NOTICE OF MEETING

CABINET MEMBER SIGNING

Tuesday, 16th May, 2017, 10.30 am - Civic Centre, High Road, Wood Green, N22 8LE

Members: Councillor Claire Kober

1. FILMING AT MEETINGS

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2. URGENT BUSINESS

The Leader/Cabinet Member will advise of any items they have decided to take as urgent business.

3. 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

4. HARINGEY AND ISLINGTON WELLBEING PARTNERSHIP (PAGES 1 - 20)

5. HARINGEY'S DESIGN FRAMEWORK FOR INTEGRATED HEALTH & CARE (PAGES 21 - 54)

6. LATE ITEMS OF URGENT BUSINESS

As per item 2

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Monday, 08 May 2017

Agenda Item 4

Report for: Leaders Decision 16th May 2017

Item number: 4

Title: **Haringey and Islington Wellbeing Partnership Agreement**

Report authorised by: Zina Etheridge

Lead Officers: Tim Deeprose, Programme Director, Wellbeing Programme
tim.deeprose@nhs.net

Ward(s) affected: All

Report for Key/ Non Key Decision: Key Decision

1. Describe the issue under consideration

Organisations in Haringey and Islington have been working ever more closely together to address the health and care needs of the population. Service redesign, through integrated working, has shown that this approach enables better provision of services in the future. The organisations want to formalise this approach and are doing so by signing up to the attached Haringey and Islington Wellbeing Partnership Agreement **(Appendix 1).** At this stage, the agreement sets out the reasons for working collaboratively and the ways in which this may be done. It sets commitments to increased collaboration and timescales for achieving these milestones.

To support this approach and provide the local context there is a companion report - 'Haringey's 'Design Framework for Integrated Health & Care' that outlines how we have been working in partnership across Public Health, Adult Social Care and Haringey Clinical Commissioning Group to develop an approach that will ensure all adults in Haringey are able to live Healthy, Long and Fulfilling Lives. This will ensure that together we deliver our vision for all adults which places an emphasis on the values which promote and maximizes an individual's independence, wellbeing, dignity, choice and control, shifting away from institutional care towards community and home based solutions where appropriate.

2. Cabinet Member Introduction

Haringey LONDON

Health and care services in Haringey are under significant pressure. In a borough where there is already a life expectancy gap of seven years between residents in the more affluent west of the borough and those in the east, recent reductions in central government funding mean that the council faces *significant challenges in addressing health inequalities in Haringey.*

Overall the populations of Haringey and Islington have similar health and care needs and both face similar challenges to improving health and care outcomes for their residents. There are therefore significant opportunities for the boroughs to integrate health and care, and a range of organisations want to formalise this approach by signing the Haringey and Islington Wellbeing Partnership Agreement.

There are already many good examples of partners working collaboratively and delivering between services for the people of Haringey and Islington. In addition we are keen to deliver a range of improvements together in the future:

- People will be able to access care that allows them to be supported in their homes within 24 hours of being agreed as ready to leave hospital;
- There will be increased capacity in primary care and faster access to local services through four integrated care networks allowing people to be cared for in their own home;
- Physiotherapy will be provided in GP practices reducing need for onward referral to hospital and increasing the ability of primary care to manage patients in the community;
- The number of occasions when people have to be admitted to hospital or are placed in residential or domiciliary care will be reduced;
- Two test sites will be set up for diabetic patients, with quick wins such as a streamlined system of access to education and supported self-management.

By working in a different way, building on existing relationships between organisations across Haringey and Islington, partners are aiming to meet current challenges by providing more care outside of hospital where this is appropriate.

3. Recommendations

To agree that the London Borough of Haringey becomes a signatory of the Haringey and Islington Wellbeing Partnership Agreement which is attached as Appendix 1.

4. Reasons for the Decision:

The statutory Health and Wellbeing Boards in Haringey and Islington have been meeting in common for over 8 months and have agreed to meet as a single joint subcommittee from June 2017. The demographics, health and care needs of the people of the two boroughs are similar and benefits have been identified in tackling the challenges facing health and social care systems together. The Boards have also supported the development of a Partnership Agreement between partner health and care organisations in Islington and Haringey in order to better address service improvements.

The Partnership Agreement sets out the governance structure for health and care partners, working together, to deliver: better health and care services, to reduce inequalities and improve health and wellbeing outcomes for the people of Haringey and Islington. This agreement includes formal commitment to the Islington and Haringey Wellbeing Partnership Board which will be the forum through which system wide partnership working will be taken forward and will interact with a range health and social care groups to enable better delivery of services through closer working.

Community involvement is also a key factor of the governance structure and it includes a 'community reference committee' to ensure engagement, co-production and assurance of user involvement in service redesign. Local stakeholders are being supported to co- produce the stakeholder input to the Wellbeing Partnership governance arrangements.

A formal commitment to the Partnership Agreement is needed from the respective borough's decision making bodies and it is envisaged that any decisions arising from the Islington and Haringey Wellbeing Partnership Board, which is an informal body, would be taken back through the decision making structures of partner organisations.

This governance structure could also enable partners, in future, to work together towards the full collaboration of an accountable care system. Such sharing should build the base for future delegation of powers to the Partnership.

5. Alternative options considered

No other formal partnership arrangements with other boroughs have been considered at this time. Haringey and Islington councils are both facing similar health and care issues in their populations, are neighbouring boroughs and this agreement would build on the existing positive history of joint working between these boroughs. Not taking forward a partnership agreement would impact on the focus and structure of the organisations working together to tackle health inequalities and also mean that services such as education, housing, planning, which have a real impact on people's health and wellbeing, are not fully involved in a much needed wider approach to meeting the health and care needs of both borough's populations.

6. Background information

The populations in Haringey and Islington have many similarities, which are greater than the differences in health and care needs. For example, there are high levels of poverty, a bigger proportion of young people and high turnover of people moving in and out of the boroughs. And although life expectancy is increasing in Haringey and Islington, people live over 20 years in poor health and often require a lot of support from health and care services. This means that the organisations in Haringey and Islington are trying to address similar issues in each borough.

Across the country health and care organisations are being asked to work together in different ways, over bigger areas, in order to tackle the shared problems that are being faced by everyone. This includes high demand for services, not enough money, an ageing population who have a number of long term health conditions, and a system which is more centred on people being treated in hospitals, rather than supported in the community. There is also a lot of variation in the quality of community and primary care services across our boroughs and people's ability to access them.

There is a simple logic to working together to address these problems. We want to look at how we can invest our combined resources across health and social care to get the best value for people in our boroughs. There is a positive history of joint working between the organisations in Haringey and Islington; not just within each borough but also between the boroughs.

What do our local residents tell us?

Our engagement with local residents over the years has clearly shown us what's important to them and what they want from local services. The things we hear regularly include:

- People want services that are easy to access - the routes into health and social care are often confusing for people and there is a lack of clarity about what services are available amongst both communities and healthcare professionals.

- Most people don't like going to hospital and would prefer to be treated in or near to their homes.

- People want services that are joined up, and work together as one team, with the service user being the key team member.

- We need to improve services so they better meet the needs of people who face barriers when accessing services, particularly around languages, transport and homelessness.

- We need to improve our administration processes - people often face barriers or feel frustrated when trying to access services or appointments.

- There is a willingness among the local population to engage in activities with a focus on preventing health problems, supporting their own health and

wellbeing and managing their own conditions. However, we know that barriers exist which prevent some from taking these steps.

- People want services that promote wellbeing and reduce loneliness and want their physical health and mental health needs to be considered together.

- People want services that enable them to do things for themselves - they want to maximise the amount of time spent in good health and want services that support them to do things for themselves, promoting their independence.

- People want more use of the voluntary sector and recognise the important role it plays in supporting people's health, in both a formal and informal capacity. Social Care, CCGs and providers need to work more closely with grass-roots organisations that work within specific local communities and have built trust with residents. This could provide opportunities to improve the health and wellbeing of disadvantaged local communities by increasing the reach of prevention and early intervention.

How will we do this? What do we mean by working in partnership?

Partners will all share collective responsibility for meeting the health (mental and physical) and care needs of our population in the long term. We will:

- Make decisions about services and how we allocate our resources together
- Set priorities together
- Have joint programmes of work
- Share leadership
- Have common goals
- Pool our resources (budgets and staff) and manage money in a fundamentally different way
- Share risks and incentives
- Plan health and social care together
- Work without organisational boundaries
- Have a single decision making and accountability structure
- Provide proper integration across health and social care
- Think as a single system – rather than as commissioners and providers

What will the benefits be of working in this way?

- We believe that by coming together as a partnership and removing organisational boundaries, we will be able to focus on people's journey through the system as oppose to thinking as single organisations.

- Having councils involved in the partnership means that we will be able to work much more closely with areas like education, housing, planning – all things that have a real impact on people's health and wellbeing.

- We will be able to look across all partner organisations at how services are provided and identify opportunities to add value (by improving outcomes and reducing costs)

- We will be able to ensure that there is a consistent and high standard of service for everybody in both boroughs, particularly in community and primary care.

- We will be able to look at data and intelligence from all our organisations to understand our population better, and intervene earlier to help keep people well and out of hospital.

- We will be able to improve the communication and information sharing between different teams and organisations which will benefit service users, and make life easier for staff.

- We will share collective responsibility for the health and social care of the population and have shared budgets and staff teams which will ensure that services and care are much more joined up than it's ever been before.

Developing the Partnership Agreement

The Partnership Agreement has been developed through discussion in the Wellbeing Programme meetings and the most recent draft was circulated for Governing Bodies to discuss and comment on informally before the final draft was produced. Most organisations offered comments and amendments have been made to reflect those comments. They may be summarised as:

- Greater emphasis given to the aim of reducing inequalities and the aims of supporting communities as well as individuals

- Offering clarity that relevant budgets and services are included as several organisations deliver services outside Haringey and Islington

- A better emphasis on the role of social care in certain paragraphs

- Suggestions on managing situations where organisations do not appear to be acting for the collective good

- Improved wording to reduce health or social care jargon.

The final version of the Partnership Agreement, attached at appendix 1, has been presented to governing bodies in May 2017 for their approval and signature of membership.

7. Contribution to strategic outcomes

LBH membership of the Haringey and Islington Wellbeing Partnership will contribute to the following strategic outcomes:

Priority one - Enable every child and young person to have the best start in life, with high quality education
Priority two - Enable all adults to live healthy, long and fulfilling lives

8. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

Finance

Whilst the agreement proposes to align budgets and practises at a future date, there is currently no commitment to amounts at this stage, therefore it does not impinge on the Medium Term Financial Strategy.

It is anticipated however that these proposals will deliver efficiency savings in the longer term and be tabled in support of the Council's overall budget position.

When formalised proposals are available at a later date, these will be presented for agreement and subject to financial analysis where comments can be made.

Procurement

The Head of Procurement supports the recommendations made in this report. The recommendations align with Strategic Procurements mid to long term strategy of collaboration with other boroughs in the Health and Care Sector.

Haringey has recently rolled out a Dynamic Purchasing System (DPS) across a number of care related categories that are designed to be adopted by other Boroughs enabling Boroughs to move towards a single market place and obtain parity of prices and efficiencies across our regional partners. There is an opportunity for Islington to adopt the DPS as an early enabler to support the opportunities stated in this report.

Legal

The agreement sets out a number of commitments and targets by partners aimed at fostering a collaborative approach in strategic planning and decision making and to improve the health and care economy for residents across Haringey and Islington.

The commitments as they are developed and progressed may require formal partnership agreements between some or all the partners and will need to be managed in accordance with the partners constitutional and decision making framework.

Overall, the push in the agreement towards more collaborative working is in accordance with health and social care legislations which actively promotes health and social care integrated working and partnership arrangements to improve the health and wellbeing of residents.

The Haringey and Islington Health and Wellbeing Board Joint Sub-Committee should have strategic oversight of the Wellbeing Partnership arrangement.

Equality

The Council has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

a) Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act

b) Advance equality of opportunity between people who share relevant protected characteristics and people who do not

c) Foster good relations between people who share relevant characteristics and people who do not.

This duty covers the following protected characteristics: age (including children and young people), disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

An equality impact assessment is not needed for this decision but consideration will be needed in the governance process of how members of partnership will pay due regard to the Public Sector Equality Duty in an effective and proportional way when making decisions through the partnership.

Becoming a signatory of the Haringey and Islington Wellbeing Partnership Agreement will allow Haringey Council to provide more effective services and help reduce health inequalities for all protected characteristic groups, particularly older people, disabled people and children and young people.

9. Appendices

The Haringey and Islington Wellbeing Partnership Agreement final version 7.0 **(Appendix 1)**

10. Local Government (Access to Information) Act 1985

No background papers are included

Haringey and Islington Wellbeing Partnership

Health & Care: working together with the people in Haringey & Islington

Partnership Agreement

1st June 2017

Signatories

The following organisations support the Haringey and Islington Wellbeing Partnership.

Organisation	Council Leader / Chairman	Chief Executive
Haringey London	……	……
Islington	……	……
NHS Haringey Clinical Commissioning Group	……	……
NHS Islington Clinical Commissioning Group	……	……
Haringey GP Federation	……	……
Islington GP Federation	……	……
Camden and Islington NHS Foundation Trust	……	……
NHS North Middlesex University Hospital NHS Trust	……	……
University College London Hospitals NHS Foundation Trust	……	……
Whittington Health NHS	……	……

Haringey and Islington Wellbeing Partnership Agreement

Date effective: 1 June 2017

Signatories: 'The partners', the CEOs/Accountable Officers & Chairs of:

1. London Borough of Haringey
2. London Borough of Islington
3. NHS Haringey Clinical Commissioning Group
4. NHS Islington Clinical Commissioning Group
5. Haringey GP Federation
6. Islington GP Federation
7. Camden and Islington NHS Foundation Trust
8. North Middlesex Hospital NHS Trust
9. University College London Hospitals NHS Foundation Trust
10. Whittington Health NHS Trust

The Partners recognise that as the work of the partnership develops other organisations may wish to join or become more formally affiliated with the partnership approach embodied in this agreement.

Purpose

The Wellbeing Partnership has been established to enable local organisations to deliver better health and care services, to reduce inequalities and improve the health and wellbeing outcomes for the people of Haringey and Islington. It is working towards the integration of health and social care services in the boroughs in order to deliver these improvements. As a result, the Partnership will be better able to deliver, at a local level, the necessary service transformation to achieve a sustainable health and social care system. It will do this by building upon locally delivered initiatives such as the Care Closer to Home Integrated Networks.

The need for change

Haringey and Islington populations are 263,386 and 215,667 respectively. The populations are expected to grow by about %% over the n next 5 years but there will be a much bigger increase in the over 65 population of 12% over the same period. This is twice the national average. This rate of growth will put enormous pressure on social care and health services.

Poverty and deprivation are key determinants of poor health and wellbeing outcomes and major drivers of health inequalities. Islington and Haringey have high levels of deprivation relative to the national picture. Residents are more likely to spend less of their life healthy compared to the England average (approx. 20 years of their life living in poor health).

Funding for social care and health services will not increase to meet the growth in demand on services and the demographic pressures. Therefore, we must change the way we deliver services, preventing poor health and supporting individuals, families and communities to achieve healthier, happier and longer lives. When people need services we must ensure they are delivered effectively and efficiently, improving outcomes.

The current focus each organisation has to have on its own goals, structure, regulators and finances, with relationships based upon a contractual framework, continues to hinder effective collaboration, creating inefficiencies and constraining our collective ability to achieve more for the local population. All the organisations face potential financial deficits in future years and so continuing to operate independently is not an option.

The Wellbeing Partnership members see an opportunity to achieve this by working more closely together than is possible as separate organisations under the current NHS and local government financial and contracting systems. This provides a collective mitigation of risks faced by individual organisations within the system.

To help us achieve our vision for our residents we will now form a Wellbeing Partnership, a form of an Accountable Care Partnership, enabling us to move towards full collaboration between organisations in a measured way.

Objectives

The programme has set out a series of objectives.

- To take a whole population approach to health and care delivery.
- To support all of our residents to achieve healthier, happier and longer lives, with a focus on preventing poor health and improving outcomes when people do need care and treatment.
- To support people, families and communities to stay and be healthy, to reduce the level of ill health within our population and reduce health inequalities.
- To simultaneously focus on improving outcomes and reducing costs for population groups who are currently high consumers of health and care.

How will we do this?

The most important way relates to a new set of behaviours from all the Partners, in order to build longstanding trusting relationships that replicate those of an accountable care system.

- By shifting resources over the longer term towards prevention and early intervention to keep people well and avoid preventable ill health e impacting directly on the health and wellbeing of the population of Haringey and Islington
- By bringing together all our resources (including budgets), sharing budget information and taking collective decisions about their most effective use.
- By working together to redesign services in a different way using all the skills and experience available to us across our collective workforce recognising that these are not vested in one organisation or professional approach.
- By ensuring every organisation is seen to succeed through collective success.

- By developing using our collective information to create insight into how we can improve systems as a whole, where investment needs to go and to drive innovative ways of doing things.
- By improving service user experience as well as outcomes, efficiency and effectiveness we should reduce inequalities.
- By bringing teams together, acting on behalf of each other, to more efficiently use our staff.
- By working together with all our communities and the whole health and social care workforce we will accelerate the transformation of the health and care system in Haringey and Islington.
- By collectively taking budget decisions, agreement will be reached on levels of activity and cost, creating joint commitment to collective financial and activity targets. This should also reduce transaction costs between organisations.

Scope

This agreement does not seek delegated powers from its statutory partner organisations. It aims to develop collective decision making through a partnership forum where the impact of service change can be managed across the whole health and care system. Partners are therefore asked to share and align their decision making recognising that for some partners there are commitments outside the Haringey/Islington geography.

The range of services which might best be collaboratively managed in this way will become clearer as the partnership develops.

Timeframe

The expressed aim of the Wellbeing Programme's Sponsor Board members is to achieve full collaboration between organisations. This will take time as organisations move from partial to full collaboration. This agreement is a stepping stone to more formal future agreement as the confidence and level of collaboration increases. This particular agreement will expire on 31st March 2020 but is expected to be refreshed within a year, by 31st March 2018, to reflect the increasing levels of collaboration or when it is replaced by a more formal partnership agreement.

Commitment 1: One ambition: To meet the challenge facing the health and care system by working together as a single team to:

- Support local people, families and communities to take an active and full role in their own health and to reduce inequalities
- Focus on prevention and early intervention, to keep people well, realise their potential, avoid preventable ill health and promote resilience and independence
- Use the best, evidence-based, means to deliver on outcomes that matter
- Focus on what adds value (and stop what doesn't)

Public expectations are that health and social care organisations should be working together around the needs of individuals, so this approach is in line with that expected of each organisation.

In practice, the Partners recognise the pressures caused by current funding, structures and contracting mechanisms. To manage these conflicting pressure we commit to be honest, transparent and to provide mutual support of each other's position. Where possible we will influence the view of regulators or external assurance bodies about the importance of the partnership approach to future local system sustainability.

Commitment 2: One set of behaviours:

All Partners agree explicitly to exhibit the beneficial behaviours of an *accountable care system*. In particular, partner organisations collectively agree to:

- **People first**: solutions that best meet the needs of today and tomorrow's local residents and health and social care users must be the guiding principle on which decisions are made. This principle must over-ride individual or organisational self-interest. Embedding the voice and views of service users in service improvement will be key to ensuring this principle is not forgotten.
- **Collective decision-making**: Chairs, CEOs, SROs and clinical leads have dedicated time *face-to-face* to build trusting relationships, improve mutual understanding and to take shared strategic decisions together.
- As **system leaders**, Partners will work together with integrity and the highest standards of professionalism, by:
    - Recognising mutuality and equality of the partnership
    - Not undermining each other
    - Speaking well of and respecting each other
    - Recognising we are each trying to optimise performance in our own part of the system
    - Behaving well, especially when things go wrong
    - Keeping our promises - small and large
    - Speaking with candour and courage
    - Seeking success as a collective
    - Sticking to decisions once made
- **Open book**: finance (cost and spend), activity and staffing data are shared between all parties transparently and in a timely manner. The purpose of this sharing is to support collaborative problem-solving.
- **Common messaging**: there is a consistent set of messages we tell our service users, residents and our staff about why we need to work together, what benefits it

will bring and how we are doing it, although how the story is told will be tailored to the audience. Each partner organisation will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials.

- **Collective monitoring**: if an organisation appears not to be acting for the collective good, Chairs / CEOs will reflect this to the organisation and provide evidence to illustrate their concern. If there isn't a change in approach, in extremis, the organisation may be asked to leave the partnership.

Commitment 3: One Plan: Joint Strategic Planning:

Recognising the strong similarities in health profile of the population of the two boroughs, **Haringey and Islington Health and Wellbeing Boards** have agreed that they will meet as a joint committee from April 2017. This significant commitment to joint working immediately prompts greater integration of the two public health teams, potentially transforming the way health and inequalities challenges are approached.

All partners have individual corporate or operational plans, for example, recently working together with other boroughs as part of the North Central London Sustainability and Transformation Plan. Partners commit to aligning individual plans where joint working can optimise delivery of improved services in Haringey and Islington.

Target:

- Form a Haringey-Islington Public Health Leadership group by June 2017 to determine a process for developing a future operating model for integrated working.
- Bring together the iterative processes underpinning the Joint Strategic Needs Assessment as a precursor to establishing a single Health and Wellbeing Strategy for the two boroughs.
- Develop a single Health and Wellbeing Strategy for the boroughs of Haringey and Islington by December 2017.
- Review commissioned services and budgets between both boroughs by September 2017: providing a deeper understanding of the services commissioned and supported by both Public Health teams. In the future, this work will serve as a guide for
    i. which services might be jointly recommissioned to potentially improve outcomes for the populations for both boroughs and
    ii. which services would be better managed locally or with other arrangements.

Commitment 4: One transformation approach: bringing together our service redesign work: Currently each organisation has (or is part of) a separate service transformation programme linked to the need to meet their financial commitments. These include Cost Improvement Programmes within Trusts, Local Authority Transformation Programmes to meet their Medium Term Financial Strategies, and CCG and Trust input into the North Central London Sustainability and Transformation Plan.

The commitment within the Wellbeing Partnership is to bring together these often complementary work programmes to optimise delivery within Haringey and Islington in order to deliver the best possible services with the resources available. Work programmes proposed by any organisation will first be shared at the Partnership Board so that the impact on the local system can be understood and collective support given to

the project. The Partnership Board will act as a sponsor board to the project. Where the project has limited impact beyond the initiating organisation this process will ensure understanding of the redesign workload in each organisation.

Target:

- To share each organisation's transformation programme with Partners by 30 June 2017
- To align local authority social care transformation programmes by 30 July 2017
- To bring together existing service improvement projects undertaken by separate organisations where they are addressing similar cohorts of the population, conditions or diseases so as to optimise improvement work under the leadership of the Wellbeing Partnership by September 2017
- To assess, by July 2017, whether the Wellbeing Partnership needs a particular focus on workforce development, to add to the work being undertaken at NCL level.
- To develop a joint savings / service transformation plan for 2018/19 between Councils, CCGs and Trusts by October 2017 so that this can be built into each organisation's financial plan for 2018/19

Commitment 5: One delivery team: The Wellbeing Programme was established with a 'light touch' programme infrastructure as the majority of staff resource coming from the alignment of organisational and joint programme priorities. Partners commit to continuing this approach by prioritising joint service redesign and supporting this with staff as part of business as usual.

All Partners commit to using the Wellbeing Partnership as an opportunity to redefine the reporting relationships of staff within their own organisations to align with joint service redesign work.

Target:

- To establish by 30 June 2017, a single management lead across all organisations for specified services e.g. diabetes, with the autonomy to make system wide decisions to improve services. The role would have accountability to all organisations through the Partnership Board.
- To complete the alignment of the CCG management teams by September 2017
- To establish joint work on council transformation programmes and peer review priorities by September 2017
- To establish two Care Closer to Home Networks (CHINs) in each borough as local delivery teams by September 2017.

Commitment 6: One approach to quality improvement and a shared approach to performance improvement: As the Wellbeing Partnership Board develops as the forum for collective management of the health and care system, then partners commit to bringing together the separate quality improvement, performance monitoring and assurance processes where possible. Providing single returns from the Wellbeing Partnership will establish the organisation as a collaborative venture.

Currently, performance and assurance returns to external bodies are required separately from each partner organisation. Organisations continue to have statutory duties to fulfil and these will be maintained. However, whilst separate organisation or borough based data will continue to be required, there are also opportunities to compare data returns

and to bring together the processes or organisations responsible for providing that information e.g. NHS Commissioning Support Unit.

Target:

- To identify, by 30 September 2017, areas of best practice in quality and quality improvement and to share these across organisations.
- To establish by 30 September 2017, a set of performance indicators (ideally from existing data sources) which will help demonstrate increased collaborative working across the Partnership.
- To investigate joint measurement of service initiatives such as the Better Care Fund and shadow these from July 2017.
- To confirm existing data sharing agreements and ensure consistency, establishing new ones where needed by December 2017, so data can be used between organisations to improve and deliver services to users.

Commitment 7: One financial plan: in line with developing the positive behaviours of an accountable care system, and in recognition of the fact that one organisation's decisions about the level of service may impact another's costs, the Partners agree they will collectively focus on activities that take cost out, make agreed investments in order to save elsewhere, and manage financial pressure across the system. System costs may be reduced by activity reductions and by unit cost reductions, and we recognise that all Partners can influence both.

Acting in this way requires:

- Commissioning intentions will be based on a clinically led, evidence-based and person-focussed appraisal of how best to meet local people's need and will be based on coproduction with local people. Once developed, Partners will discuss openly within the Wellbeing Partnership Board any new service developments, closures or relocations prior to public and staff engagement and consultation as required. The Wellbeing Partnership Board and the workstream delivery groups will be the fora for agreeing commissioning intentions.
- Relevant financial and operational plans will be aligned across health and social care: the Partners agree to plan finances and operational capacity together, neutralising any inclination to cost shift or not invest in one part of the system to save elsewhere. This will involve working from common assumptions, producing plans for regulators that are realistic and doing our best to ensure there are no in-year surprises. Where appropriate, this will also include greater use of pooled budgets between NHS and council commissioners, which will be determined on a case by case basis.
- Contract negotiation activity will be minimised during 2017/18 and 18/19 with early collective CEO engagement to agree key investment priorities and risk sharing parameters at the outset (rather than at the end). Contract management meetings will be replaced with joint place or care programme based financial assurance, performance and planning meetings.
- It is clear that developing this level of collaboration will take time to enable partners to develop an understanding of each other's business, the sometime conflicting priorities each organisation faces and through this to develop trust and mutual support. The following milestones have been suggested to begin this process.

Targets:

- To establish a regular monthly sharing of budget (and activity data) at a level of detail that enables each organisation to understand how resources are being used to deliver health and care services from June 2017.
- To bring significant investment / disinvestment decisions (eg over £250k capital or annual revenue) to the Partnership Board where this investment relates to local services for the populations of Islington and Haringey, to enable partners to understand the impact such changes might have. This does not fetter an organisation's independent decision making autonomy but ensures one organisation does not make unexpected changes which negatively impact upon another (from April 2017).
- To establish system wide budgets for specific services e.g. for diabetes, MSK, to support the transformation work of the individual work streams (by April 2017).
- To shadow a single system 'control total', taking into account the fact that several providers run services that serve a wider population (from September 2017)

Commitment 8: One set of governance arrangements: the focus of the Wellbeing Partnership is on better delivery of services through closer working. The form of the Partnership (its governance arrangements) can support staff in that closer working arrangement. The Wellbeing Partnership Board and the groups reporting to it (e.g. Delivery Board, Finance and Performance Group, and service workstreams), will be the vehicle through which system wide business is conducted.

As much system wide business as possible will be conducted through the system governance described in the appendix below, particularly in those areas where there is a particularly strong system focus, such as care closer to home and out of hospital care to support admission avoidance. This provides the forum for sharing and aligning overall strategy and decisions. The power of the Partnership forum is based on the position power of the individual members and their commitment on behalf of their organisations to an agreed course of action. It is recognised that individual Partners' Boards or Governing Bodies have statutory accountability. Time will be allowed, when planning changes, to enable collective sharing and discussion.

Targets:

- To establish the overall governance arrangements as described below by 30th June 2017.
- To support local people to coproduce the community reference group by 30th June 2017.
- To consider alternative, stronger governance arrangements and organisational forms such as Multispecialty Community Providers (MCP) or Primary and Acute Care Systems (PACS) between September 2017 and March 2018.
- To refresh this Partnership Agreement for April 2018.

A Governance Structure is described on the next page. This continues to be developed, in particular:

- reflecting that certain programmes of work (e.g. CHINs/QISTs) will have system-wide impact and will act as the catalyst across a range of other areas
- local accountability through input from councillors and health organisation non-executive directors
- primary care leadership involvement at all levels
- co-production of the Community Reference Group with local service user groups.

Wellbeing Partnership Board *

- Sets strategic direction across member organisations and agrees local delivery of STP interventions and joint efficiency plans
- Holds accountability for delivery of outcomes
- Joint oversight of key financial decisions (funding, spend and savings)

Programme Delivery Board * (Clinical, professional & operational)

- Holds responsibility for implementation of the joint work programme
- Reviews and monitors progress across all areas and reports back to Wellbeing and other organisational Boards
- Ensures clinical / professional / operations leadership in place (including housing, voluntary sector etc.)

Community Reference Committee *

- Oversee community engagement & development, self care and communications throughout partnership and all workstreams
- Assure and measure community engagement & development, self care, communications & equality & diversity throughout workstreams, CHINS and partnership.

Prevention & Wider Determinants of Health

Population wide systematic implementation of prevention and maintaining independence initiatives – Support all programme areas to include focus on prevention, independence and wider determinants of health (children and adults)

Care Closer to Home (1 Care)	Urgent & Emergency Care	Mental Health	Learning Disabilities	Children & Young People	Elective Care
Wellbeing: CHINs, LTC management (diabetes & CVD)	**Wellbeing:** Frailty, intermediate care	**Wellbeing:** Prevention and Community Resilience; community MH	**Wellbeing:** Improving health, wellbeing & opportunities and consolidating costs	**Wellbeing:** Transition, A&E attendances, LTCs (e.g. asthma)	**Wellbeing:** MSK incl. community, (gastro. Is an area of need for both H&I?)

Information and Analytics

Needs assessment, population and service information and analytics, outcome monitoring, integrated digital care record and e-communication

Finance and Performance Group

Technical development & monitoring of shared savings & performance plans – Support all programme areas to develop finance, activity and impact models

*under development – see final paragraph on page 10

Report for: Leader's Decision 16th May 2017

Item number: **5**

Title: Haringey's Design Framework for Integrated Health & Care

Report authorised by: Zina Etheridge

Lead Officer: John Everson: Assistant Director of Adult Social Services
Ext: 4433, e-mail: john.everson@haringey.gov.uk

Ward(s) affected: All

Report for Key/ Non Key Decision: Non Key Decision

1. DESCRIBE THE ISSUE UNDER CONSIDERATION

Our vision for all adults in Haringey places an emphasis on the values which promote and maximizes an individual's independence, dignity, choice and control, shifting away from institutional care towards community and home based solutions where this is appropriate for the individual.

This paper sets out the progress made in developing a Design Framework for Integrated Health & Care in Haringey that seeks to enable this, ensuring all adults in Haringey are able to live Healthy, Long and Fulfilling Lives

It describes a framework between our public health prevention opportunities and our health and social care services that will help us address the demand and budget challenges faced by the system now and in the future

The Design Framework provides a shared point of reference for partners working across a complex and rapidly changing health and care landscape. Therefore ensuring a clear and consistent process and 'framework' to align the transformation and development of our health and care services, reducing the risk of fragmentation and missed opportunities to use limited resources more effectively.

It also underpins locally the work to develop the Haringey and Islington Wellbeing Partnership agreement which provides the opportunity to shape and integrate services across a wider footprint, and therefore accompanies this report to Cabinet.

2. CABINET MEMBER INTRODUCTION

Health and care services in Haringey are under significant pressure. In a borough where there is already a life expectancy gap of seven years between residents in the more affluent west of the borough and those in the east, recent reductions in central government funding mean that the council faces significant challenges in addressing health inequalities in Haringey.

Haringey's Design Framework for Integrated Health & Care provides a strong process and framework to align the transformation and development of our health and care systems. It also importantly represents a process that will help to keep our residents and those who use services at the centre of our decision-making and help us focus as a system on those people at risk of losing their independence and declining health.

Key to our efforts in creating a more sustainable health and social care system within Haringey is a greater focus on prevention activities with partners.

As a result of the approach outlined in this report the Council and its partners will be better able to support residents to access information and make healthier choices more easily; live more independent and fulfilling lives; receive responsive and high quality services from a range of networks; and have greater confidence that they will be safeguarded from abuse when receiving care.

3. RECOMMENDATIONS

3.1 To agree the approach set out Paragraph 6.9 and **Appendix 1** and that the Design Framework be used as the strategic point of reference in continuing to develop the Council's model of integrated health and care with key stakeholders and partners.

3.2 To agree the next steps set out in Paragraph 6.10 in the application of the Design Framework. That is to:

a. *Strengthen and align the Council and Haringey CCG approach to co-design*
b. *Establish shared governance arrangements with Haringey CCG to address shared challenges & opportunities*
c. Join-up analysis and services around different 'at risk' resident groups developing the Design Framework to reflect their specific circumstances e.g. those with Autism and Learning Disabilities and their carers.

4. REASONS FOR DECISION

Adult Social Care and Health partners in Haringey, Islington, North Central London, pan-London and Nationally are operating in a highly constrained environment, with demand projected to rise at a time when funding is under considerable pressure.

The changes that will determine the financial sustainability of local services and the quality of life for our residents requires action from a wide range of stakeholders, with health and care services aiming at the same outcomes of prevention and early help to maximise independence and wellbeing .

Residents and community groups have a central role in helping both develop and inform approaches, with all council services needing to have due regard for the way their policies and decisions can enhance, or hinder, the ability of our residents and communities to live healthy, long and fulfilling lives.

We need to address fundamental questions about how we use resources and deliver services differently with our partners and we need to continue to work on these challenges together. This agenda will only become more significant over the medium term and Haringey are playing a leading role in seeking innovative solutions as part of the Haringey & Islington Wellbeing Partnership and the NHS Sustainability and Transformation Plan across North Central London.

In that context, without a process and a framework to align the transformation and development of our health and care system, there is a risk of fragmentation and missed opportunities to use limited resources more effectively.

The Design Framework proposed in this paper provides a strategic point of reference for working across this rapidly changing landscape both as a council and with our partners. It will need to develop over time, for example to reflect the circumstances of those with more specific complex needs and their carers, but it represents a process that will help to keep our residents and those who use services at the centre of our decision-making.

5. ALTERNATIVE OPTIONS CONSIDERED

Initial thinking focused on the role of adult social services in developing a target operating model. However to continue with the design and development of adult social services without recognising the role of Public Health, Health and other key stakeholders, in shaping our work with partners within the Council, with local partners and across North Central London would risk fragmentation of health and care services and reduce the ability to coordinate resources for greatest impact across the local and wider system.

Secondly, developments to aim for a more fixed and detailed integrated target operating model across the whole health and social care system was also considered. However it's lack of flexibility with partners, feedback from stakeholders and opportunities to evolve our thinking together in a time of dynamic change helped to steer thinking towards a 'Design Framework' approach. This embeds our commitment to working closely with stakeholders in Haringey (such as Haringey CCG), into Islington (as part of the Wellbeing Partnership) and across North Central London (through the Sustainability and

Transformation Plan) to ensure our joint developments remain responsive and joined up as we move forward.

6. BACKGROUND INFORMATION

In June 2015, Cabinet approved a paper on developing a new Target Operating Model for Adult Social Services, which set out high-level principles for the redesign, aligned with three drivers for reform: the Care Act 2014; Priority 2 of the Corporate Plan 2015-18; and the Council's Medium Term Financial Strategy 2015-18.

These divers have guided management actions and developments since the paper was agreed, particularly focused on delivering MTFS savings such as a focus on supporting people to remain in their own homes rather than residential care and instilling an enabling approach with practitioners as part of their practice . However the significant pressures on the health and social care system locally (as nationally) has provided the catalyst to drive forward the development of a clear design framework for health and care with Public Health and Haringey CCG to increase the scale and pace of our developments across the health and social care system.

Haringey is therefore ambitious to drive transformation, recognising we are operating in a very dynamic environment, in which we are trying to develop a model of integrated health and care that is *broader* than just delivering and commissioning as a single borough, and *deeper* than the traditional focus on health and care services.

Our ambition is not only reflected in the joint development of Haringey's design framework across Health and Social Care in Haringey, but also in the development of the Haringey and Islington Wellbeing Partnership agreement which provides the opportunity to shape and deliver transformational impact across a wider footprint - as outlined in; 'The *Haringey and Islington Wellbeing Partnership Agreement'*

Within this emerging context we recognise the interdependency and immediate opportunities presented by both programmes, and are seeking to take advantage of, and build on, work that can be joined up or integrated to deliver the greatest impact on demand and costs, whilst improving the health and wellbeing of our communities.

6.1 Vision

Our vision for all adults in Haringey, and the guiding principle for all service transformation places an emphasis on the values which promote and maximize an individual's wellbeing, independence, dignity, choice and control, shifting away from institutional care towards community and home based solutions where appropriate.

This approach is embodied by Priority 2 of the Corporate Plan, which seeks to 'empower all adults to live healthy long and fulfilling lives', and is underpinned by

the following objectives:

1) A borough where the healthier choice is the easier choice
2) Strong communities where all residents are healthier and live independent fulfilling lives
3) Support will be provided at an earlier stage to residents who have difficulty in maintaining their health and wellbeing
4) Residents assessed as needing formal care and /or health support will receive responsive high quality services
5) All vulnerable adults will be safeguarded from abuse

6.2 Challenges

The funding and demand challenges facing health and social care are severe. A key reflection of the challenge for Haringey Council is that it is estimated that in adult social care services the natural demand trajectory represents the equivalent of a c4% increase in costs every year. This is driven by increasing complexity of care needs for working age adults (LD, MH, PD), an ageing population, with large projected increases in the 65+ population, and rising prevalence of long term conditions, including dementia, diabetes and depression requiring more complex, and longer term interventions. At the same time Government funding to the local authority continues to shrink year on year.

Additionally Haringey's population faces levels of deprivation and health inequalities that are more comparable to the profile of inner-city, rather than suburban areas, yet Haringey has a comparatively smaller funding base to spend on adult care services than neighbouring inner city boroughs.

6.3 Evidence-based transformation

In response to the challenges we have put in place rigorous and systematic actions since early 2016. This included putting in place immediate measures to realise saving requirements, implementing service improvement approaches to provide strong foundations for next step developments, as well as building up engagement between Adult Social Services, Public Health and Haringey CCG to secure a consensus around the actions that could guide us coherently towards a more financially sustainable health and social care system.

Haringey's approach places an emphasis on moving towards services that promote and maximize an individual's independence, dignity, choice and control, shifting away from institutional care towards community and home based solutions.

This has been informed by evidence from the sector and from working with respected experts in the field, such as Professor John Bolton. As an indication of ambition for adult social services, the evidence suggests that if the early help offer is targeted and robust it can help support up to 75% of all adult care contacts without the need for formal support. It goes on to highlight that if the 'front door' to adult services and the reablement and rehabilitation offer is strong, it can take the percentage of those not requiring longer term support to 90%.

This evidence has pointed us towards developments (already delivering positive impact in other Local Authorities) that we have been able rapidly to learn from and begin to apply, in building the foundations for our approach. These include the following examples:

- Improving our 'front door' to services systems, processes and staff location to deliver better information, advice and guidance so that more contacts can be dealt with and, where appropriate, supported away from Adult Social Care. This has also included the redesign and continuing development to content and layout of Haricare and the Haringey Advice Partnership coming on line delivering IAG services.
- Ensuring more appropriate referrals are considered for reablement or short term packages of care that can support service users towards independence.
- Developing new approaches and improving the skills mix in hospital discharge teams to reduce unnecessary referrals to social care from hospitals.
- To inform the future model of Adult Social Care services we have instigated new approaches to delivering reviews to ensure we are maximising the wellbeing and independence of people in receipt of care, and only providing the best targeted and enabling support for the period it is required.
- To provide a stronger demand and performance management approach we have developed and introduced the Adult Social Care Performance Tracker. This has required considerable improvements in data recording and management and provides key measures that will allow the service to track and evidence the impact from remodelling and developing/improving services areas.

6.4 Developing an Integrated Approach

The evidence and the foundations that we developed reinforced the need to work in radically different ways to ensure we can address the medium and longer-term demographic, demand and cost pressures.

Therefore in 2016 we agreed a genuinely transformational approach between Adult Social Services, Public Health and Haringey CCG to ensure our vision of maximising wellbeing, independence and managing future demand pressures, whilst moving towards financial sustainability, would be delivered.

The road-map to the achievement of this was initially developed as part of an Integrated Target Operating Model (ITOM) project. This helped us to start to set out a clear and joined up framework for developing interventions to support adults who may develop or have health and care needs.

In particular, it started to provide a more coherent link between our Public Health prevention opportunities and our health and social care community support, early intervention and responsive high quality service intervention options; all of which are underpinned by the need to safeguard those people who are most vulnerable within our communities.

6.5 Mapping 'as is' services

To develop this approach further and to better understand the baseline from which a future model would be developed, we undertook a comprehensive 'As Is' service mapping that provided a detailed picture of the existing user pathway through Adults social care. This particularly highlighted the way the current configuration of services (including Front Door, hospital discharge, assessments and reviews) had limited the ability of Adult Social Services to manage its demand at an earlier stage and support people towards shorter-term support that maximised and maintained their wellbeing and independence.

In addition we were able to develop a comprehensive picture of the commissioning spend across the council, CCG and others (such as Homes for Haringey) that allowed us to map spend by commissioning and/or delivery organisation, service user group (e.g. mental health, learning disabilities, substance misuse), Prevention type (i.e. primary, secondary and tertiary) and Service type.

This provided a much clearer view of the health and social care pathway as it currently stands and has been overlaid with the existing and pilot activity to ensure that new opportunities identified throughout this process could be aligned with projects already in progress.

6.6 Embedding prevention

The centrality of prevention and early help to our approach guided innovative work that for the first time provides a clear guide for how prevention activities and services should be embedded.

This was consolidated into the 'Prevention pyramids', which forms a key part of our integrated design framework, showing how the prevention offer fits with the health and social care pathways and how key services commissioned and/or delivered across the council, CCG and partners, map across primary, secondary and tertiary prevention. This is explored in more detail in section 6.11.

6.7 Coproduction and Member Engagement

Coproduction and engagement with service users, carers, staff, Members and partners has been key in gaining an understanding of what is important to people to help them maintain their health and independence and to steer the development of our future ways of working.

Building on the feedback provided through the Better Care Fund programme and Haringey Council's Corporate Plan development a series of coproduction opportunities were held over the last twelve months, including stakeholder engagement workshops, one to one service user telephone interviews and Members Learning and Development Sessions.

These were in part designed to inform a strategic set of pithy, meaningful and readily understood statements that reflected, from an individual's perspective, what good looks like. These have been referred to as 'I statements' and are reflective of the Think Local, Act Personal approach outlined in *Making it Real - Marking Progress Towards Personalised Community Based Support,* which can be reviewed on the following link:

http://www.thinklocalactpersonal.org.uk/_assets/Resources/Personalisation/TLAP/MakingItReal.pdf

Collectively these statements are a starting point to begin to convey our shared ambition for Adult Social Services, Public Heath and Health Services and explain how we will deliver on this. Our discussions with the Adult Social Care Planning and Oversight Steering Group have identified the need for these "I statements" to be developed further in the next steps, in order to fully reflect for example, the circumstances of those with more complex needs and their carers, recognising that the current statements are more generic rather than specifically tailored at this stage.

We recognise that coproduction and engagement with stakeholders is not a one-off activity but rather part of an on-going conversation. Therefore we committed with partners and stakeholders to develop and improve our approach to co design to both inform next step developments and measure the impact of implementation. This will ensure that those people affected are an integral part of all developments and evaluation, reflective of the disability rights movements' slogan of *'No decision about us, without us'.* This is outlined in more detail in section 6.12

6.8 Haringey's Design Framework for Integrated Health and Care

Taking all of the information, feedback and learning gathered in the development phases of this work we recognised with partners in December 2016 that seeking to define a single and fixed 'integrated target operating model' across health and social care would not provide the flexibility required in such a changing and dynamic environment.

However we also recognised that to avoid the risk of fragmented or poorly aligned service development across the health and care partnership, we should use all of the work to date to inform a 'Design Framework for Integrated Health and Care' that would provide us with a shared and agreed point of reference to guide health and care transformation and development.

Therefore we have amalgamated all of our work to date into Haringey's Design Framework (**see Appendix 1**). This offers us a common language and a conceptual model around the need to consider the health and wellbeing of the whole population (set out in the Prevention Pyramid), a set of guiding principles to test the strategic orientation of our projects (set out in the Design Principles) and offers an initial version of the 'target user experience' and outcome metrics that we are aiming towards (set out against the Priority 2 objectives from the council's Corporate Plan).

This approach is not designed to be a single way of approaching transformation or service development, but we are proposing with Haringey CCG to apply it as a valuable point of reference as we seek to progress work with local partners, in other boroughs and with other services and sectors more widely.

To this end the design framework and its intended use, and proposed next steps have been agreed and endorsed to progress (pending Cabinet endorsement) by

Haringey CCG as part Joint Executive Team with Haringey Council and at the CCG Governing Body seminar.

6.9 Haringey's Design Framework – Three Key Components

A summary of the development of Haringey's Design Framework to date (slides 1 to 4) and the key components of the framework (slides 5 to 15) are represented in a presentation attached as **Appendix 1** for consideration. The following provides some additional narrative with regards to the key components to support the presentation.

The Design Framework contains three key components that we will continue to develop and build on with our partners and stakeholders across Haringey, as well as with Islington and the wider North Central London. The components are:

A. **The 'Prevention Pyramid'**

The 'Prevention Pyramid' sets out our whole population approach to health and wellbeing, reflecting the need to consider how we can support healthy, long and fulfilling lives for everyone by preventing or intervening early.

It sets out the contribution that is made to health and wellbeing by what happens in and is provided by partners within our communities and the overall policy and place-shaping decisions we make.

An example for those who are at risk of or have suffered a stroke is set out to highlight what and where we are undertaking across health and care to strengthen prevention and management of this condition.

In addition there are different health conditions (e.g. diabetes) and groups of vulnerable people (e.g. those with a Learning Disability or who are frail), where mapping our whole population approach to developing and allocating resources will help us deliver maximum impact for those at risk. In consultation with stakeholders it was recommended that developing these should be part our next steps.

B. **Design principles**

The design principles provide the criteria for all of our system wide development and transformation to ensure strategic fit of each of the parts to the overall direction of travel for health and care.

The principles reflect how we know our offer needs to change if we are to balance the constraints and the aspirations we have for health and care.

- **Prevention** – taking every opportunity to support healthy and fulfilling lives by preventing the emergence or escalation of health and care needs and reducing the long-run need for services
- **Stronger in communities** – working with residents, the voluntary sector and providers to ensure more of their needs can be met in a community setting and reflect their personal networks and relationships
- **Maximising wellbeing and independence** – helping residents, patients and service users to find ways to maintain control of their lives and their health and to receive services that are proportionate to changing needs and capabilities
- **Integrating health & care** – designing and commissioning services jointly so that resources are allocated in the most effective way and residents' experience of maintaining or regaining their health and independence is joined-up and supportive
- **A fair & equal borough** – recognising the diversity of our communities and how different groups experience risk and vulnerability so that we can reduce inequalities in their health and wellbeing
- **Co-design** – ensuring that we actively engage and work with all stakeholders in identifying the detailed models of future services and how we will be using our resources, in particular working with users, carers and their representatives in a transparent and evidence-based

C. **Objectives and Outcomes**

The Objectives and Outcomes are based around the five objectives for Priority 2 in the Council's Corporate Plan and are designed to ensure that we develop the right interventions, at the right time, in the right place to enable people to live healthy long and fulfilling lives.

We have developed and are committed to continue to evolve the strategic set of person-centred 'I statements' that summarise our shared aspirations for how Haringey residents will experience integrated health and care. In many cases, these do not describe the system as it currently works for people but indicate how we think it needs to work in future and how we can test it reflects what people tell us is important.

We have also revised the outcome metrics for each objective to ensure we are aligning our transformation work with the outcomes that matter most.

We recognise that the Design Framework in its current form cannot reflect the diversity of experience or needs of our population, particularly those who need specialist services, so we are recommending that we build on the strategic framework by exploring with service users and carers how it applies to different groups of vulnerable people.

6.10 Applying the Design Framework & Next Steps Recommendations

As described Haringey's Design Framework has been developed to provide a point of reference and set out our ongoing process and approach to whole system transformation. As such, there are a number of next step developments that follow from endorsing this approach that we are recommending with Haringey CCG:

A Strengthening and aligning our approach to co-design

Co-design has been established as one of the design principles that will determine how we develop our future health and care models. Through working with the Adult Social Care Oversight and Planning Group, which is made up of user and carer representatives, the chair of Healthwatch and senior officers, we are defining and affirming this as central to our way of working in future.

It is recognised that Co-design involves a commitment to ensuring that service clients and carers (experts by experience) are involved at the beginning of a process, working with professionals on an equal footing with the same value being given to everyone's contribution.

A co-design culture in an organisation takes time to develop and embed as it involves a very different way of working, defining and valuing knowledge. Professionals have to accept that they are not the sole experts on the subject and they need to be skilled in active listening and working as equals in mixed groups of other professionals and experts by experience.

Commitment to co-design involves forward planning to identify all those future activities where this approach will be appropriate and to give time to recruit suitable experts by experience. There is significant transformation underway across adult social care and health services currently generating a range of different opportunities for engagement and co-design, which needs effective oversight and coordination.

We are therefore reviewing jointly with user and carer representatives whether our current arrangements for resident involvement provide the oversight and the opportunities for co-design required to deliver on the principle in the Design Framework.

In particular we will be seeking balanced representation from those with varying experiences, including users of mental health services and patient representatives via the CCG to inform the co-design of integrated health and social care services.

We are still developing and agreeing the practicalities of taking this forward but in principle we would look to embed a clear and transparent coproduction approach throughout all integrated care developments. This would include evolving the 'I Statements' further to get a deeper understanding of the resident experience and helping shape approaches that ensure adults in our communities have healthy long and fulfilling lives.

Appendix 2 'The Principle of Co-Design' prepared by the Adult Social Care Oversight and Planning Group, begins to set out our discussions and direction of travel in developing a shared commitment.

B Establish shared governance to address challenges & opportunities

Agreeing the design framework as our approach for developing integrated health and care will place us in a stronger position as the national and regional landscape changes.

Strategically, as an example, ensuring that the health and care system in Haringey (and across wider footprints) is able to demonstrate its maturity in terms of integration will become more important as part of the emerging 'Integration 2020' agenda.

Details of how we will be tested against this have not yet been published but as one of three pilot sites nationally, informing the DoH integration 'balanced scorecard', we do know that the components in the design framework are consistent with early indications.

We also have a number of important and complex local agendas that are driven by the Sustainability and Transformation Plan for North Central London, notably the development of Care Closer to Home Integrated Networks. The design framework will help to make explicit the design principles and user experience that should be considered in developing an effective model for Haringey.

As this and other developments will be reliant on clear governance and accountability structures across partners it is recommended that we establish a 'design authority' across the programme and with partners.

This will ensure programme-level oversight of how our projects (including those being implemented jointly with the CCG, Islington or NCL) are incorporating the design principles and are aligned to any agreed 'I statements' and outcome measures.

C Joining-up analysis and services around different 'at risk' resident groups

As outlined in section 6.11, in developing the 'Prevention Pyramid', the value of understanding and mapping our whole population approach to different health conditions and vulnerable groups of residents is regarded as an important next step.

This will ensure that we both develop and allocate resources that will help us deliver the best outcomes with the resources we have. Those groups of people where this has been highlighted as important include those with, learning disabilities, mental health conditions, people who are becoming frail, and those at risk of CVD & diabetes. However we will work with partners and stakeholders, using the evidence of where we should be targeting our effort to inform next steps.

7. CONTRIBUTION TO STRATEGIC OUTCOMES

The Design Framework for Integrated Health & Care builds directly upon the strategic outcomes and objectives set out in Priority 2 of the Corporate Plan 2015-18. Developing the framework has required and enabled extensive discussion with CCG colleagues about the shared contribution of the council and health services to the Priority 2 outcomes, many of which relate directly to the

health and wellbeing of our residents (for example, prevalence of hypertension) and to the effectiveness of local services (for example, delayed transfers of care).

The Design Framework also builds upon the cross-cutting themes in the Corporate Plan through the Design Principles, which will support officers, Members and partners in testing that the design of future services is aligned to our overall strategic direction of travel in a way that is clear and consistent. In particular, the principle of prevention and the related development of the prevention pyramid as a conceptual model for evaluating our local offer has provided a significant additional contribution to the prevention and early help theme from the corporate plan.

8. STATUTORY OFFICERS COMMENTS

Finance:

The Design Framework for Integrated Health & Care will facilitate the achievement of the council's Priority 2 strategic objectives and MTFS outcomes and enable the development of a sustainable adult health and social care system. These will be driven by improved partnership working and co-production which will enable more effective use of available resources.

Procurement:

Strategic Procurement notes the contents of the report. The Design Framework approach and focus on integrated working and co-production with the Council's stakeholders and partner agencies is both ambitious and welcome.

Importantly, the outlined approach will maximise efficiencies and resources in the design, delivery and implementation of wide ranging, transformative care and health strategies, focussed on enablement and prevention. This should create the deepest impact on the health and well being of the borough's adult community enabling them to live, healthier, independent and fulfilling lives in a challenging demographic and fiscal environment

There are, however, no procurement implications at this stage.

Legal:

The Design Framework which includes promoting individual wellbeing and independence, prevention and co-production/co-design would facilitate the discharge of the Council's obligations under the Care Act 2014. The integrated approach with Haringey CCG is in accordance with health and social care legislations which actively promotes health and social care integrated working and partnership arrangements to improve the health and wellbeing of residents.

Equality:

The Council has a public sector equality duty under the Equality Act (2010) to have due regard to the need to:

a) Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act

b) Advance equality of opportunity between people who share relevant protected characteristics and people who do not

c) Foster good relations between people who share relevant characteristics and people who do not.

This duty covers the following protected characteristics: age (including children and young people), disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The Design Framework will help the Council develop and deliver more effective health and adult social care services that meets the needs of residents, promotes independent and healthy living and supports these services in a financially challenging climate.

The nest steps in developing the framework include:

a) Strengthen and align our approach to co-design: Consideration will be needed to ensure all groups are encouraged and able to participate in the co-production process, including offering reasonable adjustments when appropriate
b) Establish shared governance arrangements to address shared challenges and opportunities: Within governance arrangements, consideration will be needed to ensure that the decision maker(s) are able to pay due regard to the Public Sector Equality Duty in an effective manner
c) Join-up analysis and services around different ‘at risk’ resident groups developing the Design Framework to reflect their specific circumstances: Consideration will be needed to ensure this incorporates the needs and inequalities experienced by people with different protected characteristics.

9. APPENDICES

Summary of Design Framework Presentation (Appendix 1)
The Principle of Co-Design Paper (Appendix 2)

10. Local Government (Access to Information) Act 1985

No background papers are included

Haringey's Design Framework for Integrated Health & Care

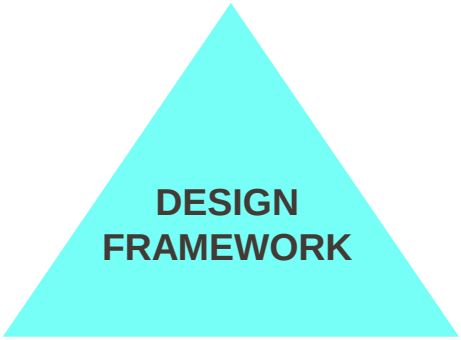
Summary – April 2017

Background

The scale of the demand and financial challenges for health and social care, driven by demographic changes and national spending decisions, has driven a new approach to designing our future local services. Since April 2016 there has been significant engagement between health, public health and social care to define a model for integrated health and care that can improve outcomes for residents as well as move our services towards financial sustainability.

Recognising the complexity of the system we are seeking to change, we have developed a Design Framework to ensure that we have a shared point of reference for defining and agreeing how we use our resources and design our services in the future. This with help us to navigate consistently between where we are starting from, the aspirations for the system and the significant constraints we are working within.

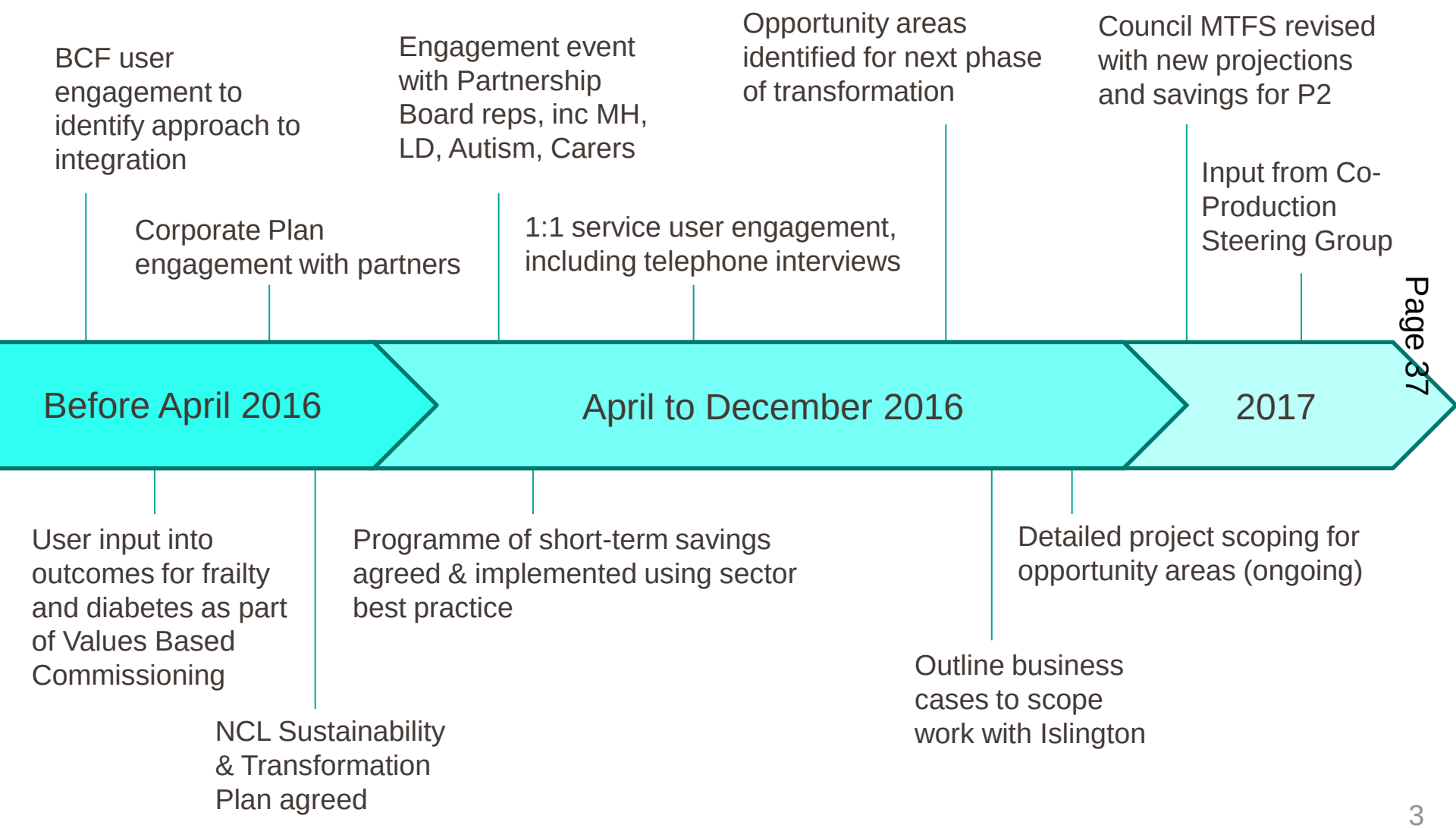
Where we are now
-Progress to date
-Budget position



Where we want to be
-Vision & objectives
-'I statements'
-Outcome measures

What the constraints are
-Financial pressures
-Demographic pressures
-National & regional expectations

Inputs to the design framework



Engaging at different levels

The Design Framework is a living document that will inform but also be shaped by our transformation. It will be used as a starting point as we work across different scales to design future health and care services with Islington and other boroughs in North Central London. It will also be used to engage other Haringey stakeholders in our strategy for health and care, including other council services, community groups and residents themselves.

*Our future health and care model needs to be **broader**, to reflect the benefits of delivering or commissioning for larger populations.*

*Our future health and care model needs to be **deeper**, reflecting the need to address population- and community-level determinants of health outcomes as well as the design & quality of services.*

Haringey's Design Framework for Integrated Health & Care

Three Key Components

Elements of the Framework

The Design Framework contains three elements that we will continue to develop and build on with our partners and stakeholders across Haringey, as well as with Islington and the wider North Central London.

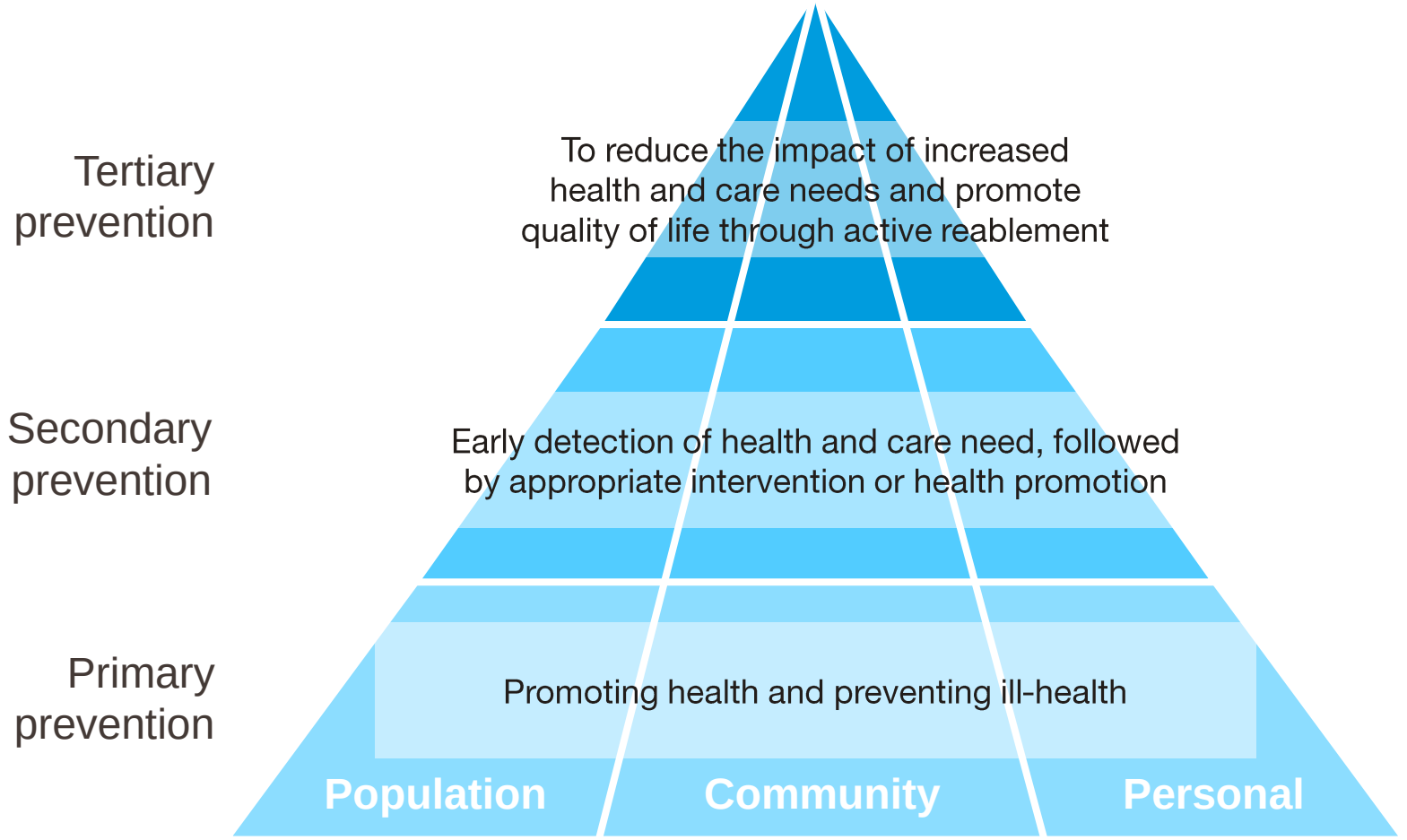
1. Prevention pyramid – sets out our whole population approach to health and wellbeing, reflecting the need to consider how we can support healthy, long and fulfilling lives for everyone by preventing or intervening early; it also sets out the contribution that is made to health and wellbeing by what happens in and is provided by our communities and the overall policy and place-shaping decisions we make.

2. Design principles – these provide the criteria for all of our transformation to ensure strategic fit of each of the parts to the overall direction of travel for health and care; the principles reflect how we know our offer needs to change if we are to balance the constraints and the aspirations we have for health and care.

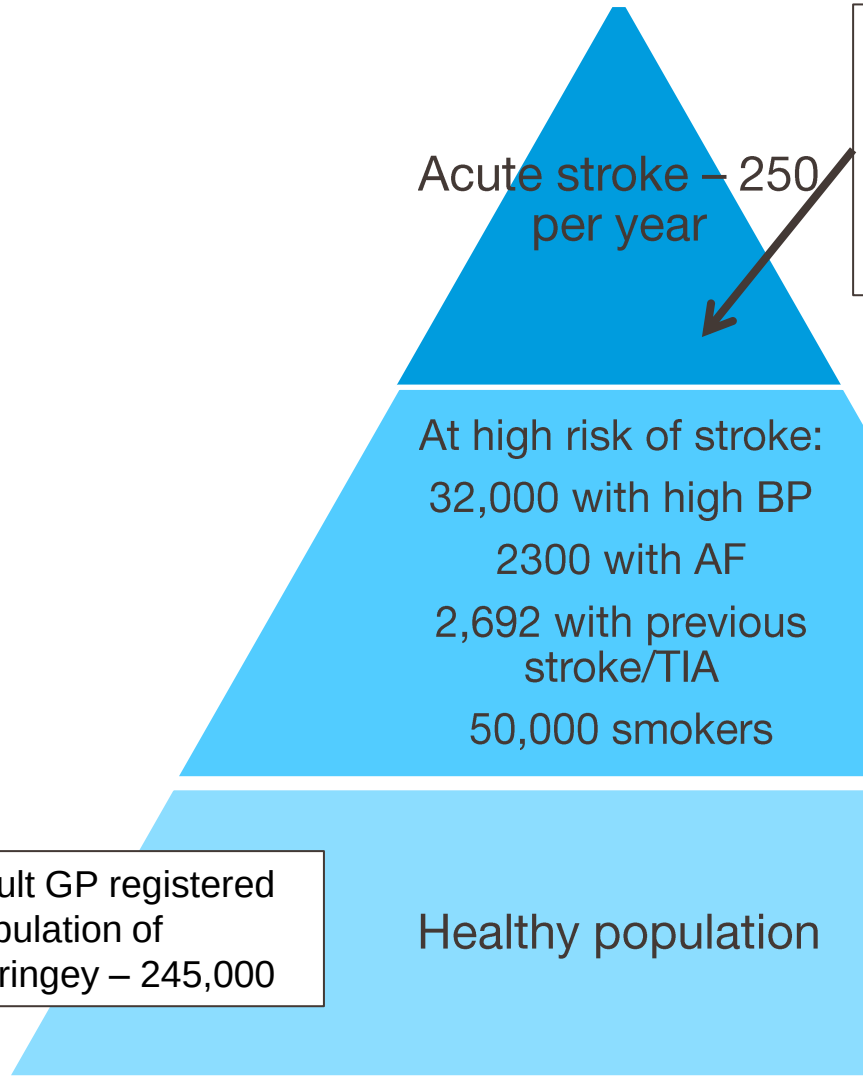
3. Objectives and outcomes – based around the five objectives for Priority 2 in the Corporate Plan, we are developing a set of pithy, person-centred 'I statements' that summarise our shared aspirations for how Haringey residents will experience integrated health and care – in many cases, these do not describe the system as it currently works for people but indicate how we think it needs to work in future. We have also revised the outcome metrics for each objective to ensure we are aligning our transformation work with the outcomes that matter most.

We recognise that the Design Framework in its current form cannot reflect the diversity of experience or needs of our population, particularly those who need specialist services, so we aim to build on the generic framework by exploring with service users and carers how it applies to different cohorts.

The prevention pyramid – our whole population approach to health & wellbeing



Example: taking a whole population approach to stroke – prevalence of need



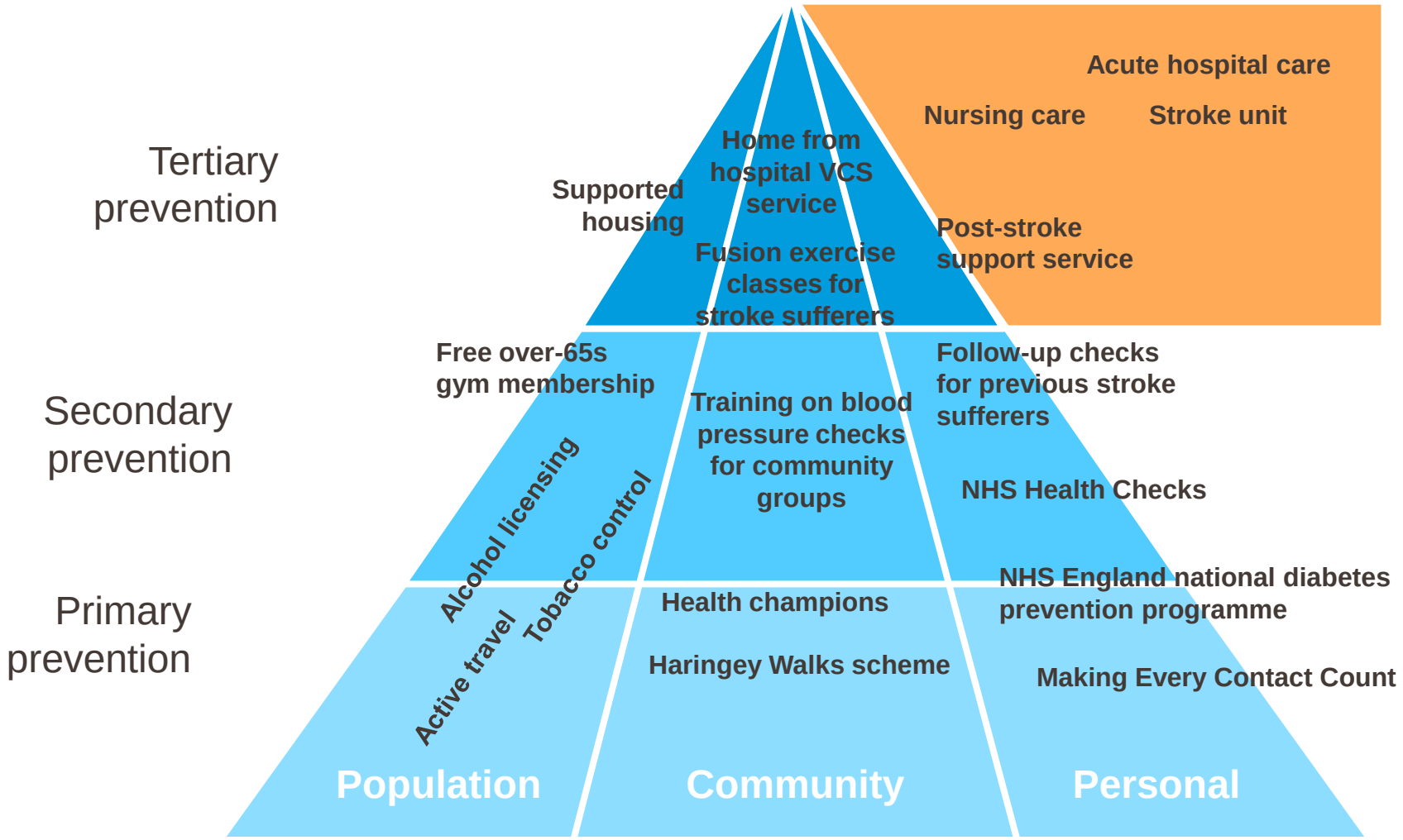
- Estimated annual cost of care following acute stroke in Haringey - £6.2million.
- Focus in London has been on centralising stroke services
- Has resulted in 1% reduction in mortality and cost savings

- Care for this cohort happens in primary care
- Quality of care variable
- Less focus on intervention and improvement at this level, but 80% of strokes preventable,
- Little investment beyond core primary care contracts – cost of care not known

- Public health programmes financed by local government
- less than £1 million on CVD prevention

Adult GP registered population of Haringey – 245,000

Example: taking a whole population approach to stroke – our current offer



Design Principles

There are six guiding principles that underpin our integrated vision for health and care in Haringey:

- **Prevention** – taking every opportunity to support healthy and fulfilling lives by preventing the emergence or escalation of health and care needs and reducing the long-run need for services
- **Stronger in communities** – working with residents, the voluntary sector and providers to ensure more of their needs can be met in a community setting and reflect their personal networks and relationships
- **Maximising independence** – helping residents, patients and service users to find ways to maintain control of their lives and their health and to receive services that are proportionate to changing needs and capabilities
- **Integrating health & care** – designing and commissioning services jointly so that resources are allocated in the most effective way and residents' experience of maintaining or regaining their health and independence is joined-up and supportive
- **A fair & equal borough** – recognising the diversity of our communities and how different groups experience risk and vulnerability so that we can reduce inequalities in their health and wellbeing
- **Co-design** – ensuring that we actively engage all stakeholders in identifying the detailed models of future services and how we will be using our resources, in particular working with users, carers and their representatives in a transparent and evidence-based

We are supporting people to make positive, informed choices about their health and wellbeing

Objective 1
A Borough where the Healthier Choice is the Easier Choice

- I find it easy to make healthy choices about the way I live my life, regardless of where I live in the borough, and often I don't even realise I make these choices.
- I have access to information and support to keep myself healthy and safe or take steps to address any unhealthy behaviours.
- I live in a borough that is inclusive and works to reduce inequalities in the health and wellbeing of its residents.

- Mortality Rate from Cardiovascular Disease (CVD) in people under 75
- Excess weight in Adults
- Smoking prevalence in adults
- Hospital admissions for alcohol-related conditions.
- Number and proportion of residents with undiagnosed and uncontrolled hypertension
- Acute STIs (including all STIs)

Progress to date

- Adopted 'health in all policies' approach within the council, recognising the impact of decisions such as licensing and planning.
- Established the Obesity Alliance and engaged a wide range of local stakeholders in recognising and challenging causes of obesity.
- Roll-out of 'healthy schools' accreditation.
- Initiated a pilot intervention for people on sick leave due to mental health to support improved outcomes returning to work.
- Offered free gym membership for over 65s to promote healthy and active lifestyles
- Established Haringey Walks initiative and campaigning.

Our future model

- Increase the council's powers to create healthy environments locally through clear asks of central government on devolution of powers.
- Work with our regeneration and housing colleagues to incorporate healthy design and planning principles into future developments.
- Improve the quality and amount of information & advice available to residents for healthy living, working with the CCG
- Working with local health providers, including hospitals, to recognise and affect the wider determinants of health.
- Develop the ability of the local workforce to 'make every contact count' for improving health behaviours

We are working with our communities and the voluntary sector so they can support wellbeing

Objective 2
Strong Communities, where Residents are Healthier & Live Independent, Fulfilling Lives

- I come together with other people to find ways we can support each other or make our neighbourhoods a healthy more fulfilling place to live
- I enjoy the support of others with similar interests and challenges to myself, so we can support each other to have full and meaningful lives
- I have a network of people who care for me – carers, family, and friends – in addition to any support staff I might required.
- I feel welcomed in my local community and valued for the contribution I can make
- I know where to get information about what is going on in my community.

- Proportion of residents that reported high or very high levels of life satisfaction
- Proportion of individuals who had participated in voluntary work in the past 12 months
- Proportion of carers whose health had been affected by their caring role
- Number of members for Time Credits schemes

Progress to date

- Haringey Advice Partnership established with Citizen's Advice to provide a first point of contact in the community for information, advice & guidance
- Updated and improved the availability of information about community groups and services on Haricare, reducing the number of unnecessary calls to Integrated Assessment Team
- Appointment of a strategic partner, Bridge Renewal Trust, to help develop community assets and build capacity in the voluntary sector.

Our future model

- Information and signposting to an up-to-date directory of community services online
- Delivering more of our health and social care services in community settings to improve links, including Care Closer To Home Integrated Networks
- Local area coordination, with a particular focus on MH & substance misuse to improve access to community services
- Improvements to the carer support service and a renewed local offer for carers that draws together contributions from across local partners to make caring easier and more sustainable
- Improving the quality of community services and ensuring they are providing the right support to local populations.

We are joining-up health and care to provide services that keep people at home & independent

Objective 3
Support at an Earlier Stage for Residents who have Difficulty in Maintaining their Health and Wellbeing

- If I'm at higher risk of a disease or losing my independence, I am offered the opportunity to know this, and supported to make changes to reduce the negative impact on my life
- I am provided with the information and choices I need to remain as independent as possible, managing my own health and care where possible.
- I have systems in place so that I can easily get help at an early stage to avoid a crisis and remain in my home.
- All long term decisions about my health and social care are made when my health needs have stabilised and I am at home
- If my health or condition deteriorate, I get support that is focused on maximising my independence and helping me to regain skills and confidence

- Total Non-elective admissions to hospital.
- Injuries due to falls in people aged 65+ (BCF measure)
- Permanent residential and nursing care home admissions for the 18-64 population
- Permanent residential and nursing care home admissions for the 65+ population.
- Proportion of older people 65 and over who were still at home 91 days after discharge into reablement / rehabilitation services (BCF measure)

Progress to date

- Locally commissioned service in place for stroke prevention, including identification and treatment of hypertension.
- Increased capacity of the Reablement Team and increased the number of clients receiving six weeks of support to regain independence, particularly from hospital.
- Improved intermediate care (including home-based rapid response and out of hospital beds) to reduce non-elective admissions to hospital due to falls for the over 65s
- Improved discharges from North Middlesex hospital has resulted in a 20% reduction in the number of delayed days in hospital for 2016-17 compared to 2015-16.
- Extended opening for GPs across four 'hubs', including two until 8.30pm Monday-Friday and 8am–8pm Saturday & Sunday

Our future model

- Single point of access for out of hospital services to improve crisis management and prevent unnecessary admissions, including enhanced rapid response and use of 'virtual wards' to enable more clients to be supported to remain at home
- Improving the guidance and support for patients to identify and manage long-term health conditions, including new secondary prevention services for diabetes, kidney disease and mental health to be commissioned over the 2017/18 and 2018/19/
- Working across Haringey and Islington to identify older people with frailty and test interventions to support and prevent a health and care crisis
- Adult social care 'first response' and short-term teams to provide problem solving for clients that helps them to regain independence, including increased use of assistive technology and reablement.

We are focusing services on maximising independence, with flexible choice & control

Objective 4
Those who Need Care and /or Health Support will Receive Responsive & High Quality Services

- I am in control of planning the support I need to manage my health and social care needs
- I am confident that professionals working with me are working together, consult with me and help me make the right decision about my needs at the right time.
- I receive quality services that are timely, responsive and safe.
- I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this.
- I am able to develop a package of support can decide the kind of support I need and when, where and how to receive it.

- Overall satisfaction of people who use services with care and support
- Delayed transfers of care (delayed days) from hospital per 100,000 population (18+) (BCF measure)
- Percentage of care homes in Haringey rated as good or outstanding for quality
- Percentage of people in the last six months who have enough support from local services/organisations to help manage long term health conditions (BCF measure)

Progress to date

- Developing new approaches and improving the skills mix in hospital discharge teams to reduce unnecessary referrals to social care from hospitals.
- Implemented a 'day opportunities' offer for Older People and adults with learning disabilities, replacing council day centres with more personalised alternatives that encourage independence
- Improved our processes for reviews for care packages and adjusted packages where they were not well targeted to promote independence for the individual based on changing needs

Our future model

- Extending the availability of assistive technologies as part of a care package in order to maximise independence
- Increased availability of supported living placements as an alternative to residential
- Multi-disciplinary teams for those with long-run social care needs to ensure health conditions are also managed
- Developing our workforce to embed the principles of 'maximising independence' through our assessments, reviews and care planning to ensure all clients are helped to progress towards identified goals
- Use of an integrated digital record across health and care to improve the ability of health and care practitioners to join-up
- Improved quality of support for those who receive direct payments to maximise choice and control

We are making safeguarding everyone's business to reduce the risk for vulnerable people

Objective 5
Safeguard vulnerable adults from abuse

- I know that I am safe from abuse by others
- I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help
- I know that those around me would know if I was at risk and would help me to address my vulnerability
- I will get help to support to report abuse I get help to take part in the safeguarding process to the extent of which I want to and to which I am able to

- Meet the outcomes defined by the person subject to a safeguarding intervention*
- Rate of Section-42 Enquiries
- Proportion of people who use services, who say that those services have made them feel safe and secure.

Progress to date

- Embedding the principles of Making Safeguarding Personal to enhance involvement, choice and control for the individual subject to a safeguarding concern
- Improved the proportion of people subject to a safeguarding intervention who say that outcomes partly or fully met.
- Reduced the number of Section 42 enquiries in Haringey to closer to our comparator boroughs by screening cases only requiring advice, information and signposting
- Improved the proportion of service users who report feeling safe and secure in those services to above the London average.

Our future model

- Focus on improving the quality of our directly delivered and commissioned services to put in place a preventative approach to safeguarding risk
- Increase the coordination and impact of our work with partners through the Haringey Safeguarding Adults Board to ensure it is a shared agenda locally
- Raise awareness of safeguarding among our residents and improve the information and advice available beyond those receiving formal services
- Further develop the awareness and skills of clinical staff across Haringey's health providers to ensure issues are raised and dealt with.

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THE PRINCIPLES OF CO-DESIGN

1. INTRODUCTION

1.1 The purpose of this Paper is to clarify the term “co-design” and set out a number of core principles and values that are necessary if a process is to be described as “co-designed” or “co-produced”. This Paper has been drafted by the Adult Social Care Planning and Oversight Group to establish standards and criteria which they will apply to their oversight of the co-design process relating to the provision of social care and related health services, including the design and use of buildings for social care, in Haringey.

1.2 The scope includes services delivered or commissioned by Haringey Council and Haringey Clinical Commissioning Group (CCG) and, in so far as they impact on Haringey residents, by the Haringey & Islington Wellbeing Partnership and the North London Sustainable Transformation and Planning (STP) Board.

1.3 The term “experts by experience” is used to include both current and past service users and Carers. Those involved in a co-design process may also be lay members of the community who have knowledge, expertise and aspirations to contribute to the process but may at the time not have used or be using these services; for simplicity they are included when using the term “experts by experience”.

1.4 It is recognised that, in the work relating to social care and health, co-design has not been embedded in the organisational culture and at this point in time it is an aspiration that all parties are committed to achieving.

2. PRINCIPLES AND BENEFITS

2.1 There are many definitions of co-design and it is a term that is becoming frequently mis-used in relation to health and social care transformation processes, in place of “engagement” which is not the same. Co-design involves a commitment to ensuring that service clients and carers (experts by experience) are involved at the beginning of a process, working with professionals on an equal footing with the same value being given to everyone’s contribution.

2.2 A co-design culture in an organisation takes time to develop and embed as it involves a very different way of working, defining and valuing knowledge. Professionals have to accept that they are not the sole experts on the subject and they need to be skilled in active listening and working as equals in mixed groups of other professionals and experts by experience.

2.3 It is an important principle that experts by experience are confident that they will be listened too and that their contribution can make a difference. Co-design is when an individual and/or groups of people get together to *influence* the way that services are designed, commissioned and delivered. The test of the process is to ask all those involved in the process, lay members and professionals, if they thought that their contribution made a positive difference to the outcome.

2.4 The benefits of adopting a co-design process are both tangible and intangible and there is a growing body of evidence to support this. There are benefits for all those involved:

Benefits for the project:

- Better idea generation
- More original and valuable ideas
- More advanced knowledge about customer or user needs
- Improved quality of service definition
- More successful innovations
- Improved decision-making

Benefits for customers or users:

- Better fit between service and customers or users
- Higher quality of service
- More differentiated service
- Higher satisfaction of customers or users
- Higher loyalty of customers or users
- More educated customers or users

Benefits for the organisations involved:

- Improved creativity
- Improved focus on customers or users
- Better cooperation between stakeholders

2.5 In order to ensure these benefits are maximised there are a number of key principles that should apply to any co-design process

- Service users and Carers should chair or co-chair groups, as appropriate to group function and reflecting relevant expertise.

- Lines of accountability and governance need to be clear at the outset.

- Transparency must be a principle.

- No decisions made 'elsewhere'. Conventional respect for committee procedures should be the norm.

- Attention needed to balance of power on panels and teams.

3. PROJECT PLANNING

3.1 Project plans will need to include specific time for the co-design process and it has to be acknowledged that this will extend project timescales. The benefit of a slightly longer timescale is the value added by including experts by experience in the design process as outlined above and should be included as a mandatory requirement in both the outline and detailed business cases.

3.2 A commitment to co-design involves forward planning to identify all those future activities where this approach will be appropriate and to give time to recruit suitable experts by experience. There is significant transformation underway across adult social care and health services currently generating a range of different opportunities for engagement and co-design, which will be overseen through the Planning & Oversight Group.

3.3 The forward plan for developing adult social care services in Haringey is described in a separate report which is regularly updated and identifies the opportunities for applying the co-design framework to these transformational activities. The updated Forward Plan will be a standing item on the agenda of the Planning and Oversight Group.

3.4 There are many areas of activity where co-design should be part of the process and the checklist below provides a framework that the Planning and Oversight Steering Group has adopted.

Service Development

1. The development of existing services and design of new services and pathways should involve experts by experience from the beginning of the process.
2. The desired outcomes and benefits to the user of service developments / redesign should be clear from the outset and monitored on a regular basis to check that the outcomes / benefits have been realised.

Recruitment

1. Involvement in defining job roles / skill sets and selection of candidates for key roles by sitting on shortlisting and recruitment panels e.g. The Ermine Road and Haven Hub Manager Posts.

Commissioning

1. Working with commissioners to consider at an early stage the key outcomes to be delivered and to contribute to the development of strategy and policy
2. Working with commissioners to design a new service specification
3. Being part of the panel to select new providers for the service
4. Reviewing the new service on any monitoring group set up for this purpose.

Buildings

1. To be involved, along with professional colleagues in the client team, in developing the functional specification, of a specialist or generic building which has an adult social care function.

2. To be involved in any discussions relating to value engineering to reduce costs to bring it in line with the cost plan.
3. Where appropriate to be on the selection panel for design consultants
4. To monitor the progress of the building works after the start on site.

4. CAPACITY AND SUPPORT

4.1 In order to meaningfully participate in the co-design process experts by experience may need some assistance and support to make the time available and also some briefing or training on the context and technical jargon. It would be appropriate to pay expenses to include carer sitting, child care, transport and a food allowance if meetings last more than a couple of hours and/or are at lunchtime. The NCL Mental Health Experts by Experience members receive a payment of £12.50 / hour for attending the Reference Group meetings, in addition to expenses. This principle could be adopted more widely for those on co-design working groups and merits further consideration.

4.2 Experts by experience may often need other support around IT infrastructure, access to printers and copiers and possibly office and meeting space. These are important considerations which will facilitate involvement from a wider group of people than may otherwise feel able to be involved.