemes.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Care Act 2014 Duties

The core objectives of the Care Act align well with the principles of Haringey Council's Corporate Plan 2013-15 including: delivering high quality services; investing in prevention and early help; promoting equality; empowering communities; and working in partnership. These objectives and principles both align further with the delivery of the BCF.

The work needed to implement the provisions of the Care Act is being led by the Adult Social Services Leadership Team which acts as the Care Act Implementation Board for part of its fortnightly meeting. Membership is extended to include health, children with disabilities and housing to ensure a corporate response and wide engagement in line with the Corporate Plan. Regular briefings are made to the Health and Wellbeing Board. Briefings have also been delivered across Haringey Council and for partners to increase awareness of the implications of the Care Act.

A programme manager has been appointed to oversee and deliver a Care Act Action Plan which has been drawn up to ensure readiness for implementation. Key senior managers have been tasked with leading work-streams in the Action Plan. This transformation work aligns with other change programmes across the Council. This includes the interplay with the BCF, Customer Services and the work to implement the reforms set out in the Children and Families Act.

The work-streams include significant pieces of work in areas such as: maximizing the use of IT; developing service directories to support information and advice; identifying self-funders and the implication of the Dilnot cap (a £75,000 cap on an individual's payment for residential and nursing care) on Local Authority budgets; mapping workforce capacity and development needs with the change in role of Social Care Managers. These work-streams will dovetail with the BCF work-streams to maximise synergies.

v) Please specify the level of resource that will be dedicated to carer-specific support

Care Specific Support

With, approximately 820 carers assessments undertaken in 2013-14 via Haringey Social Care, this gives an indication of the minimum size of the cohort of carers looking after some of the most vulnerable Haringey residents. Reablement data indicates that about 5% - 10% of people receiving Community Based Reablement make no further demand on services because of the support they receive from carers. Carers are key to the successful implementation of the BCF in Haringey and in reducing unplanned admissions to hospital.

Haringey has committed £237,000 in 2015/16 to Care Act responsibilities for the assessment and support of carers. However Haringey has made further commitments to supporting carers within its Carers Strategy.

Haringey commissions four organisations to provide support and services directly to carers. These include the Haringey Alzheimer's Society, Asian Carers Support Group; Black and Minority Ethnic Carers Support Service and the Mental Health Support Association. These organisations provide a variety of services, such as advocacy, benefits advice and counselling

Haringey Council developed and hosts a Carers Hub in Wood Green Library. The Hub is a dedicated space for unpaid carers and gives them a place where they can meet other unpaid carers and access information and advice from weekly drop ins from the carer's organisations commissioned.

Commissioned Carers services in Haringey are currently under review with a procurement exercise expected in Autumn 2014.

Haringey Council Social Care undertakes carers assessments which can result in: a one-off personal budget up to £300 annually to support a life outside caring and access to respite services; free/discounted admission to Haringey Leisure Centres; and back up cover in case of emergencies through the Carers Emergency Alert Card Scheme.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Local Authority Budget Impact

LBH budget has not been materially affected following the resubmission of the BCF plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Haringey's health and social care providers have made a commitment to ensure that services that support hospital discharges are available 7 days a week and over extended hours.

Systems Resilience Planning builds on 7 day working that currently exists in a number of

Haringey services. Reablement and Rapid Response in social care and District Nursing and Community Matrons in community healthcare, are accessible 7 days a week. Patients and service users also have 24 hour access to urgent primary care support via Out of Hours provision, which will have access to the care plans of patients at risk of a non-elective admission. Flexible working arrangements for staff in all agencies are being scoped and reviewed as part of workforce capacity planning for 7 day services with systems resilience funding being used to increase staff capacity.

End of Life Care Services was identified in 2013/14 as a key priority for 7 day working. Investment through the Better Care Fund has been used to expand a 5 day/week nursing led palliative care service into a 7 day/week service, offering both health and social care input. The new palliative care service will offer a single point of access for staff, patients and families.

Different workforce options will be employed to cover 7 day working including moving staff onto new 7 day working contracts and specifically increasing staff capacity for weekend working. The initial focus will be on assurance of seven day working in existing integrated services, prioritising reablement and rapid response. Seven day working will also be incorporated into the development of Locality Teams.

Within the community and voluntary sector a Home from Hospital service was piloted 7 days a week during the winter pressure months and this service is currently being re-commissioned on a permanent basis through the BCF. The Home From Hospital service provided services such as: transport home; assistance with ensuring access to basic food shopping; amenities such as heating and lighting; companionship and confidence building; information and links to community initiatives in order to avoid admission / readmission to hospital.

A single point of access, linked into the Haringey Customer Service Transformation programme, will provide 7 day/24 hour access across health and social care services through a range of technological channels including web-sites and a call centre. This single point of access will include access to urgent services that can respond efficiently and effectively to prevent a hospital admission. Patients at a high risk of an unplanned admission, and any services connected to their care, will also have access to a direct bypass phone number to their GP practice which is expected to provide an efficient response. Plans will be developed to link the various access points for patients and service users.

Seven day working presents two main risks:

- There will be limited capacity in services to deliver the scale of change needed
- Funding is reduced by the financial challenges within the CCG and LBH

The mitigation of these risks will be key to the implementation of seven day working and is captured within the risk log.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

NHS Number

All health and social care systems in Haringey 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. A recent audit showed that 60% of social care records had an NHS number recorded. Further actions are being considered to ensure that the use of NHS numbers in social care is improved including solutions being developed by neighbouring local authorities and potential IT tools.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Open APIs and Standards

In the procurement of new IT systems there is a commitment 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 the search for a value for money solution. Secure e-mail exchange is sued by all providers via the GCSX and N3 network.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Information Governance

There is a commitment to high standard Information Governance controls. Overall responsibility for Information Governance rests with both Haringey Council's Information Governance Board, chaired by the Council's Senior Information Risk Officer and Haringey CCG's Director of Quality and Caldecott Guardian. Haringey has 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 for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

High Risk Population

Haringey has identified the top 2% of the population at risk of an unplanned hospital admission which amounts to 4600. Their profile has been broken down in the Section 3:

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Case for Change.

Haringey has commissioned four risk stratification tools for use by GP Practices: Health Intelligence; NELIE; EMIS, and VISION. These tools were chosen to support the implementation of the Unplanned Admissions Enhanced Service for GPs. In order to meet key milestones for the implementation of the Enhanced Service, four tools were commissioned as they were each available at different dates and each provided different functionality including: access to different data sources; linkage to existing clinical IT systems; training and development support; and ability to prepopulate a care plan. Following a few months of usage GPs will be surveyed to understand which risk stratification tool provided the best functionality combined with the best predictive ability for identifying patients at most risk of a hospital admission.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Joint Assessment

A draft joint assessment tool is already in place following work between Whittington Health (as provider of Community Healthcare) and Haringey Council and requires further development of supporting processes, procedures and links to interoperable IT systems.

The Unplanned Admissions Enhanced Service for GPs has provided a good baseline in Haringey for developing joint care plans and understanding the information, in terms of intervention, outcomes and format, held by each provider involved in the health and social care of each patient. Local GPs have identified through risk stratification the top 2% of their patients at risk of an admission to hospital. This information is being used by community healthcare and social care services to achieve an integrated approach to care planning and identification of a care co-ordinator and is forming the basis of discussion at weekly MDT teleconferences for each of the GP collaboratives.

A table-top exercise with GPs and representatives from community healthcare and social care tested the care planning process to determine the professionals who would be identified as the accountable lead professional i.e. the care co-ordinator. From this exercise a minimum of 48% of patients would have the GP as the named care co-oridnator; 12% would be someone from community healthcare services; and 9% would be someone from specialist services including social care (mental health or learning disabilities) and respiratory. A further 31% would need further discussion at a Multi-Disciplinary Team meeting to determine the most appropriate lead.

In the Reablement Service, where health and social care colleagues use the same IT system, the recent introduction of MDT meetings have focused on assigning an accountable lead, setting and reviewing predictive discharge dates and ensuring a more collaborative approach to assessment, goal setting and review.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

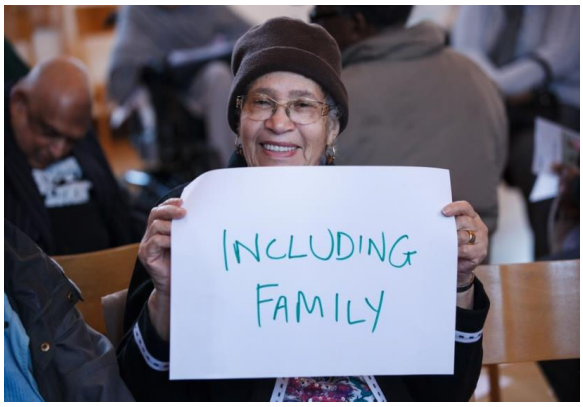
Joint Care Plan

Work is progressing to develop joint care plans for individuals at high risk of an emergency hospital admission. Currently the records of approximately 4600 patients and service users are being examined across primary care (GP practices), community healthcare and social care to look for synergies and to assign a care co-ordinator as part of the implementation of the Unplanned Admissions Enhanced Service. The number of joint care plans will be known following the deadline of 30th September 2014 for completion of this work.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future



The Haringey BCF vision is based on the experiences and priorities of local people. Avoiding a *'one size fits all'* approach, a range of public, patient, service user and carer engagement methods have been used including large and small group meetings, focus groups, semi-structured interviews and workshops. The specific BCF workshop was held in collaboration with the Third Sector (particularly Haringey Age UK and Haringey HealthWatch) and used a theatre group to bring issues to life and facilitate engagement. By working with the third sector extra efforts to engage 'seldom heard' communities were

made including outreach to various cultural and community groups and resulting in a wide cross section of the Haringey population. A key output from this workshop was the development of an *'outcomes hierarchy'* which has been used to prioritise the development of services within the BCF as described in Section 2: Vision for Health and Care.
Through these methods up to 200 people have been directly engaged in the development of the BCF (**Table 6**).

Date	Method	Number of Attendees
07/11/13	One to One Semi-structured interview	1
11/11/13	Older People's Partnership Board	11
12/11/13	One to One Semi-structured interview	2
14/11/13	One to One Semi-structured interview	1
23/01/14	BCF Workshop	117
27/05/14	CCG Network Event on Integration	30
10/09/14	Adult Partnership Board Discussion Forum	17
15/09/14	CCG Network Event	20
	TOTAL	199

Table 6: Public, Patient, Service User and Carer Engagement

An overarching BCF Communication and Engagement Plan has been developed and presented to the Communication and Engagement Sub-Committee with key messages, communication channels and an activity plan. Feedback on the plan reinforced a commitment to: feedback via a 'You Said, We did' framework; use existing networks and groups to communicate; and identify further channels of communication particularly for seldom heard communities reflecting the diversity of Haringey.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Haringey is mainly served by two core acute hospitals: North Middlesex University Trust to the north-east and Whittington Health in the south-west. Whittington Health is an Integrated Care Organisation (ICO) and runs the majority of community services in Haringey.

Acute providers face the challenge of meeting consistently high demand whilst operating at, or near to, full capacity at all times. Day-to-day this creates challenges with managing the flow of patients. For the future there is an acknowledgement that the trend towards increasing hospital admissions must be curtailed if commissioners are to succeed in improving outcomes and to maintain a sustainable health economy.

The impetus to deliver change across the health economy has led to the development of two Transformation Boards in 2012, one focused on North Middlesex (including stakeholders from Haringey and Enfield CCGs/Councils) and one around Whittington Health (including stakeholders from Islington and Haringey CCGs/Councils). Both Boards have facilitated discussions with the mental health trust for Haringey, which is Barnet, Enfield and Haringey Mental Health Trust.

From October 2013 both acute trusts have been regularly engaged in the BCF agenda through a combination of one to one meetings and the monthly Transformation Boards. The Transformation Boards have received regular verbal and written progress reports. Through discussions the impact of the BCF is reflected in the Operating plans for all Trusts.

On an operational level both trusts have been directly engaged in co-producing the services within each of the four BCF schemes including Locality Teams; Hospital Discharge Services; and IT interoperability.

ii) primary care providers

There are 49 GP Practices in Haringey. Each GP Practice is linked to one of four GP Collaboratives: West; Central; North East; South East.

Haringey GPs have had an opportunity to influence the BCF through engagement of the GP Collaboratives and their representation on Haringey CCG via the Clinical Cabinet and Governing Body. GP clinical leads have been assigned to the BCF and some of the work-streams.

At a Haringey CCG stakeholder conference in 2013, GPs were invited to comment on what they hope integration will achieve for their patients. There was considerable unanimity with most believing that integration will allow them to:

a) more easily access a greater range of services for patients;
b) obtain much improved information about service provision that is well managed and up-to-date;
c) offer a holistic response to individuals' health and social care needs.

The stakeholder conference is held annually and integration will be on the agenda for the 2014 event.

Engagement also indicates that GPs have positive experiences of participating in Haringey's Multi-Disciplinary Teams, which allow them to review high risk patients with complex needs alongside a range of health and social care colleagues. This positive experience has been used to support the implementation of the Unplanned Admissions Enhanced Service and will be used to facilitate the development of Integrated Locality Teams, which will mirror the structure of the GP Collaboratives.

GPs have been engaged in plans to develop the Locality Teams through the allocation of the Over 75s GP Case Management (£5/head) funding to each Collaborative. The funding will allow slight local variations to how the Locality Teams develop in each Collaborative, which will provide a comparison of local best practice and foster greater ownership of the BCF agenda amongst GPs.

To support the implementation of the Locality Teams, Haringey GPs have also been at the forefront of developing integrated care plans and proposals for interoperable IT.

iii) social care and providers from the voluntary and community sector

Haringey has a mixed economy of social care provision including council run and externally provided social care services. Council run services have focused on reablement and integration. Externally provided services include domiciliary care and

care home services from the independent sector and preventative services from the Third Sector.

LBH hold a regular social care Providers' Forum to influence local planning. In total 44 social care providers, drawn from 35 agencies participated in Haringey's BCF engagement process from November 2013 via the Haringey Provider's Forum, a one to one interview and a presentation at Age UK Management Committee. Providers are, generally supportive of integration and the Providers' Forum will continue to be used as the main method of engagement on integration.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The majority of Haringey's non-elective admissions (NELs) are shared amongst two acute providers (**Table 7**): North Middlesex and The Whittington. Table 7 shows the full year activity for NELs across the acute trusts. Due to limitations in the data available 'well babies' admissions have not been excluded.

Trusts	NELs 2013/14	% Share of NELs
North Middlesex University Hospital NHS Trust	8,939	44.0
The Whittington Hospital NHS Trust	6,782	33.4
Other (A number of different trusts)	2,190	10.8
Royal Free London NHS Foundation Trust	813	4.0
Barnet and Chase Farm Hospitals NHS Trust	810	4.0
University College London Hospitals NHS Foundation Trust	783	3.9
TOTAL	20,317	100

Table 7: Haringey Non-Elective Admissions by Acute Trust

The target reduction of non-elective admissions is 3.5% which translates to a reduction of 705 admissions and will generate savings of £1,247,850. Based on the percentage share of admissions amongst acute trusts, these savings break down to (**Table 8**):

Trusts	Reduction Target (no.)	Savings (£)
North Middlesex University Hospital NHS Trust	310	549,054
The Whittington Hospital NHS Trust	235	416,782
Other	76	134,768
Royal Free London NHS Foundation Trust	28	49,914
Barnet and Chase Farm Hospitals NHS Trust	28	49,914
University College London Hospitals NHS Foundation Trust	27	48,666
TOTAL	706	1,249,098

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Table 8: Forecast Non-Elective Admissions Reduction and Savings by Acute Trust

The BCF will be working alongside a broader range of Quality Innovation Productivity and Prevention (QIPP) Programmes to reduce non-elective admissions. These schemes will not duplicate BCF schemes.

The combination of activities in the BCF will result in the following impacts on acute activity:

a) Reductions in non-elective admissions will provide greater capacity within acute trusts to deliver quality improvements including performance on A&E 4 hour wait targets and Referral to Treatment Time (RTT) targets.
b) Reductions in length of stay will enable acute trusts to repatriate patients to the most appropriate setting for their care and to manage peaks in demand.
c) Improved care planning and care co-ordination will give acute trusts greater access to patient information, support the most effective treatment responses and reduce duplication
d) Self-management of Long Term Conditions will increase outpatient capacity for Long Term Conditions, where it is needed most.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

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ANNEX 1 – Detailed Scheme Description

Scheme ref no.
1
Scheme name
Admissions Avoidance
What is the strategic objective of this scheme?
The Admissions Avoidance Scheme identifies people most at risk of an emergency hospital admission and via a Care Co-ordinator, within a Locality Team, develops a care plan setting out the integrated package of support needed, either from self-care or from safe and effective services, to keep them well and independent and to prevent an admission.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To meet the strategic objective the Admission Avoidance Scheme will: • Use appropriate risk stratification tools to identify people most at risk of an emergency admission to hospital • Assign a named care co-ordinator to each individual identified • Care co-ordinators form part of a multi-disciplinary Locality Team based around GP collaboratives • Use a joint assessment tool to identify health and social care needs and desired goals, including the risk of a fall, in collaboration with the individual • Develop a care and support plan based on the identified health and social care needs, which is reviewed every three months (as a minimum) • Care co-ordinators will oversee the implementation of the care and support plans, including the monitoring of patient/service user goals and facilitate access to services • Provide urgent health and social care interventions through a rapid response service • Provide specific care co-ordination for people with mental health needs with mental health navigators • Provide specific health and social care support for dementia via a Dementia Day Centre • Provide specific health and social care support for mental health via a Mental Health Recovery College • Link people at risk of a fall into prevention programmes that treat, improve or manage risk factors. In line with the case for change the Admissions Avoidance Scheme will mainly target the top 2% of adults at risk of a non-elective hospital admission totalling 4500 people. Key milestones include: • Evaluate which of the four available risk stratification tools is preferred by Haringey GPs, based on usability and accuracy of outputs, by October 2014. • Evaluate existing admission avoidance services to identify local good practice and

align with national evidence base by November 2014 including: Rapid Response; Mental Health navigators; Dementia Day Centres; and Mental Health Recovery College
- Develop Locality Team business case by October 2014
- Co-design Locality Team Pilot with key stakeholders to implement by November 2014
- Review implementation of the Unplanned Admissions Enhanced Service and Locality Team pilot by January 2015
- Co-design and re-develop existing services, that do not meet current performance indicators or national evidence base, with key stakeholders by January 2015
- Develop service specifications for all Admissions Avoidance services by February 2015
- Commission Admission Avoidance services by April 2015
- Monitor implementation of Admission Avoidance services from May 2015

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The BCF governance structure and programme management approach have already been agreed. The Admissions Avoidance Scheme and related services will be overseen by the Integration Implementation Group which is chaired by the Haringey CCG, Assistant Director of Commissioning, with an assigned Clinical (GP) Lead from the CCG Governing Body and an LBH Commissioner and other members (both managerial and clinical/delivery) from acute, community healthcare and social care providers as well as patient/service user representation. The Integration Implementation Group has overseen the implementation of Multi-Disciplinary Team working in primary care and has started the process of overseeing the implementation of the Admissions Avoidance Enhanced Service, evaluation of existing admission avoidance services and co-designing the Locality Teams.

Once the Haringey BCF Plan has been submitted a detailed work-plan will be created for the Integration Implementation Group. An interim project manager will start full time in October 2014 to ensure that the implementation of the work plan is fully supported and monitored, escalating all issues and risks and providing an audit trail. The project manager will have a key responsibility for the development of the Locality Team including the business case and service specification and ensuring that integrated approaches are embedded in the model.

Within the current commissioning arrangement all healthcare elements of the Admissions Avoidance Scheme will be commissioned by Haringey CCG with Community Healthcare currently provided by Whittington Health and additional Primary Care capacity provided by Haringey GP Practices.

LBH Commissioning will continue to commission the social care elements of the scheme including mental health and dementia services. A number of these services are currently provided by LBH itself part from mental health navigators from Barnet Enfield Haringey Mental Health Trust, and mental health recovery co-ordinators from Clarendon Recovery College.

Commissioning arrangements may change over the delivery of the BCF due to the development of a Section 75 agreement.

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The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The key feature of the Admissions Avoidance Scheme is Care Co-ordination. The Better Care Fund Task Force, How to Guide: BCF Technical Toolkit (2014) provided the following evidence for Care Co-ordination.

Care co-ordination is the practice of having someone co-ordinate the care received by an individual that has been designated as needing additional support. Typically, these are older people and those with chronic conditions who often represent 10-20% of the population and 30-70% of costs in the health and care system. The care co-ordinator role can be effectively carried out by a range of professionals including clinicians, social workers and other practitioners. It will be key that the co-ordinator understands the wider health and care economy and the local community and can effectively oversee and connect those people most at risk into effective care and support. There are several essential steps that are required to implement care co-ordination including the identification of individuals who would benefit from care co-ordination, the enrolment of those individuals into a programme, the development of care plans for those individuals and then ongoing follow-up in line with the plan.

The evidence base highlights the following techniques:

- A holistic focus supporting self-care at home
- Single entry point to provide continuity
- Shared electronic health records
- Coordinating care at the neighbourhood level with engagement of local community
- Prioritising engagement with GPs and links with secondary care

8 out of 13 reviews which were analysed assessed care co-ordination and found a positive impact. Other reviews of literature have concluded that hospitalisations may be reduced by approximately 37% (North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews). Interventions involving care coordination have shown to reduce HbA1c (in patients with diabetes) by 22% more than interventions without care co-ordination (Shojana et al, JAMA, 2006, 296(4), 427-440).

In Haringey, Locality Teams would be expected to identify people at risk of falls as part of the risk stratification. Once identified, care co-ordinators will be able to undertake a falls risk assessment as part of the integrated assessment in line with NICE clinical guideline (2013) Falls: assessment and prevention of falls in older people. Once people have been identified they can be linked to falls prevention programmes within Scheme 3: Promoting Independence. One study in Torbay showed that falls prevention could reduce acute hospital costs by 25% (Tian et al (2013), 'Exploring the system - wide costs of falls in older people in Torbay').

4500 people have been identified as the top 2% at risk of hospital admission in Haringey. This group accounts for over 5000 acute hospital admissions per year in Haringey. If the care-coordination approach achieves a 37% reduction in hospital admissions, as reported above, 1665 admissions per year could be prevented in the long-term. Assuming that this effect will be seen in a step-wise progression over 4 years, we model that 460 admissions will be prevented in 2015/16

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Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

NA

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Haringey is participating in the North Central London Value Based Commissioning (VBC) programme. The VBC Programme has defined three levels of outcomes which will cut across the BCF Programme: Clinical Outcome Measures; Patient Reported Outcome Measures; and Patient Defined Outcome Measures. An assessment of these outcomes in August 2014 has generated a list of outcomes that could be measured now:

Topics	Outcomes
1. Mortality Rate / Age of Death	1a. A measure of mortality rate 1b. A measure of average age of death
3. Patient identified outcomes related to Quality of Life	3b. A measure of the feeling of company and contact
4. Evidence-based outcomes related to care process	4a. A measure of the rate of acquired infection rate whilst receiving care e.g. HAP, UTI (with catheter in situ), wound infection 4b. A measure of the rate of pressure sores whilst receiving care 4c. A measure of the rate of falls whilst receiving care 4d. Staying at home after discharge
5. Patient identified outcomes related to care process	5a. A measure of feeling decisions are listened to and acted on 5b. A measure of feeling in control over care
7. Fragility Fractures	7a. A measure of fragility fracture rates 7b. A measure for the recovery period to previous level of mobility post-fragility fracture
9. A 'good death': location/pain /own views considered	9. A measure of a 'good death'
11. Dementia Specific Outcomes	11a. A measure of dementia diagnosis rate 12. A measure of the extent people with dementia/their carer feel supported

LBH Public Health have been engaged in a process of agreeing appropriate outcome and process measures (e.g number of care plans completes, number of people allocated to a care co-ordinator) for the Admissions Avoidance Scheme services by November 2014. This will be based on the work of VBC and national and local evidence of effectiveness.

Monitoring of process and outcome measures using a pre-established monitoring framework will be reported into the Integration Implementation Group and ultimately the Integration Management Board at regular intervals.

What are the key success factors for implementation of this scheme?

The following 4 factors have been identified as key to the success of the Admissions Avoidance Scheme:

Public Behaviour Change: The success of the Admissions Avoidance Scheme will rely on the need for patients and service users to change their behaviours away from an over reliance on hospitals and doctors towards a greater amount of self-management, with and without support. Public behaviour change will be supported through the accessibility,

acceptability and awareness of alternative provision. Having a single point of access for the scheme that will be promoted and communicated in a variety of different ways will support the behaviour change. This scheme will also link with the promoting independence scheme to reduce demand and champion alternative provision.

Organisational Culture Change: Culture change is key to any transformational programme. The Integrated Locality teams within the Admissions Avoidance Scheme will move the culture away from silo working including: organisational (e.g social care, community health care, voluntary sector); professional (e.g. district nursing, community matrons, social workers); health (e.g. mental health will be given the same parity of esteem as physical health); care (e.g. prevention, treatment); and setting (e.g. home, community setting, acute ward). Locality teams will work across these silos working on the health and social care needs of each individual. A model of collaborative leadership, delivered through an extensive training and development programme, will be used to generate a culture of respect and reduce fears and resistance.

Workforce: Staff in all health and social care agencies have been, and will continue to be, engaged in the development of all services within the Admissions Avoidance Scheme. There will be no decisions made about staff without full and proper consultation. Workforce modelling of the number of Community Health Care and Social Care staff needed as Care Co-ordinators for almost 5000 patients/service users per year will be needed by October 2014. Care co-ordinators would be expected to retain their specialisms (e.g. social work or occupational therapy) but would also be expected to undertake a number of generic tasks to reduce the duplication of certain activities (e.g. health and social care assessments). Training and workforce development will be key to engaging staff in the development of the scheme and the skills needed to work in a collaborative way that promotes the independence of patients and service users and will be delivered via implementation of the LETB funding bid. Matrix management structures will also be created that will both support professional supervision and performance management.

Systems: Interoperable IT systems in Scheme 4 will support the implementation of integrated working within the Admissions Avoidance Scheme. Currently each service has their own separate clinical IT system and no service has access to patient and service users' information from the other service. Plans are being developed to collaborate with other HWBB areas to develop solutions on the sharing of data between services and eventually with patients themselves in the form of a person held record. The linkage of these systems will further support the single point of access as a key entry point into the Locality Teams as information will be accessible that can support a quick and efficient service response. An interim solution for interoperable IT and the viewing of care records will be ready by January 2015 with full interoperability by June 2015.

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Scheme ref no.
2
Scheme name
Effective Hospital Discharge
What is the strategic objective of this scheme?
The Effective Hospital Discharge Scheme delivers three key services: step down care via a non-acute facility to enable people to convalesce prior to returning home; a volunteer led befriending and home visiting service for people aged over 50 prior to hospital discharge; and a Multi-Disciplinary Team reablement package to patients following a hospital discharge. The reablement package includes personal care and support that enables and equips service users to carry out activities themselves in order to restore independence.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To meet the strategic objective the Effective Hospital Discharge Scheme will: • Plan for a person's discharge as soon as they are admitted to hospital ensuring that all needs are assessed to enable an effective return home • Refer to a person's care and support plan if they are known to the Locality Team to reduce duplication and ensure continuity of care • Deliver a package of care and support that most efficiently restores a service user's independence • Develop a care plan with user defined goals for independence • Hand over to the Locality Team for the monitoring of any service user within the hospital admission high risk group once independence has been regained • Be overseen by a senior clinician with specific reablement skills and knowledge In order to maximise effectiveness of the Scheme, commissioners will: • Re-commission the Home from Hospital service based on the key BCF outcomes • Review the current capacity of community step down care in light of projected needs • Review the capability and capacity of the current reablement service in light of projected needs In 2013/14 there were 20,317 non-elective admissions. Current reablement services have the capacity to target 600 adults to support their discharge. Further planning will be undertaken by November 2014 to explore the potential to expand capacity. Key milestones include: • The Home from Hospital Scheme Pilot has already been evaluated • Evaluate Reablement and Step Down Care to identify local good practice and align with national evidence base by November 2014 • Undertake detailed capacity planning for reablement and step down care by November 2014. • Develop Reablement business case and redesigned pathway by December 2014 • Develop service specifications for all Effective Hospital Discharge Services by February 2015

- Commission Effective Hospital Discharge services by April 2015
- Monitor implementation of Effective Hospital Discharge services from May 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The BCF governance structure and programme management approach have already been agreed. The Effective Hospital Discharge Scheme and related services will be overseen by the Systems Resilience Group which is chaired by the Haringey CCG Governing Body, Secondary Care Clinical (GP) Lead. Other members (both managerial and clinical/delivery) from acute, London Ambulance Service, NHS 111, community healthcare and social care providers. The main aim of the Systems Resilience Group is to develop and deliver a shared strategic vision for the provision of integrated elective and non-elective care services across the Haringey and Enfield health and social care economy. This has a particular focus on winter planning but will be sustained through the year with a clear objective of linking to BCF principles and plans for integration. The Systems Resilience Group will have oversight of the services within the Effective Hospital Discharge Scheme including Reablement, Step Down and Home from Hospital.

The Systems Resilience Group has a detailed work-plan that is overseen by the Commissioning Lead for Urgent Care. A substantive Commissioning Manager will commence work in October 2014 and will be assigned to project manage the implementation of the Effective Hospital Discharge Scheme including the development of business cases and service specifications, escalating all issues and risks and providing an audit trail.

Within the current commissioning arrangement all Community Healthcare elements (currently provided by Whittington Health) of the Effective Hospital Discharge Scheme will be commissioned by Haringey CCG.

LBH Commissioning will continue to commission the social care and community befriending elements of the scheme. The Reablement service is currently provided by LBH itself whilst the Home From Hospital Service was commissioned by the local authority and provided by the Third Sector: Haringey Age UK and Living Under One Sun.

Commissioning arrangements may change over the delivery of the BCF due to the development of a Section 75 agreement.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The main services in the Effective Hospital Discharge Scheme are intermediate care services, including rehabilitation and reablement.

The Better Care Fund Task Force, How to Guide: BCF Technical Toolkit (2014) provided the following evidence for Intermediate care.

Intermediate care has the potential to reduce length of stay in hospital by facilitating a stepped pathway out of hospital (step down) or preventing deterioration that could lead to a hospital stay (step up).

The evidence base highlights the following techniques:

- Commissioning for outcomes instead of periods and tasks
- Workforce led by a senior clinician with specific reablement services and skills
- Adequate provision for rehabilitation and reablement outside acute hospitals, based on demographic characteristics of the local population

A Department of Health funded review showed that home care reablement is almost certainly cost-effective and improves outcomes for users. The study showed that in the first year of setting up a service, set-up costs cancel out savings (http://www.york.ac.uk/inst/spru/pubs/rworks/2011-01Jan.pdf).

Reablement will be provided for 600 clients per year. A recent Randomised Control Trial (Lewin et al, 2014) showed that for every 100 clients, reablement results in 7 less hospital admissions per year compared to usual social care and 6 less people requiring residential or maximal home care per year compared to usual social care. If we assume that 1 in 6 of these step-up packages are residential packages, that equates to a reduction in 1 residential care package for each 100 reablement clients. For Haringey this will equate to 36 fewer hospital admissions and 6 fewer residential care packages in 2015/16.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Haringey is participating in the North Central London Value Based Commissioning (VBC) programme. The VBC Programme has defined three levels of outcomes which will cut across the BCF Programme: Clinical Outcome Measures; Patient Reported Outcome Measures; and Patient Defined Outcome Measures. An assessment of these outcomes in August 2014 has generated a list of outcomes that could be measured now:

Topics	Outcomes
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9. A 'good death': location/pain /own views considered	9. A measure of a 'good death'
11. Dementia Specific Outcomes	11a. A measure of dementia diagnosis rate 12. A measure of the extent people with dementia/their carer feel supported

LBH Public Health have been engaged in a process of agreeing appropriate outcome and process measures (e.g number of completed packages of care) for the Effective Hospital Discharge Scheme services by November 2014. This will be based on the work of VBC and national and local evidence of effectiveness.

Monitoring of process and outcome measures using a pre-established monitoring framework will be reported into the Systems Resilience Group and ultimately the Integration Management Board at regular intervals.

What are the key success factors for implementation of this scheme?

The following 4 factors have been identified as key to the success of the Effective Hospital Discharge Scheme:

Public Behaviour Change: The success of the Effective Hospital Discharge Scheme will rely on the need for patients and service users to change their behaviours towards a greater amount of self-management, with and without support. Service users will be supported to define their own goals in order to promote greater ownership of any treatment programmes.

Organisational Culture Change: Culture change is key to any transformational programme. The Effective Hospital Discharge Scheme will move the culture away from silo working including: organisational (e.g social care, community health care, voluntary sector); professional (e.g. district nursing, community matrons, social workers); health (e.g. mental health will be given the same parity of esteem as physical health); care (e.g. prevention, treatment); and setting (e.g. home, community setting, acute ward). The Reablement Team will work across these silos working on the health and social care needs of each individual rather than each individual meeting the needs of separate services for each of their conditions.

Workforce: Staff in all health and social care agencies have been, and will continue to be, engaged in the development of all services within the Effective Hospital Discharge Scheme. There will be no decisions made about staff without full and proper consultation. Workforce modelling of the number of staff needed for 600 patients/service users per year will be needed. Training will be key to engaging staff in the development of the scheme and the skills needed to work in a collaborative way that promotes the independence of patients and service users. Matrix management structures will also be

created that will both support professional supervision and performance management.

Systems: Interoperable IT systems will support the implementation of integrated working within the Effective Hospital Discharge Scheme. Currently each service has their own separate clinical IT system and no service has access to patient and service users' information from the other service. Plans are being developed to collaborate with other HWBB areas to develop solutions on the sharing of data between services and eventually with patients themselves in the form of a person held record. The linkage of these systems will reduce duplication and ensure continuity of care.

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Scheme ref no.
3
Scheme name
Promoting Independence
What is the strategic objective of this scheme?
The Promoting Independence Scheme delivers a range of community development interventions based on a model of prevention and early intervention to prevent ill-health arising, to support self-management of health and care conditions and to reduce social isolation. The focus of this scheme is to build community capacity to respond proactively to episodes of need. The Scheme also encompasses an integrated service to support palliative care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To meet the strategic objective the Promoting Independence Scheme will: • Outreach to local community organisations and settings • Identify people who may be pre-frail or socially isolated • Use health coaching and motivational interviewing techniques to identify goals with service users • Develop potential community responses and activities to the identified needs of service users, particularly tailored to specific health conditions • Develop community responses to falls prevention including potential exercise and home hazard interventions • Connect local residents to other services in the community in order to reduce social isolation, support healthy lifestyle and facilitate behavioural change • Enable the management of palliative care within the community via advanced care planning In line with the case for change the Promoting Independence Scheme will broadly target adults in the top 20% of those at risk of a hospital admission. This category is broader than high risk and encompasses some definitions of a pre-frail population as the approach is based on prevention and early intervention. In Haringey this is equivalent to 46,000 people. The risk stratification identifies 6,700 people as at high risk of a hospital admission in Haringey. In Haringey one of the services delivering self-care the 'Neighbourhood Connects' service will target 2000 people in this cohort by 2019, starting with 1000 people in 2015/16, with self-care including falls prevention, reducing social isolation and lifestyle and behavioural change. Key milestones include: • The Neighbourhood Connects service has already been piloted and evaluated • The Palliative Care team already operates at 5 days/week. • Map current community development services by November 2014 • Develop a business case for Promoting Independence services by November 2014 • Co-design Promoting Independence services with key stakeholders by December 2014 • Expand the Palliative Care Team to 7 day working by December 2014 • Develop service specifications for Promoting Independence by January 2015

- Re-commission the Neighbourhood Connects service by January 2015
- Commission additional Promoting Independence services by April 2015
- Monitor implementation of Promoting Independence Service from May 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The BCF governance structure and programme management approach have already been agreed. The Promoting Independence Scheme and related services will be overseen by the Promoting Independence Group which is chaired by the LBH Assistant Director of Commissioning, with representation across Haringey CCG and LBH Including Adult Social Care, Commissioning and Public Health. This group is at an early stage of development and does not yet have a Governing Body clinical lead or representation from providers or the public. The Group has agreed to oversee all projects that link to self-care and self-management including prevention and early intervention, proactive and healthy lifestyle programmes in public health, and community and voluntary sector provision that supports health and wellbeing.

Once the Haringey BCF Plan has been submitted a detailed work-plan will be created for the Promoting Independence Group. An interim project manager for self-management is already in post to ensure that the implementation of the work plan is fully supported and monitored, escalating all issues and risks and providing an audit trail. The project manager will have a key responsibility for the development of the business case and service specifications for services within the Promoting Independence Scheme.

Within the current commissioning arrangement Haringey CCG will continue to commission the Integrated Palliative Care Team from Whittington Health.

LBH Commissioning will continue to commission the Third Sector to deliver the Neighbourhood Connects Service, which was provided by Haringey Age UK and Living Under One Sun.

Commissioning arrangements may change over the delivery of the BCF due to the development of a Section 75 agreement.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The main element of the Promoting Independence Scheme is self-care, with improved connectivity to local community activities and improved social interaction.

The Better Care Fund Task Force, How to Guide: BCF Technical Toolkit (2014) provided the following evidence for self-care.

People with long-term conditions account for 70% of inpatient bed days. Self-management programmes, which aim to support patients to manage their own conditions, have been shown to reduce unplanned hospital admissions for some conditions (COPD and asthma). One study found that supported self-management had the strongest effect on clinical outcomes of all integrated care interventions, and

reduced hospitalisations by 25-30% (Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)).

The evidence base highlights the following techniques:

- Involving patients in co-creating personalised self-care plans
- Telephone health coaching
- Tailoring interventions to the condition (e.g. structured education for diabetes self-care, behavioural interventions for depression)
- Programmes to encourage lifestyle and behavioural change.

The Promoting Independence Scheme will be provided to 2000 residents via the Neighbourhood Connect service by 2019. This will begin with 1000 residents for 2015/16. Based on evidence around the effectiveness falls prevention programmes and self-care (e.g Gillespie et al. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2012) a 25% reduction in admissions, equal to 250 people, has been modelled.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Haringey is participating in the North Central London Value Based Commissioning (VBC) programme. The VBC Programme has defined three levels of outcomes which will cut across the BCF Programme: Clinical Outcome Measures; Patient Reported Outcome Measures; and Patient Defined Outcome Measures. An assessment of these outcomes in August 2014 has generated a list of outcomes that could be measured now:

Topics	Outcomes
1. Mortality Rate / Age of Death	1a. A measure of mortality rate 1b. A measure of average age of death
3. Patient identified outcomes related to Quality of Life	3b. A measure of the feeling of company and contact
4. Evidence-based outcomes related to care process	4a. A measure of the rate of acquired infection rate whilst receiving care e.g. HAP, UTI (with catheter in situ), wound infection 4b. A measure of the rate of pressure sores whilst receiving care 4c. A measure of the rate of falls whilst receiving care 4d. Staying at home after discharge
5. Patient identified outcomes related to care process	5a. A measure of feeling decisions are listened to and acted on 5b. A measure of feeling in control over care
7. Fragility Fractures	7a. A measure of fragility fracture rates 7b. A measure for the recovery period to previous level of mobility post-fragility fracture
9. A 'good death': location/pain /own views considered	9. A measure of a 'good death'
11. Dementia Specific Outcomes	11a. A measure of dementia diagnosis rate 12. A measure of the extent people with dementia/their carer feel supported

LBH Public Health have been engaged in a process of agreeing appropriate outcome and process measures (e.g number of people engaged in services) for the Promoting Independence Scheme services by November 2014. This will be based on the work of

VBC and national and local evidence of effectiveness.

Monitoring of process and outcome measures using a pre-established monitoring framework will be reported into the Promoting Independence Group and ultimately the Integration Management Board at regular intervals.

What are the key success factors for implementation of this scheme?

The following 4 factors have been identified as key to the success of the Promoting Independence Scheme:

Public Behaviour Change: The success of the Promoting Independence Scheme will rely on the need for patients and service users to change their behaviours towards a greater amount of self-management, with and without support. Service users will be supported to define their own goals in order to promote greater ownership of any treatment programmes. Public behaviour change will be supported through the accessibility, acceptability and awareness of alternative provision.

Organisational Culture Change: Culture change is key to any transformational programme. The Promoting Independence Scheme will move the culture away from silo working including: organisational (e.g social care, community health care, voluntary sector); professional (e.g. district nursing, community matrons, social workers); health (e.g. mental health will be given the same parity of esteem as physical health); care (e.g. prevention, treatment); and setting (e.g. home, community setting, acute ward). Both the Palliative Care Team and the Neighbourhood Connects Service will work across a number of these silos working on the health and social care needs of each individual in a much more holistic way.

Workforce: Staff in all health and social care agencies, including the third sector, have been, and will continue to be, engaged in the development of all services within the Promoting Independence Scheme. There will be no decisions made about staff without full and proper consultation. Workforce modelling of the number of staff needed for 2000 patients/service users per year will be needed. Training will be key to engaging staff in the development of the scheme and the skills needed to work in a collaborative way that promotes the independence of patients and service users. Matrix management structures will also be created that will both support professional supervision and performance management.

Systems: Interoperable IT systems will support the implementation of integrated working within the Promoting Independence Scheme. Currently each service has their own separate clinical IT system and no service has access to patient and service users' information from the other service. Plans are being developed to collaborate with other HWBB areas to develop solutions on the sharing of data between services and eventually with patients themselves in the form of a person held record. The linkage of these systems will reduce duplication and ensure continuity of care.

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Scheme ref no.
4
Scheme name
Integration Enablers
What is the strategic objective of this scheme?
The Integration Enablers Scheme includes a number of different and critically important strands that enable the delivery of the other BCF schemes including: Interoperable IT; Single Point of Access; Seven Day Working in Services; Workforce development and implementation of Care Act responsibilities.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To meet the strategic objective, the Integration Enablers Scheme will: • Deliver interoperability and information exchange to share data between GP's, providers and patient/service user • Deliver a digital person held health and social care record (PHR) for Haringey residents • Provide a Single Point of Access for all patients/service users via a web portal, backed up by a telephone and face to face service • Support LBH responsibilities for Winterbourne, Safeguarding, Carers, Community Capacity and Disabled Facilities. The Integration Enablers Scheme supports the delivery of each of the other schemes and so covers the widest cohort of older people and adults at risk of a non-elective admission, taken as the Promoting Independence top 20% of the population, 46,000 people. However due to the nature of the enablers they will also support the health and well-being of the whole of the Haringey population. Key milestones include: • Develop and agree plans for an interim interoperable IT system by October 2014 • Implement plans for an interim interoperable IT system by January 2015 • Develop a business case for a fully interoperable IT system by January 2015 • Develop a service specification for a fully interoperable IT system by February 2015 • Agree information governance for appropriate sharing across the health and care economy by April 2015 • Commission a fully interoperable IT system by June 2015 • Commission a Person Held Record by April 2016 • Develop plans for a Single Point of Access for Health and Social Care by November 2014 • Implement plans for a Single Point of Access for Health and Social Care by February 2015 • Monitor Single Point of Access from March 2015 • Develop linkage of the Health and Social Care Single Point of Access and the Transformation of LBH Customer Care by June 2015. • Commission Fully integrated Customer Care and Single Point of Access by September 2015

- Monitor delivery of LBH and CCG Care Act responsibilities from April 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The overarching BCF governance structure and programme management approach have already been agreed. The Integration Enablers Scheme and related services will be overseen by the Operational Management Board. This group is not fully established but the aim will be for it to be running by November 2014. The Chair is not yet confirmed but membership will be across all partners, providers and public including Haringey CCG, LBH, and managerial and clinical/delivery from acute, community healthcare and social care providers as well as patient/service user representation. The group will mainly oversee the development of interoperable IT and workforce strategies.

Once the Haringey BCF Plan has been submitted a detailed work-plan will be created for the Integration Enablers Scheme. The Commissioning Lead for the Better Care Fund (who is already in post) as overall programme manager will ensure that the implementation of the work plan is fully supported and monitored, escalating all issues and risks and providing an audit trail.

Interoperable IT will be overseen by the IT Integrated Leads Group jointly with Islington CCG. Haringey CCG has decided to partner Islington due to the shared Community Healthcare provider (The Whittington). The group will oversee the development of the IT interoperability business case and service specification.

Haringey CCG is in the process of establishing an overarching workforce training and development committee which will ultimately oversee all workforce programmes. Haringey has been successful in securing a Health Education Central East and North London (HENCEL) bid which includes listening events to co-create a training and development programme for all staff across health and social care (including primary care and third sector agencies) and the implementation of the resulting programme. A small steering group of workforce leads across Haringey CCG, LBH and provider organisations will be established by October 2014 to oversee implementation of the bid. This group will eventually form part of the wider training and development committee.

Within the current commissioning arrangement Haringey CCG will commission the interoperable IT solution. There is not a current provider for this solution but it is expected that this will be form the private sector.

LBH Commissioning will commission the Single Point of Access from the private sector.

Both the CCG and LBH will deliver their Care Act responsibilities.

Commissioning arrangements may change over the delivery of the BCF due to the development of a Section 75 agreement.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

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In order to deliver the ambitious scale and depth of integration proposed by Haringey CCG and LBH, it is recognised that the systems infrastructure needs to be redesigned to facilitate joint working, measure patient defined outcomes, share information and improve the user experience. This Scheme therefore represents a significant body of work to ensure underlying processes and systems actively support an approach based on integration, self-care, prevention and early intervention and reablement. As the Integration Enablers Scheme specifically supports the other schemes impacts have not been modelled and an evidence base is not presented.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
N/A
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Process measures for the impact of Integration Enablers (e.g number of people accessing the Single Point of Access, number of people accessing social care grants) will be developed. Monitoring of process and outcome measures using a pre-established monitoring framework will be reported into the Operational Management Board and the Integration Management Board at regular intervals.
What are the key success factors for implementation of this scheme?
As the Integration Enablers support the achievement of the other BCF Schemes they are the key success factors for the other schemes.

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ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Haringey
Name of Provider organisation	**North Middlesex University Hospital NHS Trust (RAP)**
Name of Provider CEO	Julie Lowe
Signature (electronic or typed)	Julie Lowe

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	10,427
	2014/15 Plan	10,534
	2015/16 Plan	10,850
	14/15 Change compared to 13/14 outturn	1.0%
	15/16 Change compared to planned 14/15 outturn	3.0%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	188
	How many non-elective admissions is the BCF planned to prevent in 15-16?	251

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust acknowledges the methodology that has been applied within the CCG plan to derive the numbers quoted in the document that assess the potential impact. The Trust would reference that in its opinion 14/15 outturn will material exceed 14/15 plan levels, although that does not affect the estimated impact per se.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*N/A*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust acknowledges the potential impact that the BCF schemes included within the plan may have if successfully implemented. The Trust advises that further consideration be given within BCF plans to understanding the scope and nature of transitional arrangements that may be needed to support providers in withdrawing fixed and semi-fixed capacity.

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Name of Health & Wellbeing Board	Haringey
Name of Provider organisation	**Whittington Hospital NHS Trust**
Name of Provider CEO	Simon Pleydell
Signature (electronic or typed)	 Siobhan Harrington, Deputy CEO

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	7,619
	2014/15 Plan	7662
	2015/16 Plan	7892
	14/15 Change compared to 13/14 outturn	0.6%
	15/16 Change compared to planned 14/15 outturn	3.0%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	141
	How many non-elective admissions is the BCF planned to prevent in 15-16?	188

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We agree that the data in terms of a reduction in non-elective admissions is in line with commissioners assumptions.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*N/A*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We continue to work through and consider the implications on services provided by our organisation. As an integrated care organisation we are identifying the benefits on community service provision of the local BCF plans.

Summary of Health and Wellbeing Board Schemes

Haringey

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	1,095	1,095			
Community Health	1,540	10,372			
Continuing Care	-	-			
Primary Care	108	350			
Social Care	4,182	10,257	4,182	10,257	
Other	-	-			
Total	**6,925**	**22,074**		**10,257**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure
	2015/16
Mental Health	1,095
Community Health	10,372
Continuing Care	-
Primary Care	350
Social Care	4,656
Other	-
Total	**16,473**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	(135)	(270)	
Increased effectiveness of reablement	-	-	
Reduction in delayed transfers of care	-	-	
Reduction in non-elective (general + acute only)	(673)	(1,255)	1,248
Other	-	-	
Total	**(808)**	**(1,525)**	**1,248**

Rounding of figures means figures do not match exactly

Health and Wellbeing Board Expenditure Plan

Haringey

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
1. Admissions Avoidance	Social Care		Local Authority			Local Authority	Local Authority Social Services	-	4,013
1. Admissions Avoidance	Social Care		Local Authority			Local Authority	Local Authority Social Services	340	-
1. Admissions Avoidance	Social Care		CCG			Local Authority	Additional CCG Contribution	236	-
1. Admissions Avoidance	Social Care		CCG			Local Authority	CCG Minimum Contribution	-	620
1. Admissions Avoidance	Mental Health		Local Authority			NHS Mental Health Provider	Local Authority Social Services	1,095	-
1. Admissions Avoidance	Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution	-	1,095
1. Admissions Avoidance	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	-	7,839
1. Admissions Avoidance	Community Health		CCG			Primary Care	Additional CCG Contribution	1,371	-
1. Admissions Avoidance	Community Health		CCG			Primary Care	CCG Minimum Contribution	-	1,371
2. Effective Hospital Discharge	Social Care		CCG			Local Authority	Local Authority Social Services	3,225	-
2. Effective Hospital Discharge	Social Care		CCG			Local Authority	CCG Minimum Contribution	-	3,225
2. Effective Hospital Discharge	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	48	-
2. Effective Hospital Discharge	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	-	693
3. Promoting Independence	Social Care		Local Authority			Charity/Voluntary Sector	Local Authority Social Services	146	-
3. Promoting Independence	Social Care		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	-	336
3. Promoting Independence	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	121	-
3. Promoting Independence	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	-	300
4. Integration Enablers	Social Care		Local Authority			Local Authority	Local Authority Social Services	-	1,588
4. Integration Enablers	Social Care		CCG			Local Authority	Local Authority Social Services	235	-
4. Integration Enablers	Social Care		CCG			Local Authority	CCG Minimum Contribution	-	475
4. Integration Enablers	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	-	169
4. Integration Enablers	Primary Care		CCG			CCG	Additional CCG Contribution	108	-
4. Integration Enablers	Primary Care		CCG			CCG	CCG Minimum Contribution	-	350
Total								**6,925**	**22,074**

Health and Wellbeing Board Financial Benefits Plan

Haringey

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		1. Admissions Avoidance: Rapid response	CCG	352	(1,770)	(623,040)	Rapid response service estimated to prevent admission in 352 clients	Ongoing monitoring of rapid response clinet numbers and outcomes. Monitoring of cumulative residential admissions and non-elective admissions, using pre-established monitoring framework reporting into integration management board.
Reduction in non-elective (general + acute only)		2. Effective Hospital Discharge: Reablement	CCG	28	(1,770)	(49,560)	Reablement will be provided for 400 clients pe year. A recent RCT (Lewin et al 2014) showed that for every 100 clients, reablement results in 7 less hospital admissions per year compared to usual social care.	Monitoring of re-ablement numbers and effectiveness. Monitoring of cumulative residential admissions and non-elective admissions, using pre-established monitoring framework reporting into integration management board.
Reduction in permanent residential admissions		2. Effective Hospital Discharge: Reablement	LA	4	(33,748)	(134,992)	Reablement will be provided for 400 clients pe year. A recent RCT (Lewin et al 2014) showed that for every 100 clients, reablement results in 6 less people requiring residential or maximal home care per year compared to usual social care. If we assume that 1 in 6 of these step-up packages are residential packages, that equates to a reduction in 1 residental care package for each 100 reablement clients.	Monitoring of re-ablement numbers and effectiveness. Monitoring of cumulative residential admissions and non-elective admissions, using pre-established monitoring framework reporting into integration management board.
Total for baseline in 2014/15				380				
Total						**(807,592)**		

2015/16

			2015/16					
Benefit achieved from		**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		1. Admissions Avoidance: Rapid response	CCG	-	(1,770)	-	There will be no increase in activity from 2014/15 baseline.	Ongoing monitoring of rapid response clinet numbers and outcomes. Monitoring of cumulative residential admissions and non-elective admissions, using pre-established monitoring framework reporting into integration management board.
Reduction in non-elective (general + acute only)		1. Admissions Avoidance: Locality Team	CCG	460	(1,770)	(814,200)	4500 people have been identified as the top 2% at risk of hospital admission in Haringey. This group accounts for over 5000 acute hospital admissions per year in Haringey. A review of evidence presented in NHS England's BCF technical toolkit reported that a care co-ordination approach could result in a long-term redution in hospital admissions of 37%. If the care-cordination approach achieves this level of success in Haringey's high risk population, 1665 admissions per yea could be prevented in the long-term. Assuming that this effect will be seen in a step wise progression over 4 years, we model that in 2015/16, 460 admissions will be prevented through our care co-ordination approach in 2015/16	Development of process measures for effectiveness of care-co-ordination in locality teams (e.g number of care plans completes, number of people allocated to a care co-ordinator). Monitoring of cumulative residential admissions and non-elective admissions, using pre-established monitoring framework reporting into integration management board.
Reduction in non-elective (general + acute only)		2. Effective Hospital Discharge: Reablement	CCG	14	(1,770)	(24,780)	Reablement will be provided for 600 clients in 2015/16. A recent RCT (Lewin et al 2014) showed that for every 100 clients, reablement results in 7 less hospital admissions per year compared to usual social care.	Monitoring of re-ablement numbers and effectiveness. Monitoring of cumulative residential admissions and non-elective admissions, using pre-established monitoring framework reporting into integration management board.
Reduction in non-elective (general + acute only)		3. Promoting Independence: Palliative care	CCG	60	(1,770)	(106,200)	Increase access to palliative care services and advanced care planning for 200 clients. Clients referred to palliative care services are 30% less likley to require non elective admission in last 30 days of life (Purdy S, Lasseter G, Griffin T, et al. BMJ Supportive & Palliative Care Published Online First: doi:10.1136/bmjspcare-2013-000645)	Development of process measures for palliative care/advanced care planning process.Monitoring of place of death (correspondence with patient choice) amd number of hospital admissions in service users.
Reduction in non-elective (general + acute only)		3. Promoting Independence: Neighbourhood connects	CCG	175	(1,770)	(309,750)	Connect service by 2019. 1000 clients for 2015/16. Service for pre-frail clients (i.e not in top 2%). Will include self-care elements including falls prevention and lifestyle and behavioral change.We have modeled a reduction in admissions in this cohort of 175 per year, based on evidence around the effectiveness of falls prevention programmes and self-care (e.g Gillespie et al. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2012)	Development of process measures for impact of Neigbourhood Connect (e.g number of people completing self-care interventions, number of people recievneing evidence-based falls prevention programmes, number of falls admissions). Monitoring of cumulative residential admissions and non-elective admissions, using pre-established monitoring framework reporting into integration management board.
Reduction in permanent residential admissions		2. Effective Hospital Discharge: Reablement	LA	6	(33,748)	(202,488)	Reablement will be provided for 600 clients in 2015/16. A recent RCT (Lewin et al 2014) showed that for every 100 clients, reablement results in 6 less people requiring residential or equivalent care per year compared to usual social care. If we assume that 1 in 6 of these step-up packages are residential packages, that equates to a reduction in 1 residental car package for each 100 reablement clients.	Monitoring of re-ablement numbers and effectiveness. Monitoring of cumulative residential admissions and non-elective admissions, using pre-established monitoring framework reporting into integration management board.
Reduction in permanent residential admissions		1. Admissions Avoidance: Locality Team	LA	2	(33,748)	(67,496)	See above modelling which show 462 non-elective hospital admissions reduced by care co-ordination in 2015/16. We assume that for every 200 hospital admisssions prevented 1 residential placement is avoided based on local ratios of hospital admissions to residenta placements.	Development of process measures for effectiveness of care-co-ordination in locality teams (e.g number of care plans completes, number of people allocated to a care co-ordinator). Monitoring of cumulative residential admissions and non-elective admissions, using pre-established monitoring framework reporting into integration management board.
Net saving for 2015/15 compared to 2014/15 baseline =786*1490 = £1171140				786		-		
Total						**(1,524,914)**		

Haringey

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**1,701**	**1,897**	**1,932**	**1,996**	**1,629**	**1,813**	**1,834**	**1,890**	**1,607**
	Numerator	4,527	5,048	5,140	5,310	4,392	4,888	4,945	5,095	4,392
	Denominator	266,069	266,069	266,069	266,069	269,575	269,575	269,575	269,575	273,301

Rationale for red/amber ratings

P4P annual change in admissions -705
P4P annual change in admissions (%) -3.5%
P4P annual saving £1,247,850

Please enter the average cost of a non-elective admission[1]: **£1,770**

Rationale for change from £1,490: Based on actual spend on non-elective admissions in Haringey (incl. MFF)

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Haringey	% Haringey resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Barnet CCG	7,546	7,207	6,915	7,784	1.1%	1.6%	86	82	79	89
NHS Camden CCG	4,373	4,550	4,601	4,678	0.4%	0.4%	19	20	20	21
NHS City and Hackney CCG	5,538	7,083	6,674	7,013	2.8%	2.9%	155	198	187	196
NHS Enfield CCG	7,034	5,963	5,836	6,044	1.3%	1.5%	90	77	75	78
NHS Haringey CCG	4,706	5,220	5,339	5,503	87.3%	91.6%	4,111	4,560	4,663	4,807
NHS Islington CCG	2,873	4,874	5,047	5,219	2.3%	1.9%	66	112	116	120
Total						100%	4,527	5,048	5,140	5,310

References

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

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Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)

Planned improvement on baseline

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	484.1	465.7	461.7
	Numerator	110	113	115
	Denominator	23,135	24,265	24,910
	Annual change in admissions		3	2
	Annual change in admissions %		2.7%	1.8%

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	87.6	89.5	91.0
	Numerator	80	85	91
	Denominator	90	95	100
	Annual change in proportion		1.9	1.5
	Annual change in proportion %		2.1%	1.7%

Rationale for red rating

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	870.7	655.5	941.7	897.2	655.1	580.5	833.7	794.2	644.1	570.8	819.7	780.9
	Numerator	1,780	1,340	1,925	1,864	1,361	1,206	1,732	1,678	1,361	1,206	1,732	1,678
	Denominator	204,425	204,425	204,425	207,758	207,758	207,758	207,758	211,288	211,288	211,288	211,288	214,889
								Annual change in admissions	-932			*Annual change in admissions*	0
								Annual change in admissions %	-13.5%			*Annual change in admissions %*	0.0%

Rationale for red ratings

Patient / Service User Experience Metric

Metric		Baseline Jun-13	Planned 14/15 (if available)	Planned 15/16
GP Patient Survey: In the last 6 months, has the Service User received enough support from local services (not just health) to manage their long term health condition(s)? (Measure biannually)	*Metric Value*	55.9	56.8	57.5
	Numerator			
	Denominator			
Improvement indicated by:	Increase			

Local Metric

Metric		Baseline Apr 12 - Mar 13	Planned 14/15 (if available)	Planned 15/16
Injuries due to falls in people aged 65 and over, per 100,000 people** (Note delay in reporting of this metric, so that baseline used is 12/13 figure.	*Metric Value*	2170.5	1900.0	1822.4
	Numerator	466	454	444
	Denominator	23134	23895	24364
Improvement indicated by:	Decrease			

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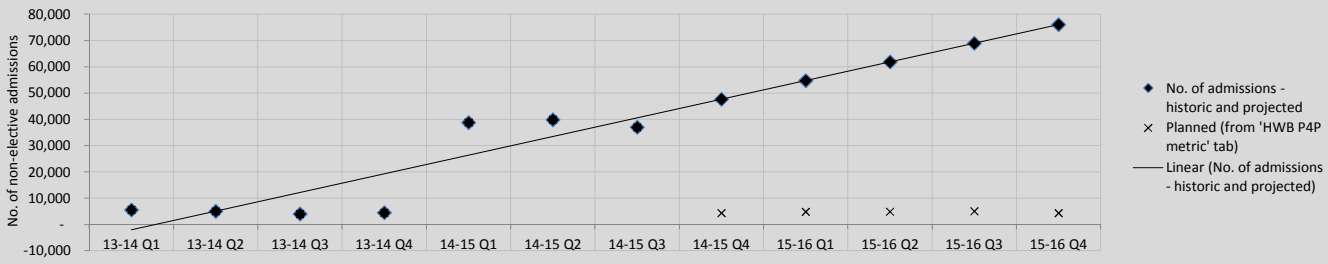
To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	5,604	5,066	4,032	4,527	38,824	39,897	37,028	47,672	54,770	61,867	68,965	76,062

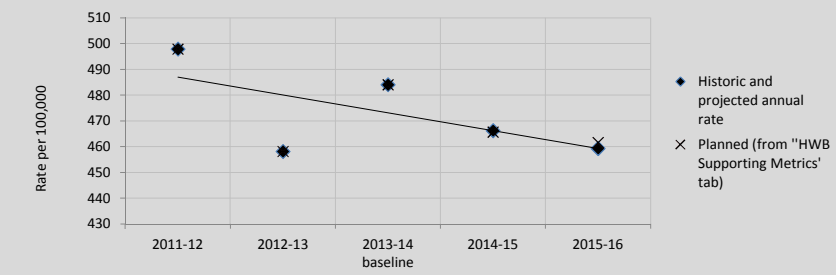


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*17,917.3*	*20,317.1*	*22,950.0*	*25,582.8*	*27,830.9*
	Numerator	*47,672*	*54,770*	*61,867*	*68,965*	*76,062*
	Denominator	*266,069*	*269,575*	*269,575*	*269,575*	*273,301*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

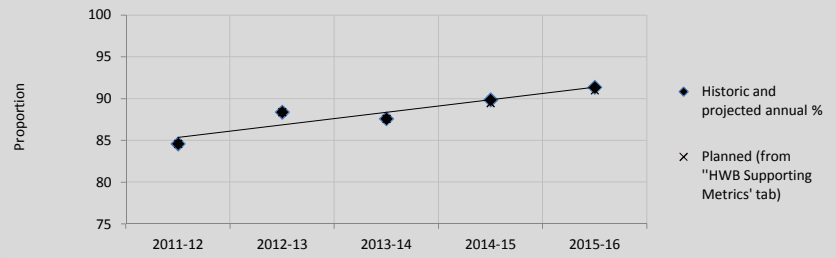
Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	498	458	484	*466*	*459*
	Numerator	110	105	110	*113*	*114*
	Denominator	22,495	23,135	23,135	*24,265*	*24,910*



This is based on a simple projection of the metric proportion.

Reablement

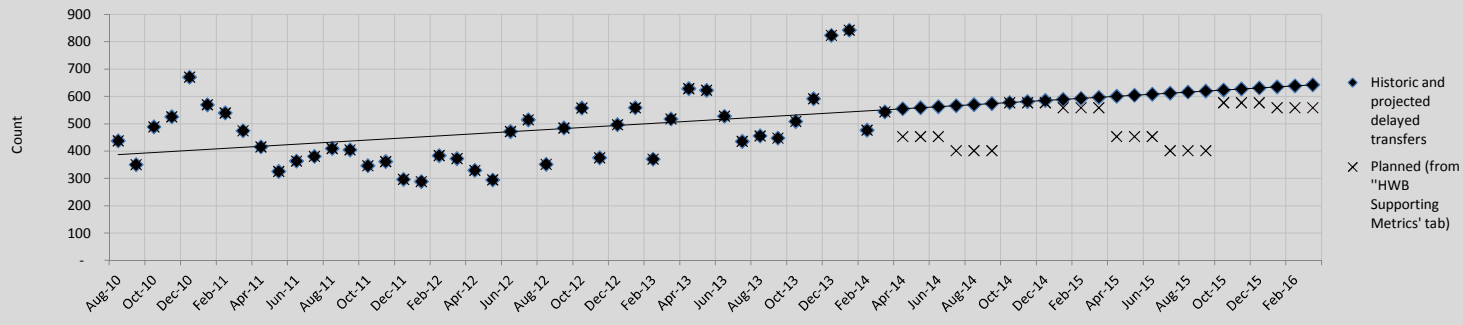
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	84.6	88.4	87.6	*89.9*	*91.4*
	Numerator	55	75	80	*81*	*82*
	Denominator	65	85	90	*90*	*90*



This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	438	351	489	526	671	570	540	475	416	326	364	381



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*807.2*	*823.8*	*840.3*	*842.5*	*858.8*	*875.1*	*891.3*	*892.4*
	Numerator	*1,677*	*1,711*	*1,746*	*1,780*	*1,815*	*1,849*	*1,883*	*1,918*
	Denominator	*207,758*	*207,758*	*207,758*	*211,288*	*211,288*	*211,288*	*211,288*	*214,889*

* The projected rates are based on annual population projections and therefore will not change linearly

Appendix 3: Summary of Changes to Haringey Better Care Fund (BCF) Plan

The following drafts of the BCF templates have been included:
Part 1 – Narrative
Part 2 – Finance and Outcomes

The changes that have been made to these templates, compared to the April 2014 submission, are:

Part 1 – Narrative

- **Vision** – Evidence from the JSNA to substantiate the targeting of older people, Long Term Conditions (e.g. Diabetes) and mental health (including dementia). Addressing service user/patient and carer defined outcomes. A clearer BCF Older Peoples' Integrated Service Pathway.
- **Case for Change** - A stronger case for change based on evidence from emergency hospital admissions data, risk stratification data and service quality data.
- **Plan of Action** – A revised list of milestones, governance structure and BCF programme management arrangements.
- **Risks and Contingency** – A revised risk log and contingency plan. The contingency plan includes assurances that NHS funding will be used to fund over-performance in acute, in line with the protection of social care.
- **Alignment** – Updated links to Social Care initiatives, LBH/Haringey CCG strategic plans and plans for Primary Care.
- **National Conditions** – Strengthening the principles for protection of Social Care services. Updated commitments to: the Care Act; seven day working; data sharing; and joint assessments.
- **Engagement** – Updated sections on engagement of patients/service users and service providers. Detailed implications of the BCF implementation on acute providers.
- **Detailed Scheme Descriptions** – Details for the four Haringey BCF Schemes: Admissions Avoidance; Effective Hospital Discharge; Promoting Independence; and Integration Enablers.
- **Provider Commentary** – Commentary for the two main acute providers to complete (North Middlesex University Hospital NHS Trust and The Whittington Hospital NHS Trust). Financial modelling based on 2013/14 figures for Non-elective admissions (NELs) demonstrates that of the expected reduction of 705 NELs for 2015/16 in Haringey, 44%/310 NELs would be attributable to North Middlesex (value of £549,054) and 33%/235 NELs would be attributable to Whittington (value of £416,782).

Part 2 – Finance and Outcomes

- **Payment for Performance** – A 3.5% reduction in emergency hospital admissions will result in 705 fewer admissions with a potential saving of £1.2M.
- **HWB Funding Sources** – Haringey CCG minimum contribution in 2015/16 is £16.5M and LBH is making a further contribution of £5.6M.

- **Summary and HWB Expenditure Plan** – Funding sources according to each of the four BCF Schemes.
- **HWB Benefits Plan** – Mapping the expected activity and savings generated by the relevant services in each scheme, and in particular: Rapid Response; Reablement; integrated Locality Teams (Care Co-ordination to avoid hospital admissions); integrated Palliative Care; and Neighbourhood Connects (third sector programme to support self-management and reduce social isolation). This demonstrates that the expected activity across these services should reduce emergency hospital admissions by 711 in 2015/16 and therefore meet the expected activity for the BCF.
- **HWB P4P Metric** – the expected performance for the reduction of emergency hospital admissions
- **HWB Supporting Metric** – The expected performance for the five BCF supporting metrics that will not be performance related. This includes the addition of a Patient Experience Metric from the GP Patient Survey: In the last 6 months, has the Service User received enough support from local services (not just health) to manage their long term health condition(s)? This metric was chosen as a proxy for the success of integrated services.

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APPENDIX 5a

Report for:	**Health and Wellbeing Board on 30th September 2014**	**Item Number:**	

Title:	**Scrutiny Reviews and Responses:** – **Mental Health and Accommodation; and** – **Mental Health and Physical Health**

Report Authorised by:	**Beverley Tarka** Interim Director of Adult Social Services beverley.tarka@haringey.gov.uk

Lead Officer:	**Beverley Tarka** Interim Director of Adult Social Services beverley.tarka@haringey.gov.uk

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

1. Summary

1.1 The Overview and Scrutiny Committee and its four Panels undertook a number of projects in 2013/14, including:

- Mental health and accommodation; and
- Mental health and physical health.

1.2 The final project reports and recommendations were agreed by the Overview and Scrutiny Committee in April 2014 and referred to Cabinet for agreement of responses to recommendations.

1.3 The responses to recommendations are presented to Cabinet in this report. An update report on the implementation of recommendations is scheduled at Overview and Scrutiny in the first half of 2015.

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1.4 This report incorporates the comments of the Clinical Commissioning Group (the CCG) and the Council to the recommendations of the two Panels.

2. Cabinet Member introduction

2.1 The reviews of the Scrutiny Panels on Mental health and accommodation and on Mental health and physical health are welcomed as an important contribution to the transformational work underway to improve responses to people with mental health needs in the borough across health and social care.

2.2 A joint post has been established to identify the best use of the accommodation resources in the borough for those with mental ill health and implement new ways of working in this area. The differential life expectancy of those with severe mental illness is well documented nationally as well as locally and these recommendations support change in this area.

2.3 The Better Care Fund is a single pooled budget to support health and social care services to work more closely together in local areas. It is noted that whilst the initial priority in Haringey is older people with frailty, the Council and the Clinical Commissioning Group will introduce a focus on mental health services into the Better Care Fund Integration Plan for 2015/16. Whilst recognising that this is not new money, it will offer further opportunity to address the needs of people with poor mental health in a joined up way in the borough.

3. Recommendations

3.1 The Health and Wellbeing Board is asked to note:

a. The responses to the recommendations made by Overview and Scrutiny, set out in the tables attached at Appendix 1 and Appendix 2.

b. That this report will be also presented to Cabinet on 14th October 2014 and that any proposals for change will be taken to Cabinet at a future date as necessary for adoption and agreement, after further work to identify resources, costs and identified risks.

4. Comments of the Chief Finance Officer and financial implications

4.1 The Council's Adults Service includes a budget of £9.3m for care, support and services for people with Mental Health Needs. The Mental Health Accommodation Strategy Commissioner referred to is a new post and is funded from the 14/15 ring fenced health funding in support of Social Care services (the Better Care Fund).

4.1 There is no further additional funding for the recommendations outlined in this report; however the service has taken the level of available resource into account in its assessment of these recommendations. Those that have been accepted are mostly fairly low cost in nature and can be met from existing resources; any

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remaining additional costs from these recommendations will need to be found by reprioritisation (i.e. shifting funding from other lower priority mental health services). However at this stage, this seems likely to be minimal.

5. Assistant Director of Corporate Governance Comments and legal implications

5.1 N/A

6. Equalities and Community Cohesion Comments

6.1 N/A

7. Head of Procurement Comments

7.1 N/A

8. Policy Implication

8.1 N/A

9. Reasons for Decision

9.1 N/A

10. Use of Appendices

10.1 Appendix 1: Mental Health and Physical Health Recommendations; and
10.2 Appendix 2: Mental Health and Accommodation Recommendations.

11. Local Government (Access to Information) Act 1985

11.1 N/A

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Appendix 1

Mental and Physical Health Recommendations

The £3.8 billion Better Care Fund (formerly Integration Transformation Fund) was announced by the Government in the June 2013 spending round to ensure a transformation in integrated health and social care. The Better Care Fund is a single pooled budget to support health and social care services to work more closely together in local areas[1].

Haringey intends to focus on mental health Better Care Fund Integration Plan on mental health services in 2015/16. Whilst recognising that this is not new money, recommendations below are made with the opportunities this presents in mind.

Recommendation	Agreed/ Not Agreed/ Partially Agreed	Response
Leadership We support the following recommendations which are made in the '*Whole-person care: from rhetoric to reality Achieving parity between mental and physical health[2]'* report and recommend that the mental health partnership consider the following recommendations:		
"That Mental Health providers and Commissioners in Haringey should have the following aspiration:	Agreed	This aspiration will be incorporated into the emerging Mental Health Framework for Haringey.

[1] http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE#sthash.XD4CAk4F.dpuf

[2] Whole person care: from rhetoric to reality – Achieving parity between mental and physical health, Occasional paper OP88, March 2013, Royal College of Psychiatrists

'*People with mental health problems who are in crisis should have an emergency service response of equivalent speed and quality to that provided for individuals in crisis because of physical health problems'*		
Achieving Parity - The NHS Commissioning Board and CCGs should allocate funding in a way which supports and promotes parity. This should include ensuring that any person with mental health problems (including co-morbid mental and physical health problems) can expect the same access to services and the same quality of care and treatment as people who have only physical health problems".	Agreed	This will be a priority for the Mental Health Framework and for the Integration Management Board overseeing the development and implementation of the Better Care Fund in Haringey.
Smoking cessation		
Public Health should continue to make those with mental health needs a priority group for smoking cessation services. There should also be continued emphasis and strength placed on the recording of data by smoking cessation services.	Agreed	This work will be incorporated into the retendering process for smoking cessation services.

BEH Mental Health Trust should have a smoking cessation champion who is responsible for those who are in direct contact with mental health patients both in the community and in the acute setting. This person should be responsible for raising awareness of the high prevalence of smoking amongst mental health patients and of encouraging staff to record, undertake brief interventions and refer patients to appropriate services.	Agreed	The lead for implementation of this recommendation lies with BEH MHT. Public Health is working closely with BEH MHT in establishing better Stop Smoking services provision, which includes the implementation of a new patient referral system (via NCSCT) into the soon to be established specialist 'core' Stop Smoking service. .
Physical Activity		
Providers and commissioners should raise awareness of the benefits of physical health on mental health, specifically targeting service users, patients and carers.	Agreed for further exploration	The Sports and Physical Activity Framework is being finalised and it is proposed that the response to each of the Physical Activity recommendations be incorporated in the Framework and its implementation, which will be taken to the Health and Wellbeing Board. There is significant work across partners to take forward these recommendations and explore the capacity for implementation. It is proposed that work in this area is brought back to the Overview and Scrutiny Committee later in the year.

Where appropriate providers and commissioners should consider physical activity as an integral part of the treatment and recovery model for those with mental health needs.	As above	As above
Haringey Council should work with Fusion Lifestyles to raise awareness of the concessionary membership scheme for Haringey Leisure Centres.	As above	As above
BEH MHT should include a 'green gym' on their site in the St Ann's redevelopment.	As above	As above
Active for Life should continue to have a Key Performance Indicator to increase the number of referrals of people with mental health needs and this target is stretched as the programme progresses.	As above	As above
Weight Management		
BEH MHT should ensure that healthy eating options and dietary advice is available to everyone at St Ann's hospital and in Recovery Houses as an integral part of the services provided to patients.	Agreed	The lead for implementation of this recommendation lies with BEH MHT. There is scope, for example, for the community dietician service for example to be extended to areas such as the recovery houses.

Public Health should consider commissioning weight management classes specifically for people with mental health needs, which reflects the unique barriers which people with mental health needs may face when trying to lose weight, for example the impact of medication.	Partially Agreed	Public health will consider link with the Health Trainers services, which have vouchers for weight management services.
Cardio-Vascular Disease and Cancer screening (Health Checks)		
Public Health should review the lessons learnt from the community Health Check programme commissioned for mental health and investigate best practice examples to increase the uptake of Health Checks amongst those with mental health needs.	Agreed	The work to evaluate the Community Health Check programme is being undertaken in Public Health
Health Trainers & Health Champions		
Information on the Health Trainer and Health Champion service should be shared across mental health services, specifically those who are most likely to come into contact with mental health service users for example mental health social workers, Care Coordinators, Key workers.	Agreed	The Health Trainers & Health Champions service continues to develop, with increasing numbers of local residents both recruited to the programme, and accessing services. Information on the Health Trainers & Health Champions service will be

		made available to local mental health services.
Dual Diagnosis		
The dual diagnosis service should work more closely with GPs when those with dual diagnosis problems are discharged from hospital back into care in the community and where the mental health issues are minor. Processes should be put in place to ensure that this happens as standard.	Agreed	Joint work across a range of services for those with dual diagnosis including GPs will support better care in the community.
BEH MHT		
BEH MHT should review their Physical Healthcare Policy to include mechanisms to ensure that when someone is referred this is followed up by the patient and/or the service which the patient is referred to. Patients, Carers and Voluntary & Community Sector organisations should be actively engaged with the policy review.	Agreed	The lead for implementation of this recommendation lies with BEH MHT.
BEH MHT should roll out a systematic training programme for front line staff in the delivery brief interventions and	Agreed	The lead for implementation of this recommendation lies with BEH MHT

physical healthcare indicators.		
Primary Care		
We acknowledge the importance of continuity of care for people with mental health needs and recommend that Haringey CCG puts arrangements in place to ensure that as far as possible (and where appropriate) all mental health service users enjoy continuity of care with their GP from the moment of diagnosis. For example consideration should be given to those with severe mental health needs having a named GP, who is also a point of contact for other mental health services.	Agreed	BEH MHT and the CCG will review these recommendations through a Mental and Physical healthcare task and finish group.
Haringey CCG and BEH MHT should develop a system to increase the access of primary care on Wards for example; consideration should be given to a GP attending Haringey inpatient mental health Wards on a regular basis.	Agreed	As above.
That NHS England, in collaboration with Haringey CCG,	Agreed.	As above.

works with local GP practices who are under-performing in relation to Quality Outcomes Framework scores around care plans for people with serious mental illness e.g. blood pressure monitoring, documented comprehensive care plan in order to improve their performance.		
Communication between BEH MHT & GPs		
Haringey CCG and BEH MHT work together to explore best practice examples to develop ways to improve communication and joint case management of patients with mental and physical health needs.	Agreed	Need to agree simple protocols for sharing information that do not get in the way of communication and the exchange of information
BEH MHT should raise awareness of the benefits of the telephone advice for GPs and consideration should be given to the development of a two way advice line so that Psychiatric Consultants are also able to contact GPs for primary care advice.	Agreed	There does appear to be a significant amount of contact between GP's and psychiatrist often by telephone.
Role of pharmacies		
The Local Pharmaceutical Committee and Public Health	Agreed	It is agreed that this recommendation

should develop programmes as part of the Pharmacy Healthy Living Scheme to focus on the overlap between mental and physical health e.g. medicine use queries, smoking cessation services and prescription reviews. Where appropriate, mechanisms should be put in place to ensure that information is fed back to GPs.		is relayed to the Local Pharmaceutical committee and GP's.
Community Mental Health Teams		
That Physical healthcare training is given to Care Coordinators who do not have a medical background to ensure that they understand physical health care indicators.	Partially Agreed	Physical health care is the primary responsibility of the GP. This information should be fed in to the MH system when a patient is referred. If there have been issues around contact with primary care then referrals should be offered a health check
That as part of the Better Care Fund plans for 2015/16 consideration is given to learning from best practice examples, such as the Manchester model outlined in this report and the proposed Older People model in Haringey, with a view to running a pilot project on increasing the role of Community Mental Health Teams on the coordination of physical health. For example integrated teams around and	Agreed	As part of the Better Care Fund development, consideration will be given to a range of integrated options which improve outcomes for people with mental health needs. Best practice examples and evidence based solutions which better integrate a range of provision will be researched.

supporting groups of GP practices which enable a single point of contact for GPs to coordinate care of most complex and vulnerable patients.		
Recovery Houses		
BEH MHT should ensure that Physical Health checks are undertaken on admission to Recovery Houses, including referral and follow up where appropriate.	Partially Agreed	They should be attending their GP for a physical health check and the recovery house should be facilitating this
Within 72 hours of admission to a Recovery House patients should be offered registration as a temporary patient at the local GP practice.	Partially Agreed	This does not support continuity of care and should possibly only occur in circumstances where there the patient has no registered GP
Social Isolation		
We recommend that social isolation and loneliness are considered for a specific piece of project work for Overview and Scrutiny in 2014/15.	Agreed	This would be supported by the service as helpful.

Appendix 2

Mental Health and accommodation recommendations

The £3.8 billion Better Care Fund (formerly Integration Transformation Fund) was announced by the Government in the June 2013 spending round to ensure a transformation in integrated health and social care. The Better Care Fund is a single pooled budget to support health and social care services to work more closely together in local areas[1].

Haringey intends to focus on mental health Better Care Fund Integration Plan on mental health services in 2015/16. Whilst recognising that this is not new money recommendations below are made with the opportunities this presents in mind.

N.B Housing – means Homes for Haringey and Registered Social Landlords operating in the borough.

A number of themes emerged from the project. The recommendations have been reviewed by the Service, and responses to recommendations are listed below.

It is agreed that this is a critical area for focus and a Mental Health Accommodation Strategy Commissioner has been engaged jointly by the Council and the CCG to work up an Accommodation Strategy and Pathway which will address a number of the issues raised by the Panel. This work will be carried out into the autumn and a further update will be provided to the Overview and Scrutiny Committee as it is progressed.

Prevention		
We recommend that there is greater focus on the preventative elements to prevent tenancies being lost once a person has been admitted to an acute Ward. This includes: • A system being put in place to enable appropriate information about the clients accommodation, circumstances and needs to be shared in a timely	Partially Agreed	All patients should have a holistic assessment on admission which identifies areas of need including accommodation to be addressed as part of the patient's care plan. This will assist a speedy and effective move towards discharge once the patient is medically fit. BEH MHT has proposed a standard of collating all relevant information on admission

[1] http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE#sthash.XD4CAk4F.dpuf

manner between BEH MHT and Housing Support & Options and in turn with the Housing Benefit Service. (See recommendation 18)		within 72 hours.
We recommend that consideration is given to establishing a Re-ablement Service, based on the older people re-ablement service model, as part of the Better Care Fund work to focus more intense support on those who need it for the initial 6-8 weeks after discharge from hospital to prevent a relapse.	Partially Agreed	Further work is needed to explore the most effective way to ensure that principles of reablement and enablement underpin all services. The specific model for doing this should be subject to further analysis and will be included in the Accommodation Pathway.
We recommend that mental health awareness is raised with housing staff who are likely to come into contact with mental health service users. • This should include Estate Managers in order to help them to identify and signpost anyone who may be having housing problems due to their mental health needs e.g. struggling to maintain their tenancy.	Agreed	This is good practice for all tenants not just those with Mental Health problems. The development of the Information Advice and Guidance Function of the Council through the implementation of the Care Act 2014 will take this into consideration in its implementation. As part of the development of the Accommodation Pathway, it is likely that awareness training will be proposed for relevant staff, including those identified in the report.
Permanent housing **i. Recommendation 2: Discharge from BEH MHT** – There can be up to 40% of patients on a ward at any given time who are clinically ready to be discharged but who are not able to be for a variety of reasons, including housing issues. Processes need to be much more effective in order to free up beds for those who need them.		
We recommend that an annual mental health housing social quota is established and agreed with Homes for Haringey and RSL's. • The number of properties per year should be based on a projected needs analysis.	Not Agreed	Excellent corporate working in this area has led to significant progress and any proposals for a quota would need careful consideration as part of the wider housing policy of the Council. The needs of mental health service users will be highlighted and picked up through the development of the emerging Housing Strategy. It is understood that it will be

		necessary to commission appropriate support service to ensure the success of the tenancies.
We recommend that private sector housing opportunities for people with mental health needs are better utilised based on best practice schemes in order to increase the number of private sector tenancies available.	Agreed	This will need close collaboration with the private sector and appropriate support to ensure that the rights of service users are safeguarded in regards to tenancy agreements.
The Panel felt that it would be beneficial if pathway moved towards a model whereby the service user is able to access more permanent housing and maintain this tenancy through the rest of their mental health recovery pathway and therefore recommends that, where appropriate, the mental health housing pathway moves to a more permanent housing model in order to provide stability to the service user.	Agreed	The specific arrangements to deliver this including the appropriate support will be part of the nascent Accommodation Pathway. Other organisations which have successfully delivered better outcomes for people with mental health problems, including having secured tenancies, ensure that care and support are arranged around the service user rather than people having to move to another tenancy to obtain the type of care they require. This should be an aspiration for local services.
We recommend that the Haringey Housing Allocations Policy reflects and promotes parity of esteem between mental and physical health to ensure that mental and physical health are weighted equally.	Agreed	Indeed, failure to ensure this would arguably be a breach of the equality duties of the Council.
Move on Project **i. Recommendation 3: Housing Related Support** – There is a proportion of people who have been in Housing Related Support placements for up to 5 years; the service is intended to be used for 18 months to 2 years. This is creating a blockage in the pathway. Work is being done to work through these cases and the Panel supports this work, and feels that greater impetus should be placed on it, again to un-block the pathway.		
We recommend that there is greater collaboration and continued impetus across the whole partnership (both within	Partially Agreed	The practice of moving people out of their homes in order to receive care is not in line with the

the Council and partnership) on the Supported Housing Move On project and that any lessons learned on issues which have prevented move on be regularly shared and learnt from across the partnership.		principles of personalisation. The Accommodation Pathway will need to revisit how housing related support and other support is secured to enable people to exercise choice and control over their own services, based on good holistic assessments, direct involvement of service users and an array of good quality support services.
Step Down		
We recommend continued identification of suitable properties which can be used for step-down projects, like Truro Road, based on an ongoing needs analysis	Partially Agreed	Through the Accommodation Pathway work, this will be aligned so that service users have access to accommodation and appropriate support services.
Recovery House		
To reflect current demand we recommend that BEH MHT commissions a recovery house in the East of the Borough.	Not Agreed	Whilst the role of the Recovery House in Haringey is important, this recommendation pre-empts the development of the Pathway, working across BEH MHT, the CCG and the Council to ensure the appropriate use of all elements of building and treatment based services. It may be that additional capacity in the recovery house model is required and it may be that this when developed should be sited in the East of the Borough, but constraining the process at this stage would not be advisable.
Bed and Breakfast accommodation		
We recommend that the use of Bed and Breakfast	Agreed	The lead for ensuring implementation of this recommendation lies with BEH MHT.

accommodation for mental health service users on discharge from BEH MHT is phased out as soon as is practical.		
Mental Health Housing Pathway		
We support the Better Care Fund focus for 2015/16 on Mental Health and the planned integrated Mental Health Recovery Pathway and recommend that the Health and Wellbeing Board ensure that housing forms an integral part in this pathway.	Agreed	To facilitate this recommendation, the draft Accommodation Strategy and Pathway will be presented to the Health and Wellbeing Board for approval.
We recommend that Public Health map the mental health and housing pathway across the partnership so that it is clear which organisation/team is responsible for each step along the pathway. • This should include a short high level protocol with agreed roles, responsibilities and accountabilities and which is signed up to by all organisations. • The Pathway should be signed up by all relevant organisations.	Agreed	As noted elsewhere in this report, an Accommodation Strategy Commissioner has been appointed jointly by the Council and the CCG to steer the development of a Strategy and Pathway. As part of this work, mapping will be undertaken and the input and expertise of Public Health would be welcomed as part of this process.
We recommend that the new BEH MHT Enablement Officers form a close working relationship with the Haringey Vulnerable Adults Team as early as possible. In order to achieve this we recommend that: • They meet as part of the Enablement Officers induction; • Within 4 weeks of their start date to have agreed communication processes to ensure that Vulnerable Adults Team and Housing Benefit know who has been	Partially Agreed	BEH MHT is the lead for implementation of this recommendation – these posts are not yet in place.

admitted to a Recovery House/Ward and are able to begin work on any possible housing issues, as near as possible to admission, which may prevent a timely discharge.		
Commissioning		
We recommend that there be joint commissioning arrangements across health, housing and social care throughout the pathway to ensure a seamless pathway for mental health service users.	Agreed	As noted elsewhere in this report, an Accommodation Strategy Commissioner has been appointed jointly by the Council and the CCG to steer the development of a Joint Accommodation Strategy and Pathway..
We recommend that there is a JSNA deep dive in order to model future housing needs across the mental health population.	Agreed	As part of this work, there will be a comprehensive needs assessment to ensure current and future needs are effectively addressed and consideration will be given to future joint commissioning arrangements
Haringey Adult Panel – mental health		
We recommend that a joint health and social care Mental Health Panel is established, with a mental health clinician as Deputy Chair, as per the arrangements currently in place for Learning Disabilities. • This should include a Multi Disciplinary group which sits under the panel and which meet prior to the Panel meeting to discuss cases, ensure all paperwork is present and make recommendations to the Panel. • We recommend that the Panel meeting frequency be increased on a temporary basis to clear the backlog	Partially Agreed	The Council is unaware of any backlog of cases. There needs to be clarity about the functions of the several Panels which are currently meeting to agree requirements for funding and allocation of resources as part of the development of the Pathway.

of cases.		
Housing Benefit		
We recommend that BEH MHT put a process in place to ensure that the Housing Support & Options team are fully aware of a person's housing circumstances within 7 days of admission. • This information should specifically be shared between the BEH MHT Enablement Officer and the Vulnerable Adults Team so that they can liaise with the Housing Benefits Service to prevent Housing Benefit payments being stopped, and a patient subsequently losing their home.	Agreed	The lead for this recommendation would be BEH MHT.
We recommend that there is a named person in Housing Benefits who has responsibility for Mental Health matter and who can be a point of contact for BEH Mental Health Team /Vulnerable Adult Team.	Agreed	This recommendation will be picked up through the development of the Accommodation Strategy and Pathway.
Care Coordinators		
We recommend that the Care Coordinator service should be assessed as soon as possible with a view to alleviating the work load and increasing the number of posts, capacity and skill mix.	Partially Agreed	This should only be in the context of a model of care that is being delivered by the community teams.
We recommend that Care Coordinators receive ongoing training in:	Partially Agreed	Welfare Rights and Benefits are a complex and specialist area and advisors in this area undertake regular training and updating in light of changes. The time often involved in undertaking this work

• Welfare and benefits in order to assist them in keeping up to date with welfare reforms. • Housing pathways, particularly in light of the planned Recovery Pathway.		can be significant for those that undertake this work regularly. Whilst it is acceptable to provide information and briefings to keep care coordinators informed of changes it is not reasonable to expect a care coordinator to be fully conversant with the benefit system. M H service users should have access to staff trained in welfare rights and benefits that can follow through any applications and appeals which the care coordinator could then support the service user to attend for example.

Agenda Item 9

Haringey Council

Report for:	**Health and Wellbeing Board – 30 September 2014**	**Item Number:**	

Title:	**GP Services in Haringey**

Report Authorised by:	**Dr Jeanelle de Gruchy Director of Public Health**

Lead Officer:	**Neil Roberts, Head of Primary Care Fiona Erne, Deputy Head of Primary Care NHS England**

Ward(s) affected: **All**	**Report for Key/Non Key Decisions:** **N/A**

1. Describe the issue under consideration

1.1. The presentation provides information about GP services in Haringey, including:

- An overview of current challenges for services generally
- Information about access to GP services
- An update on how services in Haringey compare with national peers
- Constraints within the system
- NHS commissioner response
- The vision and transformation of Primary Care Services
- Co-commissioning and what it means
- Addressing access in the Tottenham area

2. Recommendations

2.1. The HWB is asked to note the information presented by NHS England and provide feedback on how the actions described and proposed in the presentation.

Haringey Council

3. Background information

3.1. NHS England, as part of it's direct commissioning responsibilities, commissioners services from GP practices. Some responsibilities have been delegated to CCG's, i.e. quality improvement, peer support and clinical leadership.

3.2. The performance of some GP services in Haringey does not compare well with peers across the country, particularly in relation to patient experience. National and local initiatives are in place to improve access and quality for local people. However transformational change will take time and is reliant on change elsewhere in healthcare services to release the needed funded to improve and expand provision in primary care.

4. Comments of the Chief Finance Officer and financial implications

4.1. The report includes reference to work being jointly undertaken to identify new infrastructure (Premises and IT) in the Tottenham area. This is in response to regeneration projects and will make a call on S106 or CIL funding. However this is yet to be quantified.

5. Comments of the Assistant Director of Corporate Governance and legal implications

5.1. The Assistant Director Corporate Governance has been consulted about this report. There are no legal issues arising for the Board

6. Equalities and Community Cohesion Comments

6.1 The presentation proposes a number of measures to address the access and quality issues and they include:

- Financial management measures to address inequity and rising funding gaps due to inequitable contract payments as a result of historical local and national agreements.
- A more equitable distribution of resources through PMS and MPIG reviews which include issues such as patient online services, extended opening hours and improved patient and family participation.

6.2 The presentation acknowledges too that General Practice needs to change the way services are provided so that they become more:

- Centred on the needs of users;
- Accessible;
- Proactive in preventing illness and supporting health;
- Engaging with patients, their families and communities to co-design approaches to improve health and wellbeing of the local population as a whole;

Haringey Council

6.3 All of these measures will support performance on the general duty imposed by section 149 of the Equality Act 2010 by contributing to improve health and wellbeing of the people of Haringey whatever their protected characteristics. They will also contribute to delivery of the Council's priority to tackle health inequalities.

7. Policy Implication

n/a

8. Use of Appendices

8.1. Appendix 1: Health and Wellbeing Board Presentation

9. Local Government (Access to Information) Act 1985

n/a

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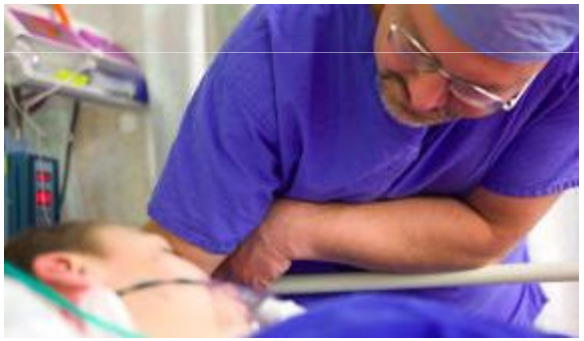
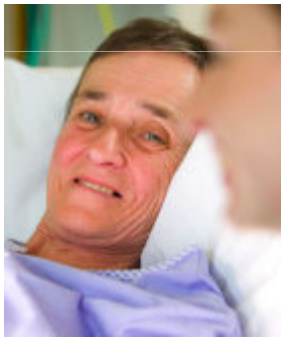
Haringey GP Services Report

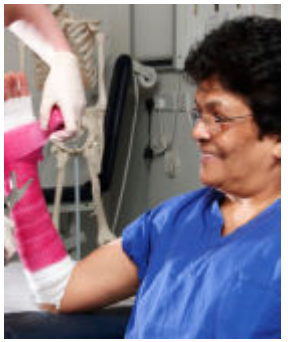


September 2014

Section 1.1

General Information and Background for GP Services





1.1

Current Challenges in GP Services

- Changes in patient expectation and demographics, including an increasingly large number of elderly have driven demand. The response of the NHS has usually been to expand capacity rather than address demand management. There are significant challenges to be met. There are undoubtedly increasing demands on the system. Patient satisfaction is falling
- Outdated and under-utilised infrastructure (Premises, IT, Telephony)
- There has been a 75% increase in demand for GP consultations between 1995-2009 (Kings Fund 2013) and ONS reports a 40% increase in work-load for GPs now compared with 1998
- People can't use what they can't access and will use other parts of the care system e.g. A&E, WiC, LAS or they don't access care at all and conditions worsen/go unnoticed

GP Commissioning - Contracts

Type	Description	Hours	Funding
GMS	A national contract to deliver core services (routine and urgent) to meet the reasonable needs of patients	8am to 6:30 pm (plus extended hours)	Capitation Enhanced Services Local incentives QOF
PMS	Local contract to deliver routine and urgent care services with locally KPI's /standards	Locally defined:	Capitation (with premium for KPI's/standards) Enhanced Services Local incentives QOF
APMS	Local fixed term contract to provide routine and urgent care services with defined KPI's and standards	Locally defined	Capitation (with premium for KPI's/standards) Enhanced Services Local incentives QOF

Performance Monitoring

- Primary care commissioning managers also work closely with colleagues in the medical directorate who are responsible for monitoring the clinical and professional standards of GP's. This is to ensure that information is shared and reviews/investigations are coordinated.Performance is monitored against 4 domains:
- Clinical outcomes
- Patient Experience
- Governance
- Quality and Safety

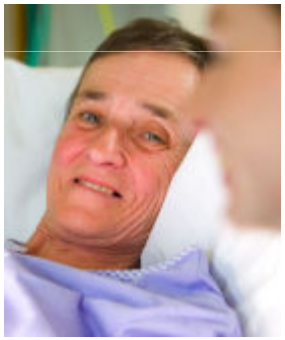
Information Sources

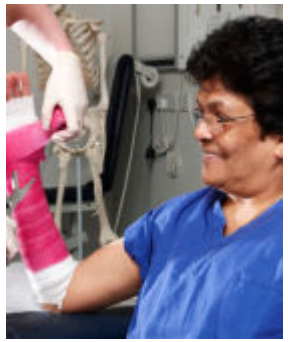
A variety of information sources are available to assess performance against the domains and to identify areas of risk and possible performance concerns. This includes:

- High Level Performance Indicators (HPLI's)
- GP Outcome Standards (GPOS)
- Patient Survey Results
- CQC Inspection Reports
- Practice Declarations
- NHS England Audits

Section 1.2

Access





Access- Contractual Requirements

- The financial construct of the GP contract (known as the Carr Hill formula) allows for a figure of 72 appointments for 1000 patients per week as the benchmark although this is not stipulated in the majority of GP contracts
- The nature of the national (GMS) contract is such that commissioners do not:
  - specify how many appointments should be made available each week
  - define the scheduling of appointment slots (e.g. 10 minutes, 12 or 15 minutes)
  - specify the skill mix a practice should offer for the clinical staff engaged in delivering services
  - define the consulting hours to be operated by a practice
  - define the method by which the practice ensures access to services
  - have access to GP clinical systems to know the number of appointments offered.

Current Capacity Planning

- Carr-Hill funding formula identified benchmark for access as 72 appointments per 1000 patients for practices
- National guidance on appropriate floor-space to list size ratios
- Focus on utilisation of floor-space and clinical rooms
- Planning assume 60% utilisation of clinical rooms in new developments
- Extended hours funding available nationally with high uptake locally
- CCGs can commission “surge plans” from GPs to boost access

Capacity Planning Issues

- There is evidence of significant list inflation in practice list sizes – this can impact practices' ability to plan
- Significant list turnover impacts both list inflation and capacity
- Lack of property options for practices seeking to relocate and expand
- Practice income is dependent on incremental list growth which impacts on marginal costs (staff and service costs) and creates financial risks for practices wanting to grow.

Access is more than making appointments…

There is significant access by

- telephone
- home visiting and
- newer technologies.

It is also important to see access in the context of a range of pressures on practices that include:

- Rising prevalence of chronic disease
- Clinical commissioning responsibilities
- Work-force pressures and constrained funding growth
- Earlier discharges from hospital into the community with increased complexity
- Shift of care closer to home
- Rising patient expectation

Going forward…

- “7 day a week” pilots to be implemented during 2014
- National contracts inflexible; local contracts not necessarily so
- Improved utilisation of physical assets (premises) through longer opening
- Use of technology to improve access
- Improved skill mix to offer greater clinical capacity
- Practices will be encouraged to co-operate and collaborate to create improved economies of scale for themselves, e.g. joint back-room activities or provision of urgent care. Federations to deliver wider access
- Must make better use of Community Pharmacy - widely available 7 days a week and nationally see over 1.4 million people a day
- Emerging 5 year strategies have access and transformation as priorities
- NHS England currently scoping and costing a “4 hour access” for GP services across London

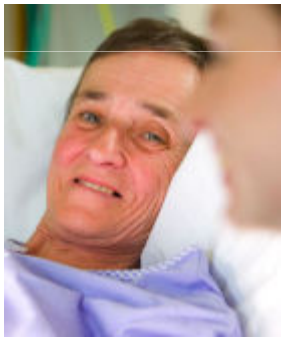
How poor accessibility impacts on other parts of the health system

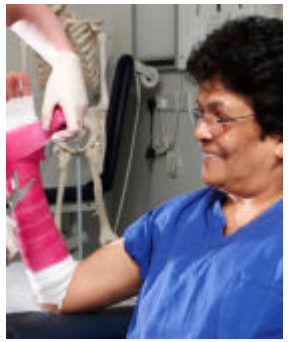
People can't use what they can't access and…

- use other parts of the care system e.g. A&E, WiC, LAS
- don't access care at all and conditions worsen/go unnoticed
- may consequently need more expensive or more invasive intervention
- become marginalised because they can't access services
- talk to their friends and family and bad news spreads… fast.

… but impact is not necessarily easy to assess or quantify

Section 2
Performance

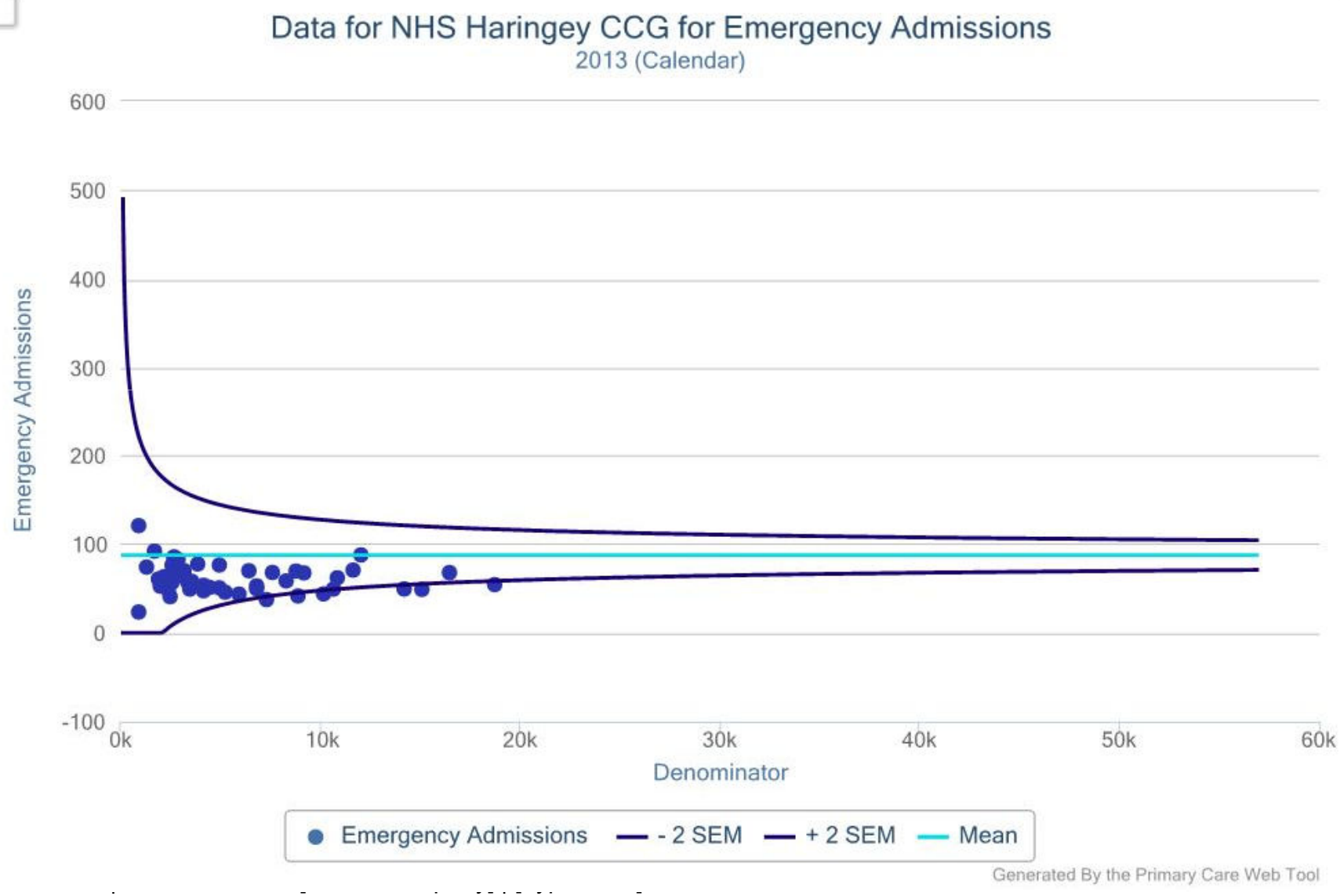




GP Performance in Haringey

- There are 11 practices who are an outliers against 6 or more HPLI's, most of these are in the east of Borough
- 54 % of practices in Borough are identified as requiring a review against national OS (compared to an NCEL average of 38%)
- Patient Satisfaction is poor with 34% of practices identified as either Red or Black against national norms (more than 1 or 2 SD's from national mean)
- 37% of practices are single-handed and of these 34% are at risk of the GP retiring over the next 10 years

GPHI Data


Data for NHS Haringey CCG for Emergency Admissions
2013 (Calendar)
Emergency Admissions
600
500
400
300
200
100
0
-100
0k
10k
20k
30k
40k
50k
60k
Denominator
Emergency Admissions
- 2 SEM
+ 2 SEM
Mean
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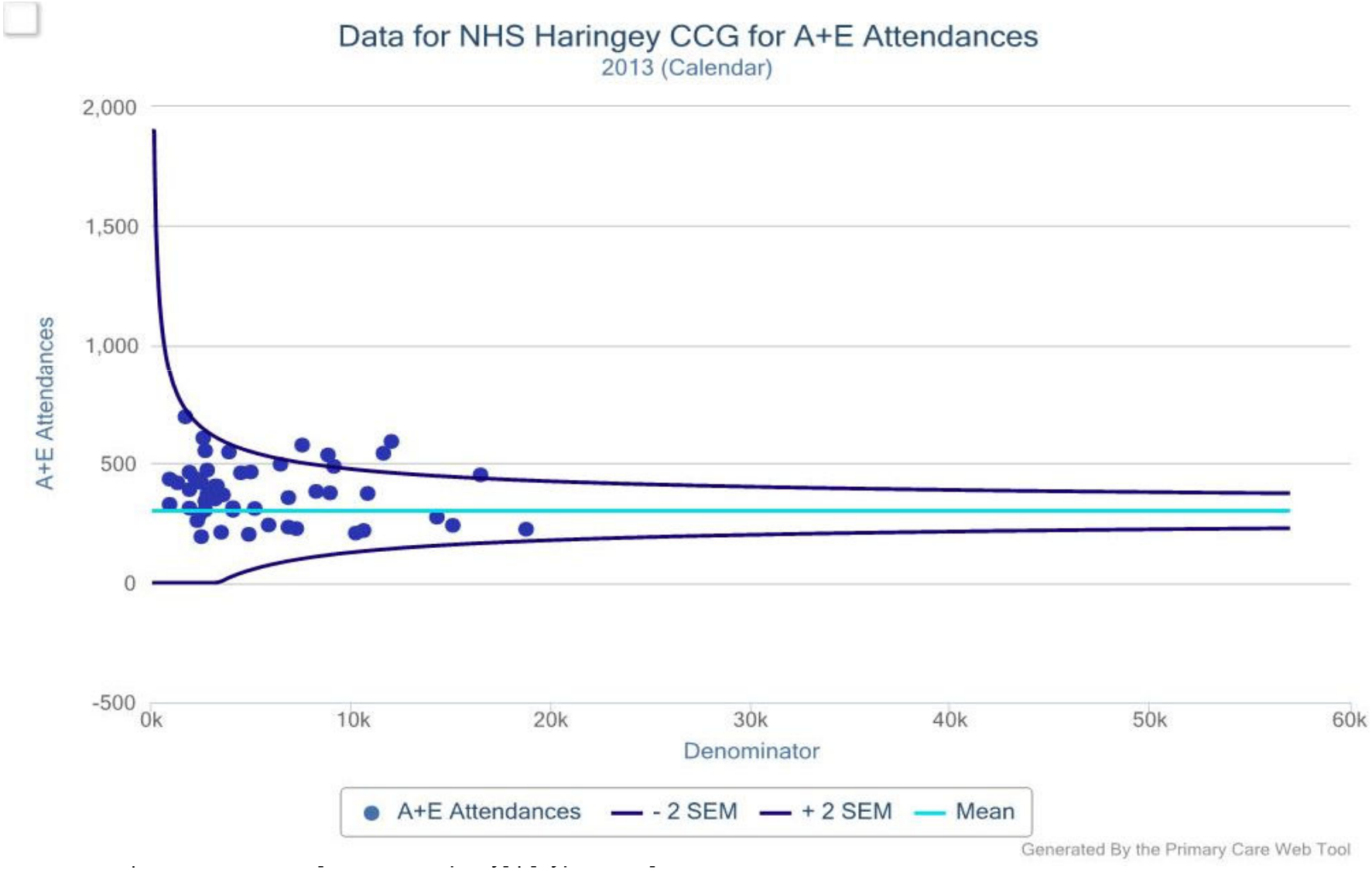
Data for NHS Haringey CCG for A+E Attendances
2013 (Calendar)
2,000
1,500
1,000
500
0
-500
A+E Attendances
0k
10k
20k
30k
40k
50k
60k
Denominator
A+E Attendances
- 2 SEM
+ 2 SEM
Mean
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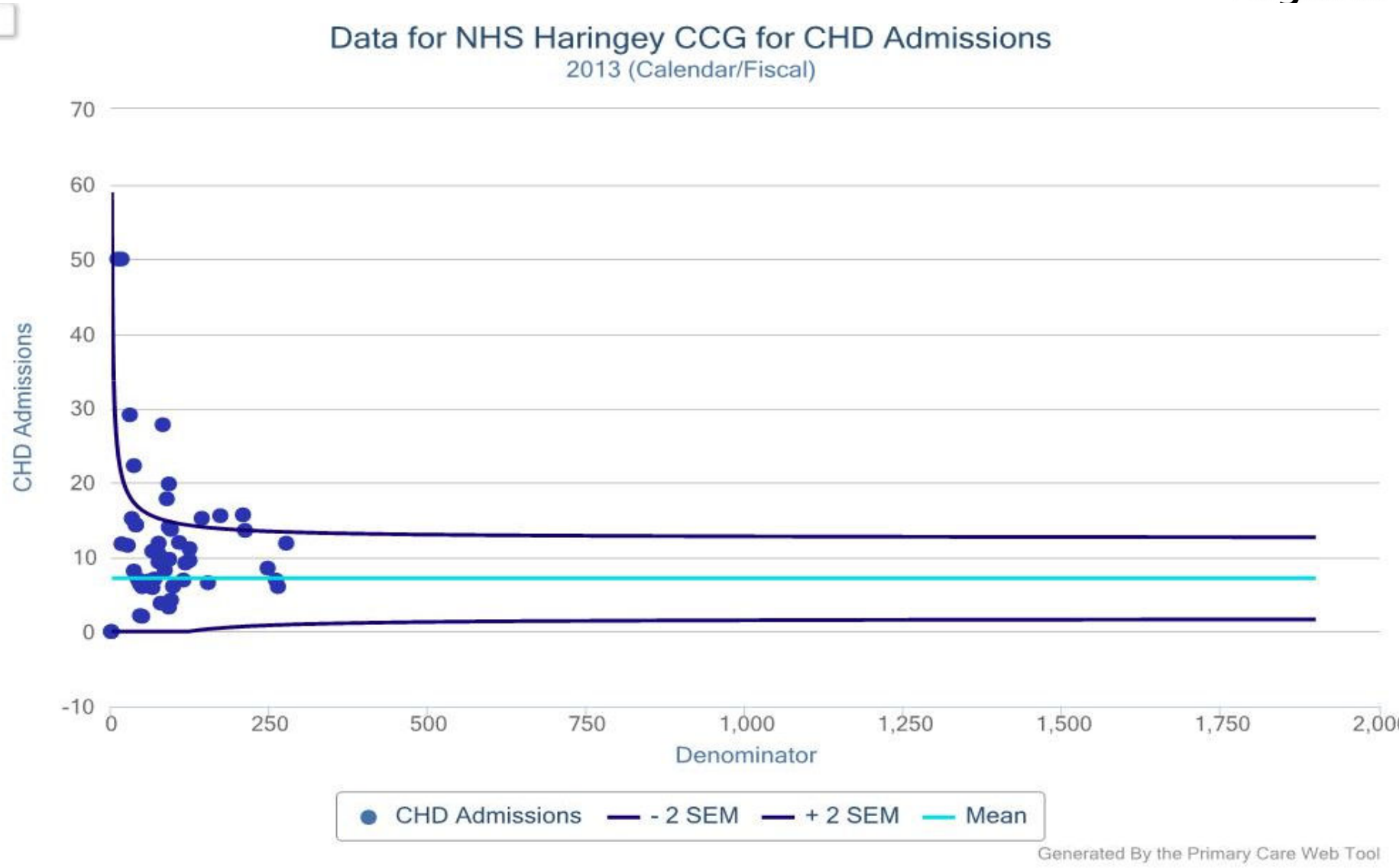
Data for NHS Haringey CCG for CHD Admissions
2013 (Calendar/Fiscal)
CHD Admissions
70
60
50
40
30
20
10
0
-10
0
250
500
750
1,000
1,250
1,500
1,750
Denominator
CHD Admissions
- 2 SEM
+ 2 SEM
Mean
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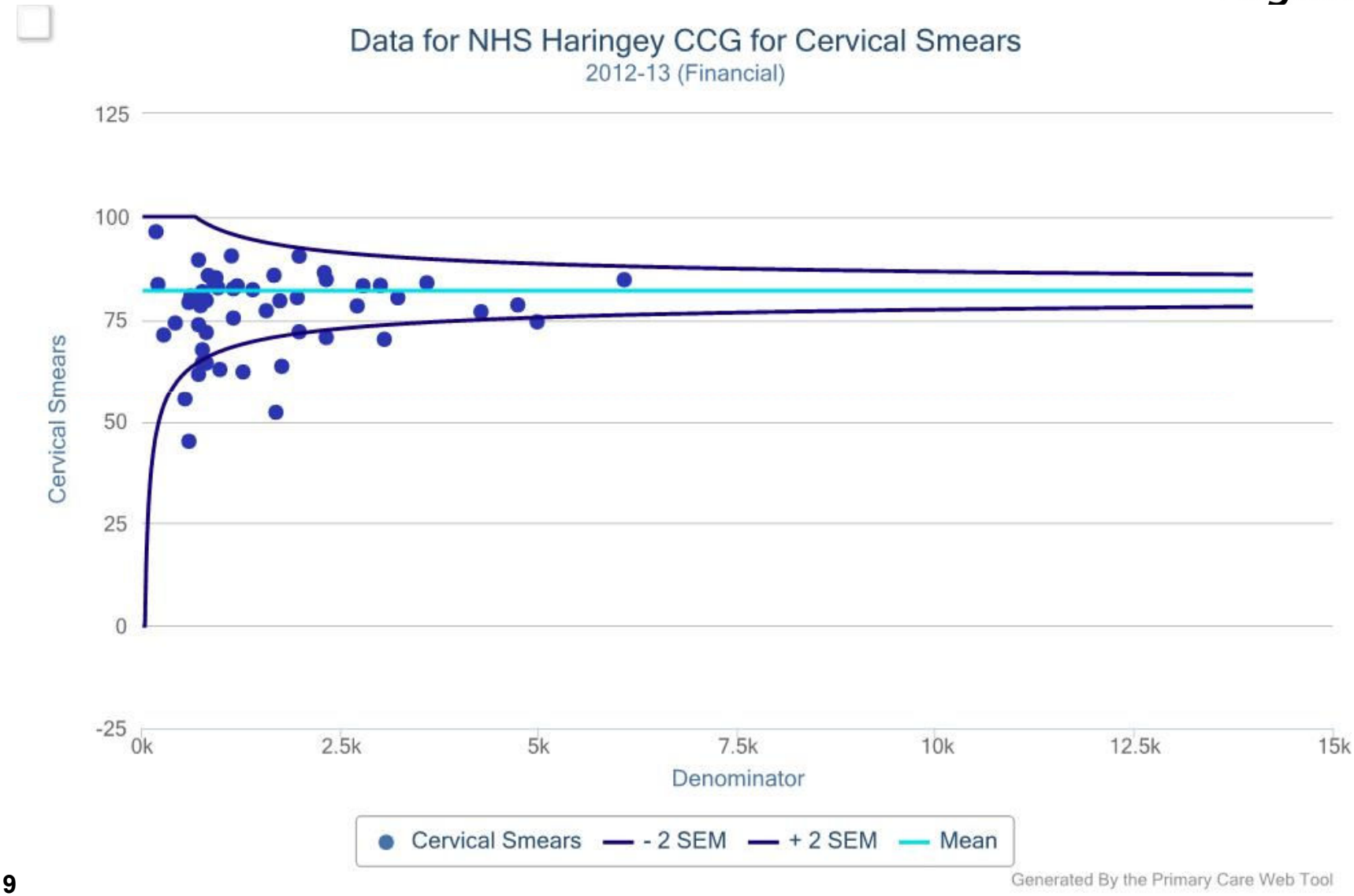
Data for NHS Haringey CCG for Cervical Smears
2012-13 (Financial)
125
100
75
50
25
0
-25
Cervical Smears
0k
2.5k
5k
7.5k
10k
12.5k
15k
Denominator
Cervical Smears
- 2 SEM
+ 2 SEM
Mean
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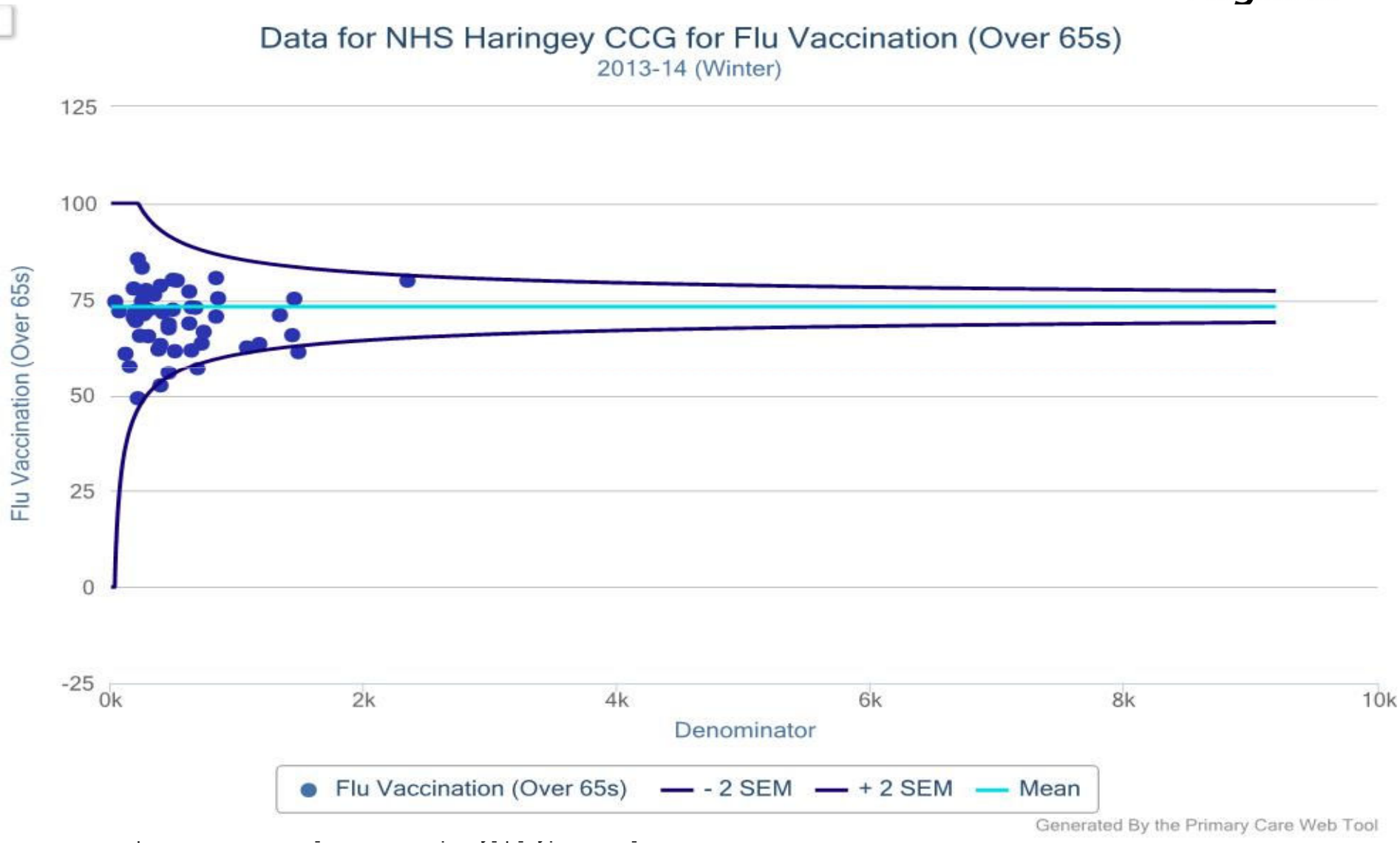
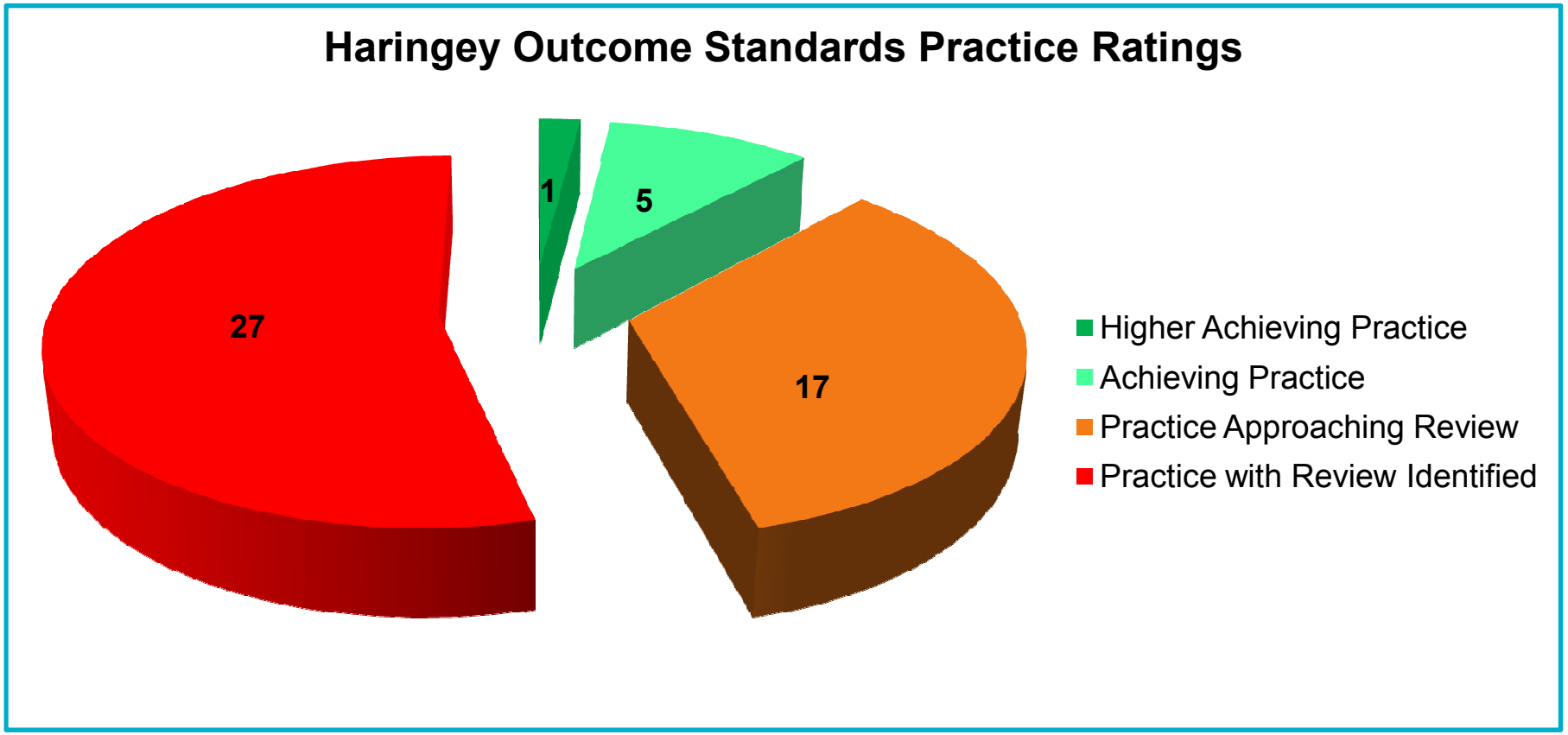
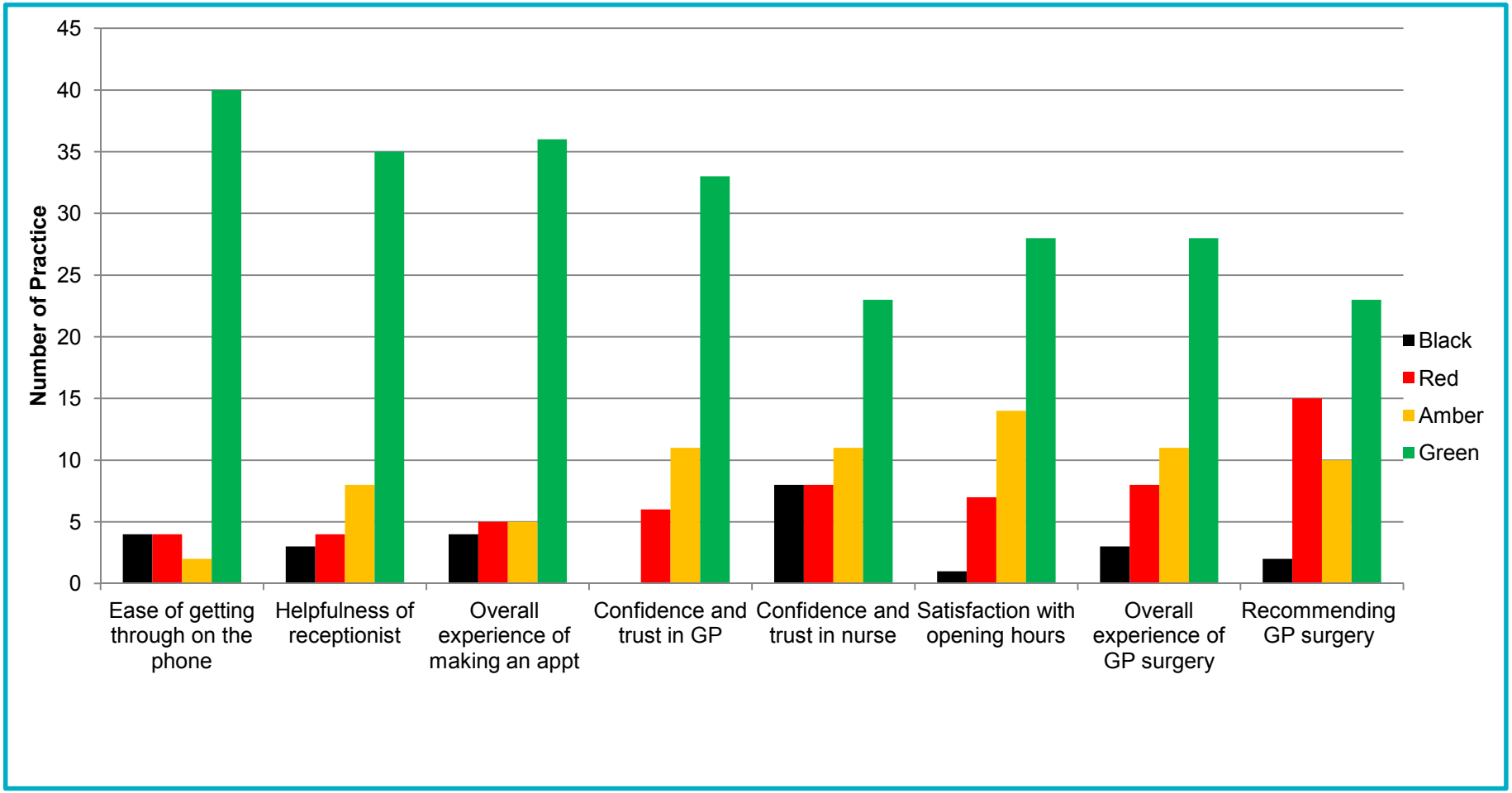

Data for NHS Haringey CCG for Flu Vaccination (Over 65s)
2013-14 (Winter)
125
100
75
50
25
0
-25
Flu Vaccination (Over 65s)
0k
2k
4k
6k
8k
10k
Denominator
Flu Vaccination (Over 65s)
- 2 SEM
+ 2 SEM
Mean
Generated By the Primary Care Web Tool

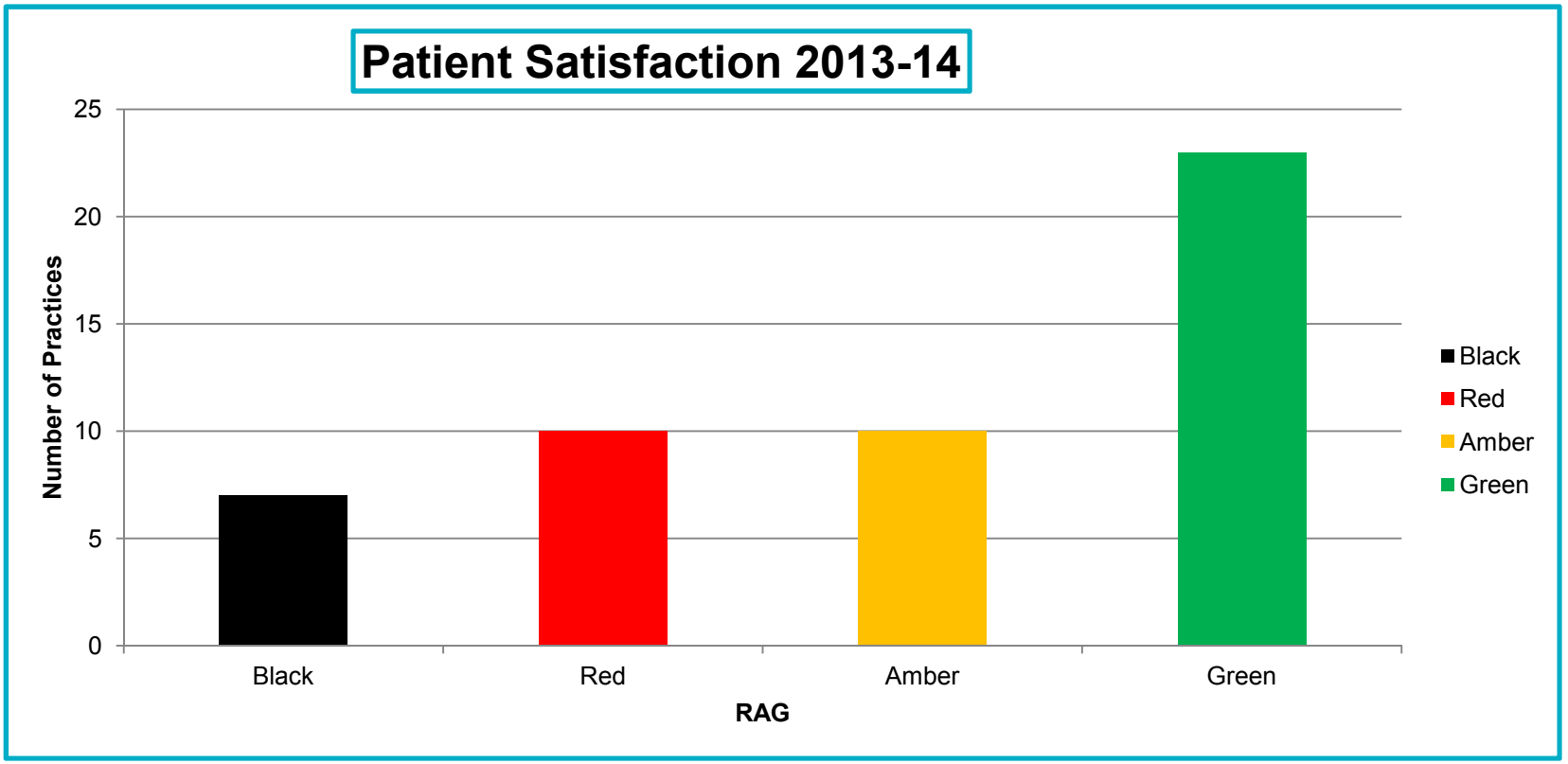
Outcome Standards



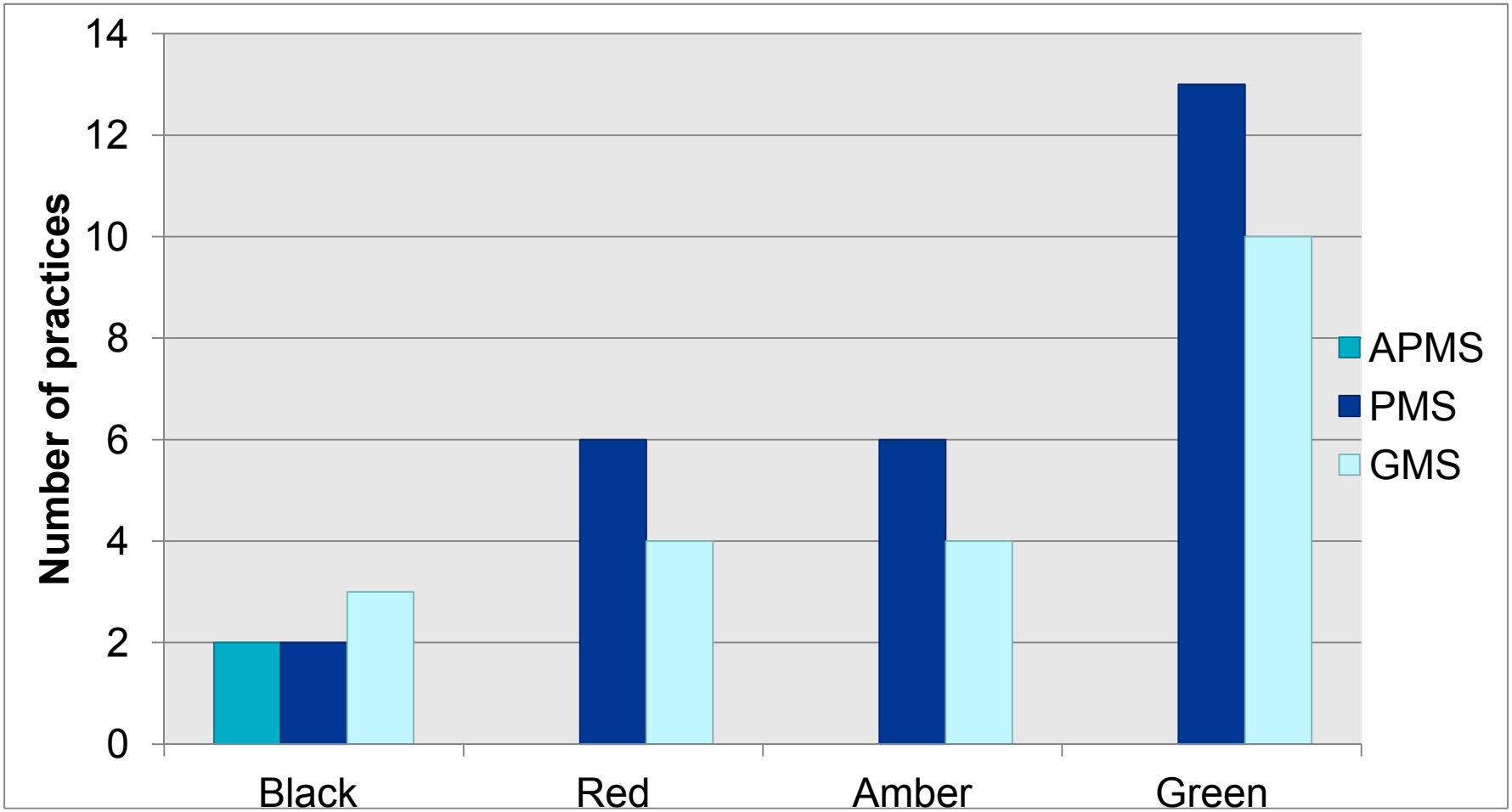
Patient Satisfaction by Question



Patient Satisfaction Results -overall



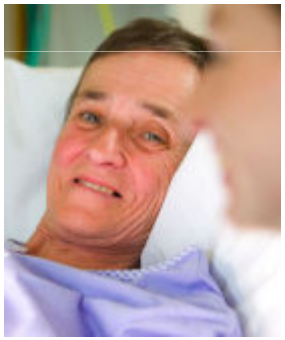
Patient Satisfaction by contract type

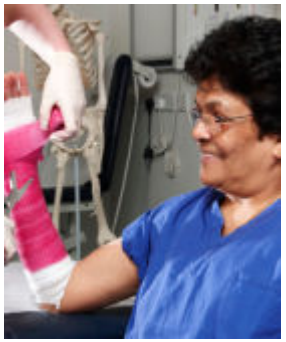


Primary Care Spend per weighted patient

Spend	GMS (pwp)	PMS (pwp)	APMS (pwp)
Capitation (inc KPI / Premiums)	£76.89	£92.65	£103.72
QOF	£9.26	£8.77	£7.79
Enhanced Serv	£6.84	£7.39	£3.49
TOTAL	£92.99	£109.38	£115.00
Total weighted list	110,399	147,694	20,700

Section 3
CONSTRAINTS





Practice Size

- The average list size is low ~5700 compared to national average of 7000 (2011/12 baseline)
- Half of practices have a list size of less than 4,000 the benchmark for practice viability
- There are a high proportion of single-handed practices ~37%
- Small practices are constrained in delivering:

➢ convenient opening times due to smaller workforces

➢ effective / optimal skill mix

➢ sustainability

➢ succession planning

Financial context

- GP contract payments are inequitable due to historic local and national agreement. This is due to minimum practice income guarantee for GMS practices and PMS premiums
- London funding (based on historic commitments) is over target and is being brought in line with national targets
- London commitments remain until historic commitments can be reviewed and made more equitable. This is leading to a growing funding gap
- Nationally we receive growth of 1.17%. This falls short of the expected population growth in London and does not address rising premises costs

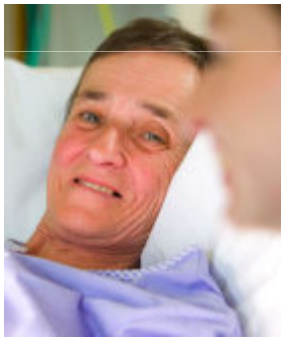
Financial Management

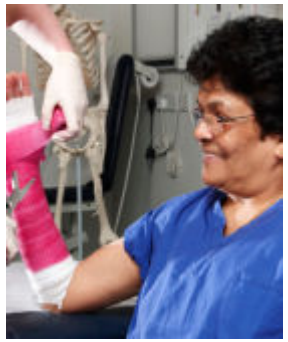
To address inequity and the rising funding gap, NHS England have;

- A QIPP (Quality Innovation Productivity and Prevention) programme in place across London aimed at standardising payments to providers and meeting the funding gap
- Agreed to remove MPIG (Minimum Practice Income Guarantee) payments over a 7 year period and reinvest the saving across all practices. Haringey practices gained overall from this process by £80K pa for the seven years of implementation
- Directed Local Area Team's to review all PMS contracts to bring them in line with GMS contract funding (by March 2017). Haringey practices receive an estimated £2.2m in premium PMS contract payments
- Directed Local Area Team's to offer KPIs /premium payments to all practices equally (by March 2017)
- The impact of the PMS Contract review in Haringey will be significant at a practice and Borough level

Section 4.1

Commissioner Response
2014/15 Initiatives





4.1

Response – NHS England Incentives

- Equitable distribution of resources through PMS and MPIG reviews`
- Named GP for over 75's
- Remote care monitoring
- Reducing unplanned admissions ES : improve practice availability, including same-day telephone consultations
- Choice of GP practice. From October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a duty to provide home visits
- Patient online services
- Extended opening hours
- PMCF Pilots (national and associate)
- Improved patient participation, Friends & Family Test, and practice requirement to react to this

Avoiding Unplanned Admissions ES aims

- provide timely telephone access, via ex-directory or bypass number, to relevant clinicians to support decisions relating to hospital transfers or admissions, in order to reduce avoidable hospital admissions or A&E attendances
- proactively case manage vulnerable patients (both those with physical and mental health conditions) through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator
- improve access to telephone or, where required, consultation appointments for patients identified in this service who have urgent enquiries
- work with hospitals to review and improve hospital discharge processes, sharing relevant information and whole system commissioning action points to help inform commissioning decisions.
- undertake internal reviews of unplanned admissions or readmissions or A&E attendances

Response – Performance Management & Remediation

- Case Management Team -Collates and reviews data on performance to identify practices who are falling below standards across a range of indicators and proactively performance managing the bottom 5%
- Challenge letters: Raising issues direct with practices as a contractual matter
- Meetings with practices and their PPG with/without local councillors
- Contract breaches & sanctions issued
- Remediation plans put in place where appropriate

Response- Local Incentives

- CCG provides clinical leadership and support for practices
- CCG offering incentives to practices in 2014/15 to develop network solutions to key challenges including access to care
- CCG developing strategic plan to improve the quality of primary care and develop integrated primary care networks to support patients with LTC in the community
- CCG strategic plan will address and manage demand for urgent care across the system.

Some CCG's work…

GPs keen to work collectively to improve patient outcomes and experience around access.

All practices received a Practice report and profile which includes bench-marking to their locality, (Haringey) and nationally the patient survey outcomes on access. All practices have developed action plans based on these reports.

CCG-wide audit on access :

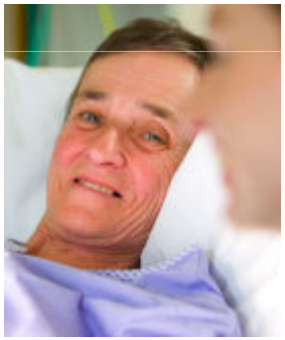
- Uses a clinician to complete a questionnaire with patients who have recently attended A+E to find the reasons for attendance and make a clinically-informed decision on appropriateness
- Looks at practice capacity by looking at the total appointments for the week
- Maps demand by keeping a spread sheet of requests for appointments
- Demand-proofs by a clinician on appointment type, new or follow-up, problem-type and best person to deal with this
- This will allow practices to start to determine the best solutions to meet their patients' demands
- Practices have been invited to put in Innovation bids supporting innovative approaches by practices singly or in groups to address their practice access issues

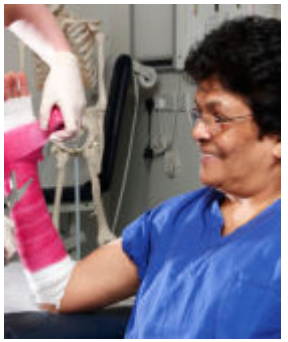
Some CCGs' technology work has included…

- EMIS web across all practices, with Orion system joining up all IT systems across health and social care with data-sharing arrangements already in place. This will both enable localities to look at how they can offer unscheduled care appointments across practices and increase the efficiency of clinical information exchange reducing unnecessary need for follow-up appointments
- Enhanced phone systems that offer more options and allow the boking of appointments when practices are closed
- Extension of the text messaging system which has reduced DNAs
- Remote access through tele-conferencing for all practices commencing with use in the multi-disciplinary team meetings but with the potential to allow remote consulting with HD screens

Section 4.2

Vision & transformation





4.2

Primary care strategic plan on a page

NHS England

Vision

Primary care services that consistently provide excellent health outcomes to meet the individual needs of Londoners

Form

Objective One
Co-ordinated Care

Objective Two
Proactive Care

Objective Three
Accessible Care

Function

Objective Four
Collaborative models of delivery

Quality Standards and Outcomes
- Ensuring consistency of service across London
- Performance management

Premises
- Making best use of the assets available
- Borough based strategic planning to inform investment decisions

Workforce
- Commission and maintain a diverse primary care workforce that supports collaborative 24/7 working

Technology
- Joined up working that meets the needs of patients
- Integrated systems and better data sharing

Commissioning and contracting
- Managing the provider landscape
- Redesigning incentives
- Primary care contract that delivers national consistency which enables programme of change in local context

Stakeholder engagement
- Ensuring ongoing engagement of patients, healthcare providers and other key stakeholders in service design and programme of change

Change management
- Organisation design
- Clinicians and organisations collaborating to deliver integrated care for patients

Governance arrangements
- Overseen by the Primary Care Programme Board
- Borough based accountability – via the SPGs?

Success criteria
- Enables effective delivery of out of hospital care
- Demonstrable improvement in:
  - Outcome standards across all London CCGs
  - Public confidence in NHS England's ability to address and act upon poor quality (premises, clinicians, systems)
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Primary care system that prevents ill health and supports healthy lifestyle choices
- Patients and stakeholders are at the heart of commissioning decisions

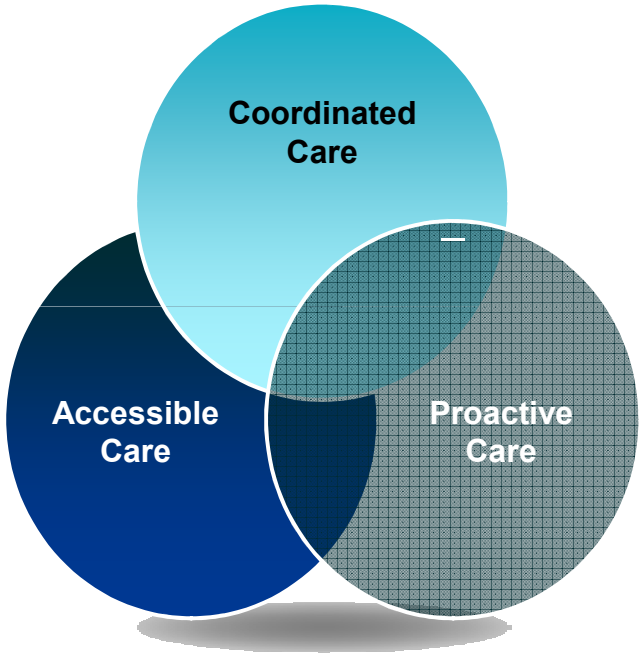
High level risks to be mitigated
- Information governance – linking IT systems across different organisations involved in the pathway.
- Engagement with key stakeholders will be crucial to ensuring the success of this strategy
- Finance – investment required to support the transformational change over the next 5-7 years

VERSION 1, 10/12/13

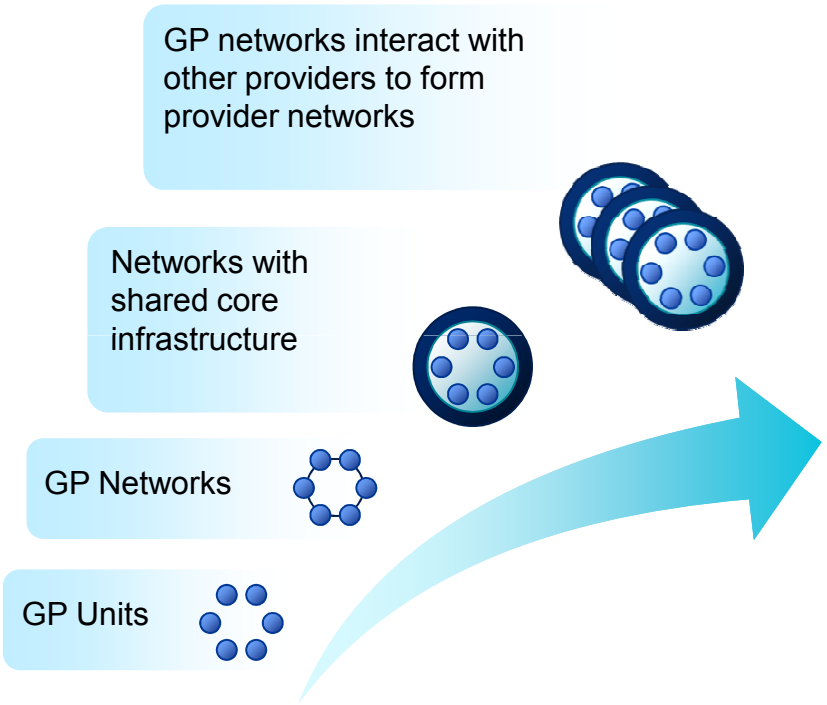
The Vision: How General Practice is changing

NHS England

A **Patients tell us they want improvements in**



B **This will require general practice to work at scale**



A The way services are provided will need to change, becoming more centred on users' needs, more accessible both by traditional and innovative routes, and more proactive in preventing illness and supporting health

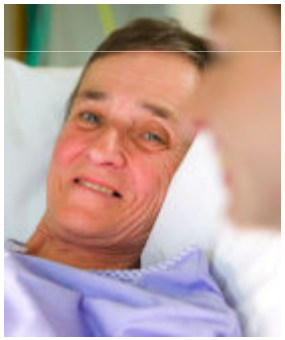
B To enable GP practices to interact as equal partners with other organisations in an integrated health system, they will need to form networks with shared management infrastructure. This change will also facilitate change in service provision

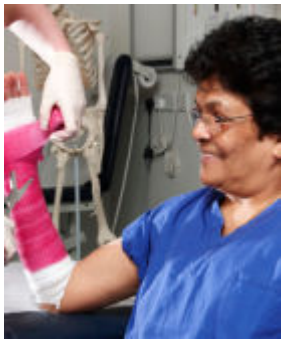
To enable primary care to work better today, a set of standards for general practice is being refined

Category	Standard	Description
Pro-active Care	P1. Co-Design	Primary care teams will work with patients, their families and communities to co-design approaches to improve the health and wellbeing of the local population
	P2. Developing assets and resources for improving health and	Primary care teams will work with others to develop and map the social capital and resources locally that could empower people to remain healthy and to feel connected within their local community.
	P3. Personal conversations focused on individuals' health goals	Where appropriate patients will be asked about their wellbeing, capacity for improving their own health and their health improvement goals.
	P4. Health and wellbeing liaison and information	Primary care teams will enable and assist people to access information advice and connections that will allow them to achieve health and wellbeing. The provision of this health and wellbeing liaison role will extend into schools, workplaces and other community
	P5. Patients not currently accessing primary medical care	Primary care teams working together at scale will design ways to reach patients who do not routinely access services, who may not be registered with a GP practice and who may be at higher risk of ill health, for example those who are homeless, those released from custody or places of detention, in care homes, those with severe mental illness or those who do not take up invitations for screening and vaccinations. Primary care teams will work with their Clinical Commissioning Groups to design ways to reach and care for the unregistered population within the CCG catchment area.
Accessible care	A1. Patient choice	Patients will be given a choice of access options and should be able to decide on the consultation most appropriate to their needs.
	A2. Contacting the practice	Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will actively promote online services to patients including appointment booking, prescription ordering, viewing medical records and email.
	A3. Continuity of care	All patients will be registered with a named GP who is responsible for providing an ongoing relationship for care coordination and care continuity. Patients will be able to book an appointment with their named GP (or if they choose other members of the primary care team) up to at least 4 weeks ahead. Practices will provide flexible appointment lengths as appropriate.
	A4. Routine opening hours	Patients will be able to access pre-bookable routine appointments with a primary health care professional (GP, nurse, pharmacist) 8 am – 6.30pm Monday to Friday and 8 am to 12am on Saturdays.
	A5. Same day access for urgent conditions	Patients with urgent conditions will be able to access a consultation with a GP/or appropriately skilled nurse on the same day within routine surgery hours (8am to 6.30 pm Monday to Friday)
	A6. Emergency care	Primary care teams working together at scale will have systems in place to ensure patients receive appropriate care and in appropriate time in the case of emergencies.
	A7. Extended opening hours	Patients will be able to access a primary care health professional (GP, Nurse, Pharmacist, Community Specialist) 7 days per week, 12 hours per day (8am to 8pm) in their local area for immediate, urgent and unscheduled care.
Co-ordinated care	C1. Case finding and review	Primary care teams working together at scale will identify their cohort of patients who would benefit from coordinated care and proactively review them on a continuous basis.
	C2. Care planning	Patients identified for coordinated care will have a care plan, which follows the approach set out in "Delivering Better Services for People with Long Term Conditions – Building the House of Care"
	C3. Patients supported to manage their health and well-being	Primary care teams working together at scale will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing
	C4. Named clinician	Patients identified as needing coordinated care will have a named GP/lead clinician and team from which they routinely receive their care.
	C5. Multi-disciplinary working	Patients identified for coordinated care will receive multidisciplinary reviews. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed by the patient/carer.

Section 4.3

Co-Commissioning





4.3

Co-Commissioning

The 2013 re-organisation transferred primary care commissioning responsibilities to NHS England, CCGs and PH teams. This has resulted in a need to co-ordinate strategies and plans to ensure that we are not duplicating activities or working at cross purposes.

As each organisation has it's own governance structure this has increased bureaucracy and delayed decision making.

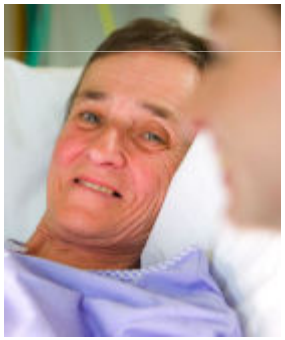
Resourcing and investment decisions are complicated and lack local inputs

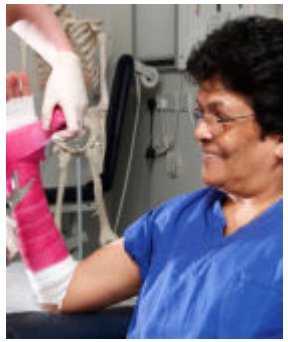
Co-commissioning will establish a joint commissioning governance structure for primary care commissioning with delegated responsibilities from the existing statutory bodies

CCGs in North Central London and NHS England are working together to develop a co-commissioning solution for the area that will align to the Strategic Planning Group

Section 5

Tottenham Regeneration Project





Joint Working

NHS England, LBH and the CCG met to discuss how we can work together to ensure people in Tottenham, including expected population increases, will have access to good quality services in the future.

We agreed to work together to develop a report that will support the case for change and new investment. Each party took away actions.

Proposal to the HWB

- To identify the services that need to be commissioned to deliver good quality services and access to primary care

- To identify the capacity needs and opportunities that exist to deliver these services

- To ensure that identified options are feasible, sustainable and affordable to commissioners and providers

Case for Change Report

Main output	Sub-Products	Potential Leads
Case for Change	Population Demographics including growth and impact of regeneration project	Public Health (PH)
	Practice List Demographics	Local Area Team (LAT)
	Practice Performance data, including Outcome Standards, High Performance Indicators other information relevant to succession planning	LAT
	Patient Feedback Experience information (local and national)	All
	Information from Local and National Strategies relevant to primary care	
Capacity Planning	Quality and capacity of GP Premises	LAT
	Capacity within community based premises developments (existing and planned)	All
	Workforce Assessment	LAT
	New Capacity Requirements & GAP analysis	LAT/CCG/PH
Options	Regeneration, S106, CIL or local authority opportunities	LA
	Reconfiguration /Basic Property Search (optional)	Property Organisations
	Basic feasibility / options appraisal	LAT
Funding	Potential commissioner /stakeholder investment	All
	Outline sustainability model	All

Agenda Item 10

Haringey Council

Report for:	Health and Wellbeing Board	Item Number:	

Title:	GP Access in Tottenham Hale: Capacity Study

Report Authorised by:	Sharon Grant, Chair Healthwatch Haringey

Lead Officer:	Mike Wilson, Director Healthwatch Haringey

Ward(s) affected: Tottenham Hale and surrounding Wards in the North East GP collaborative area	Report for Key/Non Key Decisions: N/A

1. Describe the issue under consideration

1.1 This report deals with access to GP services in the Tottenham Hale area of Haringey and in doing so also includes comparative information relating to GP access in the four area collaboratives and in Haringey as a whole. All the evidence, both qualitative and quantitative, that we have described in this report confirms that residents in Tottenham Hale have serious difficulty accessing local GP services. This is within the context of poor GP access in the wider North East collaborative area. The anecdotal evidence, in the form of complaints about GP services in the area, received by Healthwatch Haringey over recent months is corroborated by the systematic evidence presented in this report.

1.2 These access issues, and related issues of service quality, need to be addressed urgently as lack of fit for purpose primary care services for residents in the North and East of Haringey threatens to undermine all the objectives for Health and Wellbeing in the Borough, as well as creating fear and concern amongst patients. In our view this situation is on the verge of presenting a crisis of patient safety for individual patients and another for services providing unscheduled or out of hours care.

1.3 Furthermore, a whole series of nationally driven policy reforms now place GPs as the gatekeeper to a wider range of services in the community than ever before. The fact that substantial numbers of residents are unable to gain access to their GP services, as demonstrated by Healthwatch Haringey's research, ought to be a wake-up call to NHS England, and the issue taken up with the utmost urgency by both the local authority and by the Haringey Clinical Commissioning Group.

2. Recommendations

2.1 The Health and Wellbeing Board note the findings outlined in the attached report relating to the very poor access to GP services for residents in the Tottenham Hale area, highlighted in both the qualitative and quantitive evidence.

2.2 The Health and Wellbeing Board note the findings outlined in the attached report relating to the very poor access to GP services for residents in the North East GP collaborative area, highlighted in both the qualitative and quantitive evidence.

2.3 The Health and Wellbeing Board note the findings outlined in the attached report relating to the relatively poor access to GP services in Haringey compared to the national benchmark, and in comparison with Camden, reflected in the number of actual GP appointments per week.

2.4 Immediate steps be taken to supplement the GP capacity in Tottenham Hale pending the proposals arising from recommendation 2.5

2.5 That a working group be set up as a matter of urgency to review the evidence and make recommendations to the Health and Wellbeing Board, within three months, for immediate actions to improve access to GP services in the short term for the residents in Tottenham Hale and surrounding wards. The membership should include NHS England, Haringey CCG, Public Health, patient representatives and other partners that the Health and Wellbeing Board wish to nominate.

2.6 That a planning group be established to develop a strategy and plan for GP services in Haringey over the next five years, with priority given to the North East and South East GP collaborative areas. The terms of reference to include the impacts of demographic change, housing growth, integrated care in the community and GP workforce issues. The membership should include NHS England, Haringey CCG, Public Health, planning / Regeneration, patient representatives and other partners that the Health and Wellbeing Board wish to nominate.

3. Background information

3.1 This research began because Healthwatch received a number of complaints from residents in the Tottenham Hale area regarding their difficulty in accessing GP appointments. Issues have also been raised about the quality of the services and although this is outside the scope of this report, a negative imbalance between

the demand for and supply of GP services will understandably impact on quality and patient safety. In our view we may have reached the point where patient safety is at risk, both through inability to access primary care and the pressure on GPs which weigh heavily against providing a quality service.

3.2 We should emphasise that our purpose is not to criticise GPs or challenge their efficiency; they are also victims of the capacity issues and in many cases are struggling to meet the overwhelming demands upon them. It is hoped that the evidence presented in his report will help the local GPs to meet the needs of their patients, making their job more rewarding and encourage them to continue practising in the area

3.3 Complaints from residents of Hale Village and the surrounding area of Ferry Lane about a lack of GP services in the area are not new and have been exacerbated by the new developments in the area and the closure of the satellite GP service on the Ferry Lane estate. The developer of Hale Village, Lea Valley Estates, made provision for a GP surgery in their master-plans since 2009 and had discussions with the former Primary Care Trust but with no success. The provision made available for a GP surgery is now used as a Renal Unit which, whilst providing a valuable service, does not meet the need of the growing population in this area for primary care services.

3.4 The detailed comments from residents responding to the Tottenham Hale GP Access Survey are included in appendix 1 of the attached report as their voices should be heard. They are saying we cannot access the GP services we need for ourselves and our families; there is no point in registering with a local GP as we cannot get an appointment; and when we do get an appointment the service often falls below the standards they could reasonably expect. These voices have been raising concerns for many months, even years, but they have not been listened to and their concerns have not been addressed.

3.5 In writing this report Healthwatch Haringey is listening to these voices and confirming that they do indeed reflect the situation that residents in the area face every day and that there needs to be an immediate, practical response to improve the access to and supply of primary care services. In our view the access issues are serious enough to be more than an inconvenience for residents they are a real threat to patient safety.

4. Comments of the Chief Finance Officer and financial implications

4.1 There are no financial implications for the Council arising directly from the recommendations in this report. However, in order to increase the capacity and accessibility of GP services in the North and East of the Borough there will be need for additional capital and revenue investment, some of which may come from the private sector through developer contributions. NHS England, as the commissioner of GP services, would be responsible for the major public sector

investment but some additional funding could potentially come from the Haringey Clinical Commissioning Group and Public Health.

5. Comments of the Assistant Director of Corporate Governance and legal implications

5.1 The Local Government and Public Involvement in Health Act 2007 (Section 222) gives the local Healthwatch powers to carry out activities that include obtaining the views of local people about their needs for, and their experiences of, local care services and making these views known, and making reports and recommendations about how local care services could or ought to be improved. Local care services means services provided as part of the health or social services function.

5.2 Local Healthwatch reports and recommendations should be directed "to persons responsible for commissioning, providing, managing or scrutinising local care services" i.e. National Health Service Commissioning Board, Clinical Commissioning Group, National Health Service Trust, NHS Foundation Trust or a Local Authority. NHS England and/or Haringey Clinical Commissioning Group are responsible for the commissioning and provision of local GP services. Therefore, the findings of the GP Access Capacity Study and the action required should be directed to them.

5.3 The Health and Wellbeing Board as part of its strategic oversight of health and social care needs and provision in the area should take into account the findings of the Study.

6. Equalities and Community Cohesion Comments

6.1 This report highlights significant and substantive inequalities between access to the National Health GP services provided in the North East and West of the Borough.

6.2 The North East area of Haringey has a relatively high proportion of vulnerable and disadvantaged residents, as measured by a number of socio-economic indicators (see pages 16-19 of the report), and therefore primary care health provision should be specifically targeted in order to achieve better outcomes and improve the long-term health of local residents. For example, there are high concentrations of temporary accommodation (75% of all TA in Haringey) and care establishments in the Tottenham area which will continue to provide challenges for local health services.

6.3 The public sector equality duty consists of a general equality duty, which is set out in section 149 of the Equality Act 2010 itself, and the specific duties which came into law on the 10th September 2011. In summary, those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

Haringey Council

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The Act also states that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status.

6.4 The picture is one of marked inequality between the east and west of the borough in terms of access to GP's with only 8% of residents in the West stating that they were unable to get an appointment at their most recent attempt compared with an average of 25% in the Tottenham Hale "cluster" (NHS Patient Survey 2014).

6.5 In relation to the number of appointments offered against the national benchmark the North East collaborative area has a very significant shortfall of GP appointments per week of c.900 and 1,345 if you apply a deprivation weighting of 10%. This is a substantial shortfall of at least 20% (27% weighted) less than could reasonably be expected or over 50,000 appointments per annum. In comparison, the West GP collaborative area has a shortfall of 170 appointments per week, 9,000 per annum; 3% less than the national benchmark.

6.6 Data on local demography, some of which is included in the report, shows that the area has a high concentration of people who share the protected characteristics to whom public sector bodies including statutory health providers owe a general equality duty as set out above. The evidence presented in this report indicates that there may be a risk of meeting the responsibilities of this duty. To address this, the task and finish group that is suggested as the next step on the primary care issue will be asked to look in more detail at the equalities impacts, using an EQIA approach if appropriate.

Haringey Council

7. Policy Implication

7.1 The Council's three Health and Wellbeing Strategy objectives, relating to mental health, children and young people and health inequalities will be significantly impacted by inadequate primary care services in those areas of the Borough where the needs are greatest. Unless primary care services in these areas are significantly improved health inequalities are unlikely to narrow and may indeed get worse.

7.2 The current demands on primary care services in the North East and South East of Haringey will make it very difficult to successfully deliver the strategy to move services from hospital into the community and expect GPs to play a key role in service integration and case management. Residents in these areas will be at a relative disadvantage and may receive an even worse service as a result of the service transformation process.

7.3 Concern must also be expressed about the cumulative effect of denial of access in an area to already have challenging health status. This may become apparent in subsequent years in respect of conditions which are most susceptible to early diagnosis and intervention. Healthwatch Haringey believes that action should be taken to avert such likely trends.

7.4 It would appear that neither NHS England nor the Haringey CCG has a strategy in place which will successfully address these issues in the short term. Any strategy must also take account of workforce issues; there is a very high % of GPs over 60 years of age (32%, 2011) who will be leaving the profession in the next few years, compared to the London average of 16% and 7.5% in Camden.

8 Use of Appendices

8.1 Appendix 1: GP access in Tottenham Hale Presentation

9 Local Government (Access to Information) Act 1985

NA

Agenda Item 11

Haringey Council

Report for:	Health and Wellbeing Board – 30 September 2014	Item Number:	

Title:	Annual Public Health Report

Report Authorised by:	Jeanelle de Gruchy, Director of Public Health

Lead Officer:	Jeanelle De Gruchy, Director of Public Health

Ward(s) affected: All	Report for Information

1. Describe the issue under consideration

1.1 The Annual Public Health Report is the Director of Public Health's professional statement about the health of local communities, based on sound epidemiological evidence and interpreted objectively. The report should be publicly accessible.

1.2 The annual report is an important vehicle by which Directors of Public Health can identify key issues, flag up problems, report progress and, thereby, serve their local populations. It is also a key resource to inform local inter-agency action.

1.3 This year's report focuses on the Health and Wellbeing Strategy outcome: Improving mental health and wellbeing. It explores what we mean by 'wellbeing' and how this is linked to both our physical and mental health.

2. Cabinet Member introduction

2.1 Haringey has a high level of mental illness and that can impact on any sphere of life: family, employment, education or social interactions. Tackling this issue is a priority for the Council and I am pleased to introduce 2014 Annual Director's of Public Health report with the focus on mental health and wellbeing.

2.2 Improving mental health and wellbeing of local residents is everyone's business and can only be delivered if we work in partnership across the Council and

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wider. It is good to note that a range of interventions offered locally are holistic and include joint work with education, housing, employment, leisure and planning.

3. Recommendations

3.1 The HWB is asked to note the Annual Public Health Report and planned local anti-stigma and mental wellbeing campaign for October 2014.

4. Alternative options considered

4.1 N/A

5. Background information

5.1 Good mental health and wellbeing is defined as a state in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. This is why mental health and wellbeing has been highlighted as a local priority in the Health and Wellbeing Strategy 2012-15, Haringey's Corporate Plan 2013-15 and it is the focus of this year's Annual Public Health report.

5.2 Many factors affect our wellbeing positively and negatively such as our education, job and income, housing or experiences of crime. These factors are not spread equally across society; some have stronger support networks and links with their community; yet others are unfairly pushed to the edge of society because of poverty, or as a result of discrimination.

5.3 Low levels of wellbeing do not necessarily lead to the development of mental illness; likewise those with mental illness can recover and develop a positive state of wellbeing.

5.4 Poor mental health is extremely common; 1 in 4 people will experience a mental illness (mainly anxiety and depression) at some point in their lives. In Haringey, it is estimated that 34,500 people have a common mental health problem. About half will seek help from primary care (e.g. a GP), with only half of these having their illness recognised and diagnosed as a mental illness. This suggests that many residents are suffering with anxiety and depression without help or support from health services.

5.5 This year's Public Health Annual report is focusing on communicating messages that would engage all residents in Haringey, regardless of their mental health and wellbeing state. It is envisaged that the report will initiate open discussions about people's own mental health and wellbeing, promote early recognition of signs and symptoms and encourage people who need help to access most appropriate services.

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5.6 The launch of the report will be followed by a local mental health and wellbeing campaign that is aiming to raise awareness on mental health and wellbeing, reduce stigma and discrimination and promote early help and access to a range of services tailored for varying needs of our diverse communities.

5.7 Our local campaign will start with a cycle ride on 6th October followed by a football match involving service users and mental health services staff on 8th October.

5.8 The Haringey Mayor will open 'Mind, Body, Art – facing the stigma' art exhibition at Wood Green Library on 9th October where service users will exhibit drawings, paintings, photos and computer generated images.

5.9 A Grand event celebrating mental health and wellbeing in Haringey is organised for World Mental Health Day, 10th October at 639 Enterprise Centre with musicians, singers, comedians, drama groups and stall exhibition.

5.10 Haringey Council will be signing the 'Time to Change' pledge that is focusing specifically on reducing mental health stigma and discrimination amongst the workforce, and will encourage partners to join them in this pledge.

6. Comments of the Chief Finance Officer and financial implications

6.1 There are no financial implications arising directly out of this report. Issues highlighted in the Annual Public Health Report will be incorporated into the development of the Council's Medium Term Financial Strategy. The local anti stigma campaign will be funded from within this year's public health grant.

7. Comments of the Assistant Director of Corporate Governance and legal implications

7.1 Under Section 73B (5) and (6) of the NHS Act 2006, the Director of Public Health has a statutory duty to publish an annual report on the health of the local population. The content and structure of the report is to be decided locally. The Council is required to publish the report.

7.2 Under Section 2B of the NHS Act 2006, the Council must take such steps as it considers appropriate for improving the health of the people in its area. The steps to be taken may include providing information and advice, providing services or facilities designed to promote healthy living and providing services or facilities for the prevention, diagnosis or treatment of illness."

8. Equalities and Community Cohesion Comments

8.1 The most disadvantaged sections of Haringey Community experience poor outcomes on those factors such as education, employment, income, housing

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etc, that affect wellbeing. These groups also experience a broad range of health inequalities including inequality in mental health which is the focus of this report. The measures set out in this report to tackle mental health will contribute to tackling this aspect of health inequality experienced within this group, most of whom share the characteristics protected by the Equality Act 2010.

9. Head of Procurement Comments

N/A

10. Policy Implication

10.1 Mental Health and Wellbeing is one of the Health and Wellbeing Strategy 2012-15 Outcome and is articulated as a priority in the Corporate Plan.

11. Use of Appendices

Appendix A: Annual Public Health Report

12. Local Government (Access to Information) Act 1985

What is wellbeing?

'Feeling happy' is an important part of mental wellbeing – but it's more than that, it's also about feeling content and confident, having self-esteem and living in a way that is good for you and for those around you. Wellbeing involves both the mind and the body – physical and mental wellbeing are closely related.

A key part of improving population wellbeing is ensuring a good start in life. For babies and young children, care and development are strongly linked, and the bond between baby and parent (or carer) is crucial, affecting the physical growth of the child as well as their emotional and mental development and wellbeing.

Good mental wellbeing does not mean that you never experience feelings or situations that you find difficult.

But it does mean that you feel you have the resilience to cope when times are tough. Parts of Haringey have it tough; it is the 4th most deprived London borough with high unemployment (9%) and the 2nd highest proportion of people living in temporary accommodation. While three wards were in the top 25% for wellbeing in England in 2012, nine wards – mostly in the east of the borough – were in the bottom 25%.

Many factors affect our wellbeing positively or negatively such as our education, job and income, housing or experiences of crime. These factors are not spread equally across society; some have stronger support networks and links with their community; yet others are unfairly pushed to the edge of society because of poverty, or as a result of discrimination.

Wellbeing and poor mental health

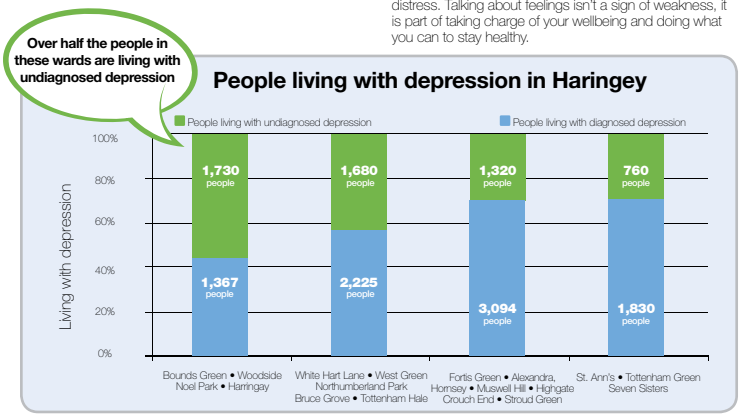
Low levels of wellbeing do not necessarily lead to the development of mental illness; likewise those with mental illness can recover and develop a positive state of wellbeing.

Poor mental health is extremely common; 1 in 4 people will experience a mental illness (mainly anxiety and depression) at some point in their lives. In Haringey, it is estimated that 34,500 adults have a common mental health problem. About half will seek help from primary care (e.g. a GP), with only half of these having their illness recognised and diagnosed as a mental illness. This suggests that many residents are suffering with anxiety and depression without help or support from health services.

Untreated depression is an important risk factor for suicide. Diagnosed depression in Haringey is lower (4%) than in England (6%), yet the suicide rate is 33% higher than the London average. The suicide rate is especially high for young men in Haringey. Are people in Haringey suffering in silence?

Felt or perceived stigma and discrimination is a known barrier preventing people from seeking help. The attitudes people have towards mental illness mean it is harder for those who suffer from mental illness to work, make friends and live a normal life.

Views about masculinity, can also contribute to a reluctance to talk to others and get help in times of distress. Talking about feelings isn't a sign of weakness, it is part of taking charge of your wellbeing and doing what you can to stay healthy.



What are we doing to improve wellbeing?

We need to ensure our policies and services, including education, housing and employment, leisure and planning, actively promote wellbeing. We collectively need to build resilience in our communities, and challenge mental health stigma and discrimination. More specifically, there are a number of innovative projects in Haringey which aim to enhance resilience and break the silence for people who are struggling. These include:

Supporting people and communities

Including new teenage parents with the Family Nurse Partnership "I like seeing [my health visitor] every two weeks, feel better after the visit, more positive" (18 year old mum).

Building community connections through Tottenham Thinking Space a "safe and welcoming space to exchange ideas and build connections" and Neighbourhoods Connect – supporting local residents to connect and live independently.

Providing free 24/7 online support for adults struggling with common mental health issues at www.bigwhitewall.com and for young people through www.opendooronline.org

Promoting recovery for those with severe and enduring mental health illness at the Clarendon Recovery College.

Supporting people with disabilities and **at risk people after an illness or accident** to maintain their independence and take control of their lives.

Schools, helping children learn to express themselves through Therapeutic Story Writing and training teachers in mental health.

Turkish and Kurdish communities, and local employers through mental health champions.

Challenging stigma and discrimination

Among young people through sport in partnership with the Tottenham Hotspur Foundation and New Choices for Youth.

Through Mental Health First Aid training for front line staff "I now feel better able to support my community when presented/coming into contact with people in mental health crisis". (Neighbourhood Connector).

Through the MAC-UK Integrate Project which puts mental health at the heart of solutions for excluded young people aged 16-25 years. It will target those involved in gangs and antisocial behaviour who do not access traditional services.

How good are we feeling?

2014 Annual public health report

Dear all,

One year on: strengthening public health

The Council has been hard at work to ensure it delivers on its new duty to improve the health of all our residents and reduce the profound health inequalities in the borough. There is a reinvigorated focus on the many policies and services that fundamentally influence our health and wellbeing. In fact, housing, employment, the environment, crime and poverty all have a bigger impact than the NHS alone – and we need to ensure that we accentuate the positive and mitigate any negative impacts. Working in partnership, local government can now put public health at the heart of our community.

Addressing mental health and wellbeing

This year's report focuses on the Health and Wellbeing Strategy outcome: improving mental health and wellbeing. It explores what we mean by 'wellbeing' and how this is linked to both our physical and mental health. Haringey does have many assets that contribute to our positive sense of wellbeing. However there are considerable challenges too – the recent recession, welfare reforms and housing pressures are all adding to the stress – and these impact negatively on many residents' sense of wellbeing, threatening our mental health and increasing the risk of mental illness. An estimated 3,000 children and 34,500 adults in our borough struggle with common mental health problems; yet half of these conditions go unrecognised.

We are working with local people, voluntary organisations, schools and NHS partners to improve the mental wellbeing of all residents. We will continue to support people with advice and tools to improve their mental wellbeing, to challenge people's perceptions of mental health and mental illness, to tackle stigma and discrimination and to understand better the barriers (real or perceived) to services, including healthcare. Our user-led anti stigma and mental wellbeing campaign, launched in October is an important way to highlight these issues. But we need to do more.

Recommendations

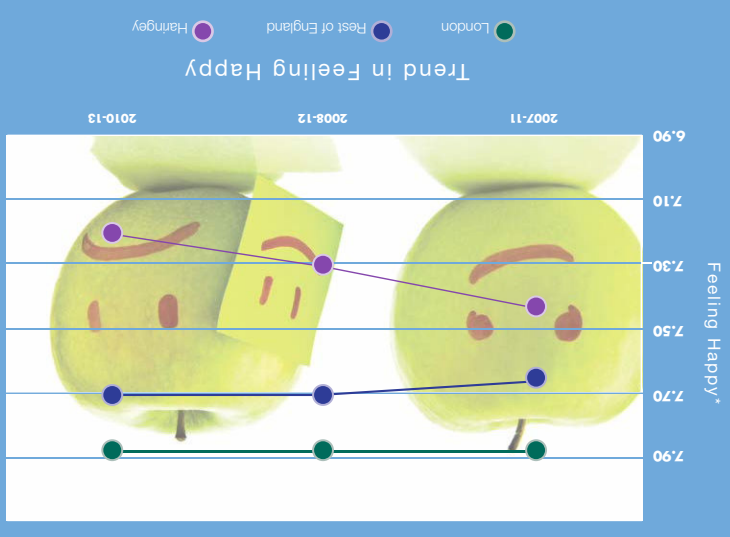
1. Ensure 'healthy public policy' to create a supportive environment to enable people to lead healthy, fulfilling, independent lives.
2. Ensure that plans for the regeneration of Tottenham address factors closely related to poor mental wellbeing such as employment, poor quality housing and overcrowding, noise, 'ugly' environments and lack of green space, anti-social behaviour and fear of crime.
3. Undertake a survey of issues affecting our residents' wellbeing to understand the key issues we need to focus on.
4. The Council and partners to sign the Time to Change pledge - with clear plans to promote wellbeing and tackle stigma and discrimination against those with mental health problems.
5. Develop a Mental Health and Wellbeing Framework to ensure a quality service offer that improves outcomes for service users.
6. Continue to focus on the early years of a child, on the bond between parent and baby.
7. We each need to look after our own mental health, support each other and build resilience in our communities.

I would like to hear your stories, thoughts or ideas on how as a community we can promote good mental health and build mental wellbeing. Please contact me at Jeanelle.degruchy@haringey.gov.uk.

I look forward to hearing from you all.

Jeanelle de Gruchy

Director of Public Health



* The survey asked: 'Taking all things together, how happy would you say you are' between 1 (very unhappy) to 10 (extremely happy). There was no data collected in 2009/10.

www.haringey.gov.uk

Haringey Council

THINGS THAT AFFECT OUR WELLBEING
EVERY DAY IN HARINGEY

1 in 10 HOUSEHOLDS CAN'T AFFORD TO HEAT THEIR HOMES

4 OUT OF 5 RESIDENTS **133,300** PEOPLE GO TO WORK

£0.00

16,405 CHILDREN LIVE IN POVERTY

RESIDENTS CAN PLAY IN MORE THAN **600** ACRES OF PARKS, RECREATION GROUNDS AND GREEN SPACE

1 IN FOUR OF ADULTS PROVIDING ONGOING CARE FOR A FAMILY MEMBER FEELS LONELY

OVER **10,000** PEOPLE DRINK ALCOHOL IN A WAY THAT HARMS THEIR HEALTH OR SAFETY

7 OUT OF 10 YOUNG PEOPLE PARTICIPATE IN SPORTS, ARTS MUSIC OR ATTEND A YOUTH GROUP

3 HOUSEHOLDS ARE PLACED IN TEMPORARY ACCOMMODATION

61 CRIMES ARE COMMITTED

1 IN 5 RESIDENTS VOLUNTEER THEIR TIME TO HELP OTHERS (AT LEAST ONCE A MONTH)

5 INCIDENTS OF DOMESTIC VIOLENCE ARE REPORTED TO THE POLICE

1 RESIDENT SUCCESSFULLY COMPLETES DRUG OR ALCOHOL TREATMENT

How are you feeling today?

Use the online wellbeing checker to get your score and information on where to get help and support if you need it. Visit **haringey.gov.uk/mentalwellbeing**

Five ways to improve your wellbeing*

1. **Connect...** With the people around you, with family, friends, colleagues and neighbours. At home, work, school or in your local community. Join Tottenham Thinking Space, start your own book or gardening club
2. **Be active...** Go for a walk or run. Step outside, cycle, play a game, garden, dance – exercising makes you feel good. Make use of our green spaces, visit **www.haringey.gov.uk/greenspaces**
3. **Take notice...** Be curious, catch sight of the beautiful, remark on the unusual – notice the changing seasons in Haringey. For a range of events, visit 'What's on?' **www.haringey.gov.uk/whatsonsearch**
4. **Keep learning...** Try something new, rediscover an old interest, sign up for that course, take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Learning new things will make you more confident as well as being fun. Free courses through Haringey Adult Learning Services (HALS), visit **www.haringey.gov.uk/hals**
5. **Give...** Do something nice for a friend, or a stranger, thank someone, smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you. Find out about volunteering at **www.do-it.org.uk**

*Source: nef (www.neweconomics.org)

Five ways to improve the wellbeing of others

1. **Talk, but listen too** simply being there will mean a lot
2. **Keep in touch** meet up, phone, email or text
3. **Don't just talk about mental health** chat about every day things as well
4. **Remind them you care** small things can make a big difference
5. **Be patient** ups and downs can happen

Find out more about mental health and how to be there for someone at **www.time-to-change.org.uk #timetotalk**
Need help now? Speak anonymously and in confidence with Samaritans on **020 8368 6789**, 24 hours a day, 7 days a week, **www.samaritans.org**

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Agenda Item 12

Haringey Council

Report for:	Health and Wellbeing Board – 30 September 2014	Item Number:	

Title:	Pharmaceutical Needs Assessment

Report Authorised by:	Jeanelle De Gruchy, Director of Public Health

Lead Officer:	Tamara Djuretic, Assistant Director of Public Health

Ward(s) affected: All	Report for Information and decision

1. Describe the issue under consideration

1.1 From 1st April 2013, every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep an up to date statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). PNAs will have to be published every three years.

1.2 The PNA is the document that NHS England uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 require every HWB to publish its first PNA by 1st April 2015.

1.3 This paper sets out progress to date with respect to developing a new PNA and asks for approval of PNA Terms of Reference and proposed timetable.

2. Cabinet Member introduction

2.1 A PNA is a useful document that comprehensively encapsulates the needs of the local population and describes pharmaceutical services offered to meet that need. Pharmacies are universal points of contact for the public and, as such, trusted public health resource with a potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities.

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2.2 It is reassuring to note that the development of a PNA is progressing under the leadership of a PNA Steering Group.

3. Recommendations

3.1 The HWB is asked to note progress made to date with respect to developing the new PNA;

3.2 The HWB is asked to formally delegate development of the PNA to the Director of Public Health;

3.3 The HWB is asked to approve the PNA Steering Group's Terms of Reference and membership;

3.4 The HWB is asked to note and approve the timetable in Paragraph 5.9 of the report for consulting on, approving and publishing the PNA;

4. Alternative options considered

4.1 None

5. Background information

5.1 The provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing appliance contractor or dispensing doctor (rural areas only), who wishes to provide NHS Pharmaceutical services, must apply to be on the Pharmaceutical List.

5.2 The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) set out the system for market entry.

5.3 From 1st April 2013, Health and Wellbeing Boards (HWBs) assumed responsibility for publishing and keeping up to date a statement of the needs for pharmaceutical services of the population in their area, referred to as a Pharmaceutical Needs Assessment (PNA). Under the same Regulations, the PNA is used by NHS England to consider applications to open a new pharmacy, move an existing pharmacy or when commissioning services.

5.4 A PNA is a document that includes a count of local pharmacies and the services they already provide including dispensing, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users. A PNA often includes other services, such as dispensing by GP surgeries, and services available in neighbouring HWB areas that might affect the need for services in its own area. A PNA also describes the demographics of its local population, across the area and in different localities, and their needs. It should look at whether there are gaps that could be met by providing more pharmacy

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services, or through opening more pharmacies. It should also take account of likely future needs. The PNA should contain relevant maps relating to the area and its pharmacies. A PNA normally takes at least 9 months to develop because of the complexity of the process and the statutory requirement to undertake a formal consultation which must run for a minimum of 60 days.

Progress to Date

5.5 The HWB has initiated the formal process to develop a new PNA.

5.6 A multi-agency Steering Group has been established and met first in February 2014. The draft Terms of Reference are attached as Appendix A for approval by the HWB;

5.7 Following a procurement exercise, Webstar Lane Ltd were appointed to support the development of the new PNA and commenced work in May 2014. This support includes the provision of subject matter expertise, project management support and capacity to write the PNA. Haringey Council has retained responsibility for stakeholder engagement, producing the maps and running the formal consultation.

5.8 To date, the majority of required information on the current needs of the population and current pharmaceutical services delivered in Haringey has been collated using various data sources (e.g. community pharmacy questionnaires, NHS England dataset and public health intelligence dataset). A first draft of the PNA is due in mid-October.

5.9 The proposed timeline for the PNA is set out below:

- PNA draft for consultation to be ready with a view to initiating the 60 day consultation by 30th November 2014. HWB to be consulted within this time period;
- PNA to be completed and ready for presentation to the HWB by mid-March 2015.
- Subject to the HWB approval, PNA to be published on Haringey Council's website by 1st April 5pm.

6. Comments of the Chief Finance Officer and financial implications

6.1 The Pharmaceutical Needs Assessment is funded from the 2014/15 Public Health Grant until March 2015.

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7. Comments of the Assistant Director of Corporate Governance and legal implications

7.1 Under Section 128A of the NHS Act 2006, amended by the Health and Social Care Act 2012, the Health and Well-being Board (HWB) must in accordance with regulations assess needs for pharmaceutical services in its area and publish a statement of its first assessment and of any revised assessment.

7.2 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements relating to the production of pharmaceutical needs assessments ("PNAs"). The HWB must publish the first PNA by 1st April 2015 and the revised assessment within 3 years of publication of their first assessment.

7.3 There is a consultation requirement that must be complied with before a PNA is completed and published. Regulation 8 "Consultation on pharmaceutical needs assessment" provides a list of bodies that HWB must consult about the contents of the assessment it is making. This include any Local Pharmaceutical Committee, any Local Medical Committee, any persons on the pharmaceutical lists and any dispensing doctors list for its area, any Local Healthwatch organisation for its area, and any neighbouring HWB. They must together be consulted at least once during the process of developing the PNA. The bodies consulted must be given a minimum period of 60 days for making their response to the consultation. Those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

8. Equalities and Community Cohesion Comments

8.1 The public sector equality duty consists of a general equality duty, which is set out in section 149 of the Equality Act 2010 itself, and the specific duties which came into law on the 10th September 2011. In summary, those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The Act also states that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.

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- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status.

In developing the PNA statement, consideration will need to be taken of the impact on the local the population when conducting a needs analysis. This will also need to address equality issues that are identified and in particular, will consider what opportunities the PNA presents for addressing any of the existing health inequalities.

Head of Procurement Comments

N/A

9. Policy Implication

9.1 The Pharmaceutical Needs Assessment is the document that NHS England uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies.

9.2 The Pharmaceutical Needs Assessment can be used as part of the Joint Strategic Needs Assessment (JSNA) to inform future commissioning strategies.

9.3 As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities[1]. In addition, community pharmacies are an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long term partner.

10. Reasons for Decision

10.1 The HWB Board's statutory duty is to produce a PNA every three years. The Public Health Directorate will conduct the PNA on the HWB Board's behalf and the process will be overseen by the PNA Steering Group.

[1] "*Healthy lives, healthy people*", the public health strategy for England (2010)

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10.2 The Board is asked to formally delegate development of the PNA to the Director of Public Health and the Steering Group.

10.3 The HWB is asked to approve the PNA Steering Group's Terms of Reference and membership (Appendix A).

10.4 The HWB is asked to approve timetable set out in 5.9.

11. Use of Appendices

Appendix A: PNA Steering Group Terms of Reference

12. Local Government (Access to Information) Act 1985

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Haringey Pharmaceutical Needs Assessment Steering Group

Terms of Reference

1. Background

The provision of NHS Pharmaceutical Services is a controlled market. Any pharmacist, dispensing appliance contractor or dispensing doctor (rural areas only), who wishes to provide NHS Pharmaceutical services, must apply to be on the Pharmaceutical List.

The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349) set out the system for market entry[3].

From 1st April 2013, Health and Wellbeing Boards (HWBs) assumed responsibility for publishing and keeping up to date a statement of the needs for pharmaceutical services of the population in their area, referred to as a Pharmaceutical Needs Assessment (PNA).

A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services that are currently provided, together with when and where these are available to a given population.

Under the same Regulations, the PNA is used by NHS England to consider applications to open a new pharmacy, move an existing pharmacy or when commissioning services.

Formerly published by primary care trusts (PCTs), the PNA is a key tool, for commissioners in other organisations, for identifying what is needed at a local level to support the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers. The last PNA was published in 2011 and can be downloaded using the following link http://haringey.gov.uk/jsna.

2. The importance to HWBs

- HWBs now have a legal duty to check the suitability of existing PNAs, compiled by primary care trusts (PCTs), and publish supplementary statements explaining any changes.
- HWBs will need to ensure that NHS England and its Area Teams have access to their PNAs.
- Each HWB will need to publish its own revised PNA by **1st April 2015**. This will require board-level sign-off and a minimum period (of 60 days) for public consultation beforehand[2].
- Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings.
- PNAs must be aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy.
- The PNA should identify gaps in service, current need and identify any anticipated future needs with specific attention to the Tottenham regeneration area.
- As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities[4].
- In addition, community pharmacies are an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long-term partner.

3. What should a good PNA cover?

- The PNAs should meet the market entry regulations[3].
- PNAs should include pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.
- It should look at other services, such as dispensing by GP surgeries, and services available in neighbouring HWB areas that might affect the need for services in its own area.
- It should examine the demographics of its local population, across the area and in different localities, and their needs and also look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs.
- The PNA should also contain relevant maps relating to the area and its pharmacies.
- Finally, PNAs must be aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy.
- The PNA should distinguish between services commissioned by NHS England and other areas of public health need that are locally commissioned that are available outside of the scope of the NHS England contract.
- The PNA should identify gaps in service, current need and identify any anticipated future needs with specific attention to the Tottenham regeneration area.

4. Steering group duties/responsibilities

The Haringey Steering Group (PNA SG) has been established to:

- Oversee the production of the Haringey PNA in accordance with DH regulations and deadlines.
- Ensure that the PNA captures the specific needs of the local population, with a focus on reducing inequalities and aligning with the existing corporate plans of the HWB partners, where relevant.
- Establish arrangements to ensure the appropriate maintenance of the PNA, following publication, as required by the Regulations

The PNA SG will ensure that the findings of the PNA are presented to the HWB once published, and disseminated to those who need to know and will work towards implementation of the recommendations with relevant partners.

5. Key Objectives

- Champion the work to develop the PNA with internal and external stakeholders, including patients, service users and the public

- Approve the project plan and timeline

- Drive the project ensuring that key milestones are met

- Ensure that the requirements for the development and content of PNAs are followed and that the appropriate assessments are undertaken, in line with the Regulations

- Determine the localities which will be used for the basis of the assessment

- Undertake an assessment of the pharmaceutical needs of the population and make recommendations based on this assessment

- Determine the criteria for necessary and relevant services and apply these to pharmaceutical services, taking into account stakeholder feedback including views from patients and the public

- Determine the maps which will be included in the PNA

- Approve the framework for the PNA

- Develop a draft PNA for formal consultation with stakeholders for approval by Senior Officers of the HWB prior to consultation

- Oversee the consultation ensuring that this meets the requirements set out in the Regulations

- Consider and act upon formal responses received during the formal consultation process, making appropriate amendments to the PNA

- Develop and approve a consultation report as required by the Regulations and ensure that this is included within the final PNA

- Submit the final PNA to the Health & Wellbeing Board for approval prior to publication

- Consider and document the processes by which the HWB will discharge its responsibilities in relation to maintaining the PNA; and formally responding to consultations initiated by neighbouring HWBs. This includes making a recommendation on the long term structures required to underpin these responsibilities.

6. Policy Implications

- The Pharmaceutical Needs Assessment is the document that NHS England uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies.
- The Pharmaceutical Needs Assessment can be used as part of the Joint Strategic Needs Assessment (JSNA) to inform future commissioning strategies.
- As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities4.
- In addition, community pharmacies are an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long term partner.

7. Governance

The following Governance arrangements have been established:

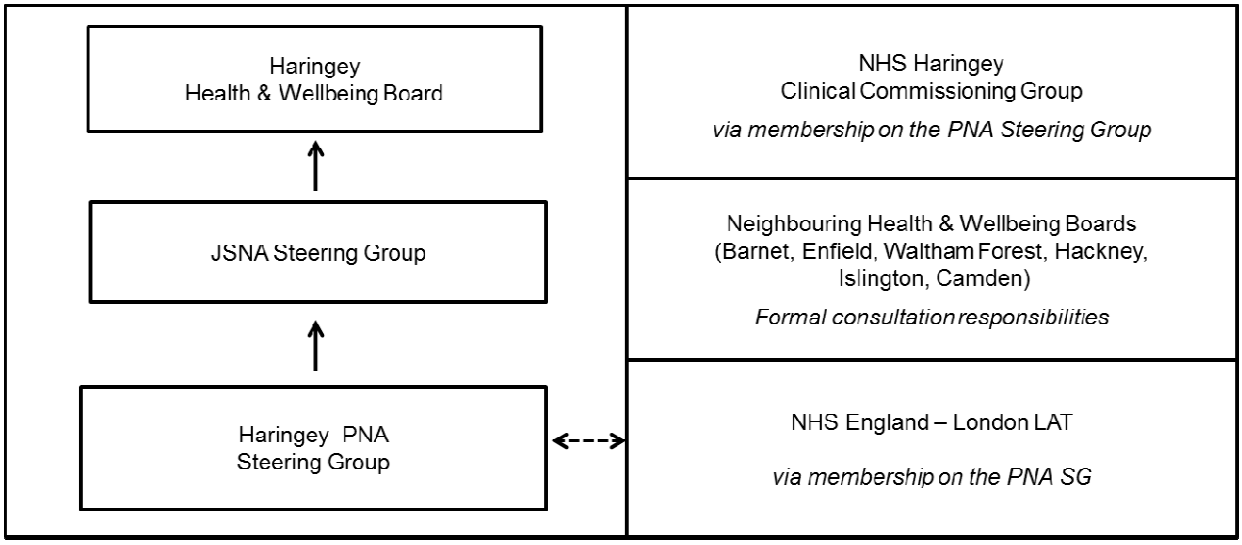
- The HWB has delegated responsibility to the Director of Public Health who will act as the designated officer to maintain the PNA going forward. Her Assistant Director will discharge this responsibility via the PNA steering group.

- The work of the Steering Group will be governed by the HWB for Haringey. The consultation documentation will be approved by Senior Officers of the HWB and the final PNA will be formally signed-off by the HWB.

- Progress on the PNA will be reported to the Health and Wellbeing Boards (HWB) through the JSNA Steering Group.

- NHS England and NHS Haringey CCG will be informed of progress via membership on the PNA SG

- The diagram below illustrates the accountability and reporting lines between the Haringey PNA SG and the various committees and organisations with which it needs to interact with respect to discharging its responsibilities:



8. Conflicts of interest

Some pharmacy data are commercially confidential and cannot be released into the public domain. As the PNAs are publicly available documents, if and where required, these data will be suppressed in accordance to information governance arrangements surrounding their use.

Transparent arrangements to manage actual and potential conflicts of interest have been established as follows:

- A register of interests will be maintained. This will be updated at each PNA Steering Group meeting and signed by members.
- The register will be kept under review.
- Declaration of interests will be a standing item on each PNA Steering Group agenda; any interests which are declared will be recorded.
- Where a member has a conflict of interest for any given agenda item, they will be entitled to participate in the discussion but will not be permitted to be involved in final decision making.
- Agenda items marked 'confidential' should not be disclosed outside the Steering Group without consent.

9. Meeting Frequency

The PNA Steering Group will meet, either on a face-to-face basis or virtually (conference call or email discussion), approximately every 4 - 6 weeks, in accordance with the needs of the project plan.

Following publication of the final PNA, the PNA Steering Group will be convened on an 'as required' basis to fulfil its role in timely maintenance of the PNA.

10. Membership

Membership needs to reflect that pharmacy commissioning involves: NHS England, Public Health & CCGs. Other members will be co-opted at different times to advise on different areas of work as needed.

The following will be members of the steering group:

- Assistant Director of Public Health for Haringey (Chair)
- Clinical Commissioning Groups (CCG) – Head of Medicines Management
- Local Pharmaceutical Committee (LPC) Lead
- Head of Primary Care – (CCG)
- NHS England – representative
- Health Watch representative for Haringey
- Senior Public Health Information Analyst
- Local pharmacy representation
- Webstar Lane (project management)

Co-opted members (to attend when required):

- Communications Lead for CCG and LBH
- Consultation Manager LBH
- Patient / Public involvement (PPI) Group Lead/s (patient association)

The PNA SG may co-opt additional support and subject matter expertise as necessary. In carrying out its remit, the PNA SG may interface with a wider range of stakeholders.

11. Quorum

- Chair (or nominated deputy)
- Community Pharmacist (LPC or local contractor)
- One other member (CCG, LBH, Healthwatch or NHS England)

12. References

1. The most recent PNA published by Haringey PCT in 2011 is available to steering group members upon request. They will be available in a PDF format at the 1st steering group meeting.

2. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/

3. http://psnc.org.uk/contract-it/market-entry-regulations/

4. “Healthy lives, healthy people”, the public health strategy for England (2010)

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