Corporate Plan 2015-18

Status Report February 2018

Priority 2

Corporate Plan Priority [1, 2, 3, 4, 5]	2
Priority Name	Outstanding for all
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Date	13.02.2018

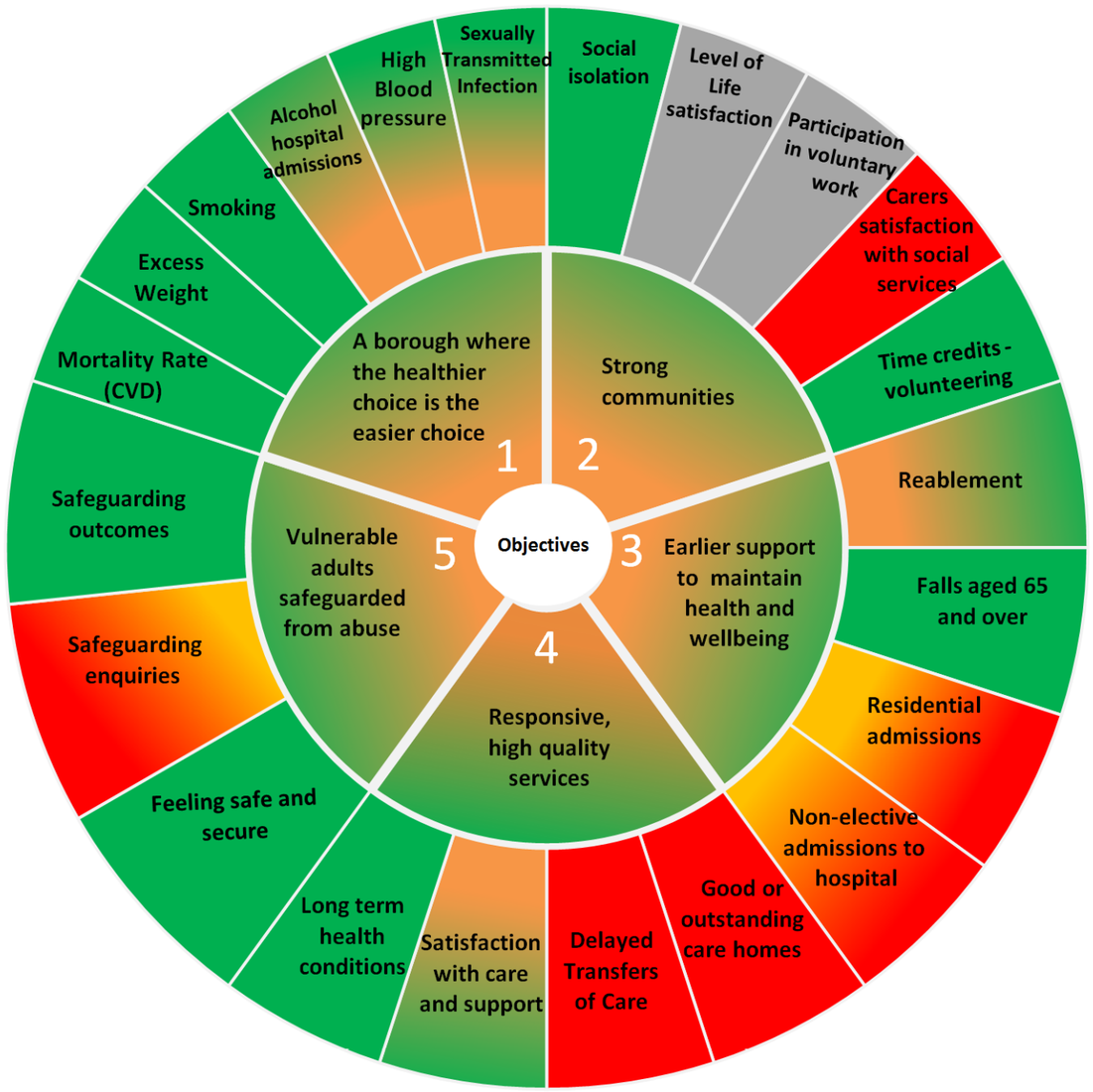
Priority Summary

Enable all adults to live healthy, long and fulfilling lives.

"We will support people to live healthy, long and fulfilling lives with control over what is important to them."

- Health and Wellbeing Board

Priority Objectives



Objectives – Status Report

Objective No.	Objective Description	Target (Mar 18)	Latest Performance Information	What has been achieved to date	What will be achieved by end March 2018	What will not be achieved and why?
1	**Making the healthier choice the easier choice**					
a	CVD Mortality rates	**Reduce rate to statistical neighbour best of 80.7 deaths per 100,000 by 2016-18**	**84.6 deaths per 100,000 in 2014-16**, which is higher than the London average of 77.4 deaths per 100,000 for London, but lower than our statistical neighbour average of 90.1 deaths per 100,000 people.	There has been a significant improvement in the CVD mortality rate from 90.2 per 100,000 in 2012-14, to **84.6 in 2014-16.** Haringey is now **8th out of 32** London boroughs for early death from stroke, down from 1st out of 32 in 2012-14. This represents a **21% decrease** since 2012-14, bucking the upward trend and moving us closer to our statistical neighbours and London. Smoking, excess weight, physical inactivity, smoking, high blood pressure and excess alcohol intake are all key risk factors for cardiovascular disease. Achievements in tackling these risk factors are described below for outcomes 1b, 1c, 1d and 1e	In May 2017 we agreed a joint programme of work with Haringey CCG on stroke and cardiovascular disease, this has been captured in a new P2 project brief "Stroke and cardiovascular disease prevention". This project brief brings together and strengthens existing work as well as capturing some new initiatives. Key aspects of the project are as follows: • Communicating key messages to our residents about how to prevent strokes and other cardiovascular diseases, • Improving pathways into services that support people to stay well, such as smoking cessation, NHS Health checks and exercise programmes • Consistent, high quality detection and management of people with risk factors for cardiovascular disease in primary care. This will be supported by Locally commissioned services – initially prioritising stroke prevention and diabetes. • Building our "Making Every Contact Count" approach to lifestyle change including across primary, secondary and community health care. • A new programme of community based blood pressure checks	We are on track to achieve our target for this indicator, but as the latest data we have on this indicator is for the period 2014/16 and our trajectory is set until 2016/18, we will need to continue to monitor this indicator The programme of work on CVD prevention is due to continue in 2018/19 and beyond – into the next corporate plan period.
b	Excess weight	**Maintain our current 3-year average of 54.2% by 2016-18**	Excess weight in adults has remained largely stable with 55.5% in 2012-14 and **54.2%** in 2013-15. Currently lower than our statistical neighbours, London and England	The Haringey Obesity Alliance (HOA) was established to lead a partnership approach across Haringey where organisations commit to a 'pledge' to tackle obesity. The Health and wellbeing Board endorsed the Local Government Declaration. Commissioned weight management service redesigned to reduce waiting times.	The HOA will expand to include more local employers The service redesign will reduce the 'drop out' rate from weight management services.	We are on track to achieve this indicator. We only get data on current performance on this metric in arrears, The latest data we have is for 2013-15, so we need to monitor this beyond the end of the current corporate plan phase to see the impact of work we are currently doing and to see if we have achieved our target.
c	Smoking	**Reduce to statistical neighbour best of 15.9% by 2016-18**	Overall smoking prevalence for 2016 was 17.7% and decreased by 4.2% from 2015 to 2016.	Overall smoking prevalence is now at a 5-year low. Haringey's smoking prevalence is now lower than our comparator boroughs but still higher than London and England Re-commissioned a Stop Smoking Service in April 2016 – performance has been variable. Council smoking policy updated and agreed.	Performance of Stop Smoking Service is expected to improve as management has changed. Targeted work will take place jointly with Islington to address cohorts where smoking prevalence remains high.	We are on track to achieve our target for this indicator, The latest data we have is for 2016, so we need to monitor this beyond the end of the current corporate plan phase to see the impact of work we are currently doing and to see if we have achieved our target

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d	Alcohol hospital admissions	Maintain current downward trajectory to reach 621.5 per 100,000 by 2016-18	Hospital admissions for alcohol-related conditions has reduced slightly from 649.3 per 100,000 in 2013-15 to 642.5 in 2014-16	Focus on prevention and early intervention through challenging new alcohol licence applications and the re-procured alcohol liaison service. New alcohol liaison service fully operational in North Middlesex Hospital funded by Haringey CCG.	Continued focus on prevention and early intervention.	We are amber/green for this indicator, so need to ensure that the interventions we currently have in place are sufficient to achieve the long-term target. We only get data on current performance on this metric in arrears, The latest data we have is for 2014-16, so we need to monitor this beyond the end of the current corporate plan phase to see the impact of work we are currently doing and to see if we have achieved our target.
e	High blood pressure	45% patients with diagnosed and controlled hypertension by 2018/19 (London best).	There has been an increase in the number of patients diagnosed with hypertension, rising from 30,400 in 2015/16 to **31,842** in 2016/17. The proportion of patients with diagnosed and controlled hypertension has improved from 41% in 2015-16 to 42% in 2016-17.	Large scale work to detect people with high blood pressure in primary care through carrying out blood pressure checks at every clinical contact began in 2015. This has resulted in over 2,000 new cases of high blood pressure being identified Over 3,800 NHS Health checks, which include blood pressure detection delivered each year.	We have new areas of work coming on stream now: • Community blood pressure checks (British Heart Foundation grant-funded) - Working with Bridge Renewal Trust, Embrace and THFC foundation to carry out over 2,500 blood pressure checks per year in community settings. • CCG funded stroke prevention scheme to be expanded so that there is a focus on better treatment of high blood pressure as well as identification.	We are amber/green for this indicator, so need to ensure that the interventions we currently have in place are sufficient to achieve the long-term target. We only get data on current performance on this metric in arrears. The 2017/18 end of year performance will not be published until November 2018 – so we need to monitor this beyond the end of the current corporate plan phase to see if we have achieved our target.
f	Sexually transmitted infections	Maintain Haringey's current downward projection to reach a new STI diagnosis rate of 1,417 per 100,000 by 2018	New STI diagnosis rate has remained relatively steady since 2013. The rate for 2016 was**1552.4 per 100,000** and remains higher than London and England but significantly lower than our statistical neighbours at 2,541.6 diagnoses per 100,000.	Over the last 3 years there has been significant redesign of commissioned services both at the local and London level. Channel shifting into our local prevention services i.e. primary care (GP's and pharmacists), community service provision for marginalised vulnerable communities and a dedicated young people STI and women's LARC provision. In addition, we have developed a regional collaborative partnership to expand the provision of complex GUM services. All procurement is complete. All services operational	Last piece of the service redesign will be the E-portal going 'live' across London in a phased implementation. This supports residents to 'self-serve' and avoid the need to attend complex GUM services.	We are on track to achieve our target for this indicator. We only get data on current performance on this metric in arrears, The latest data we have is for 2016, so we need to monitor this beyond the end of the current corporate plan phase to see the impact of work we are currently doing and to see if we have achieved our target.
2	**Stronger communities**					
a	**Social isolation**	**To be in the top London quartile (42.8%) by 2017-18**	Data indicates that Haringey's performance has improved from its previous decline in 15-16, and is now back up to 43.3% in 16-17, slightly above previous performances and now 3% above its statistical neighbour average, which fell in the last year.	Commissioned a VCS strategic partner, Bridge Renewal Trust, to support development of our community and voluntary offer. Mapped community assets and used to improve directories of services on Haricare and BRT website. Promoted opportunities for volunteers to reduce social isolation, such as The Good Gym. Recruitment of two Local Area Coordinators to support people in	Ongoing improvements to the directories and to the Council's webpages to facilitate navigation. Pilot of London Independent Living Service finalised to support work with older people living at home.	New data for this outcome measure will not be available prior to March 2018. Progress will need to be monitored in the new corporate plan period to assess impact of work since 16/17.

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				identifying and accessing community opportunities.		
b	Resident life satisfaction	No metric identified for future reporting	In 2015 the percentage of adults who had a high or very high level of satisfaction with their life as a whole was actually higher in the most deprived area of Haringey (78.7% satisfaction) compared to Haringey as a whole (77.8%). The majority of Adults responded with a High level of satisfaction (56.3% Haringey, 56.2% Most Deprived Areas).		This topic is expected to be explored in the upcoming residents survey (early 2018) for future data. This will provide a greater range of data from which to derive an outcome measure.	An update on this outcome measure will not be available prior to March 2018. The metric available from the residents survey may not be directly comparable to the original survey.
c	Participation in voluntary work	No metric identified for future reporting	In 2015, the percentage of adults who had participated in voluntary work was slightly lower in the most deprived area of Haringey (14.3%) compared to Haringey as a whole (19.8%).	Commissioned a VCS strategic partner, Bridge Renewal Trust, to support development of our community and voluntary offer. Transfer of the Haringey Volunteering Centre to Bridge Renewal Trust. Two stakeholder workshops with BRT and Voluntary and Community Sector organisations and statutory partners to identify current gaps and barriers.	This topic is expected to be explored in the upcoming residents survey (early 2018) for future data. This will provide a greater range of data from which to derive an outcome measure. Further workshops with Bridge Renewal Trust and the VCS. Priorities for future development of the voluntary sector and the council's role in supporting volunteering in the borough to be agreed. This will inform the People theme under the Borough Plan from 2018.	A direct update on this outcome measure will not be available prior to March 2018.
d	Carer satisfaction with social services	To reach the statistical neighbours average (32%) by 2018-19	Haringey's performance decreased to 25% in the 2016/17 survey, taking it below the performance of London and similar Boroughs. No new data has been available since mid-2016.	Put in place additional capacity as part of service redesign to improve timeliness and effectiveness of carers assessments. Development of improved practitioner guidance and a tiered carer support offer, linked to use of support direct payments, due to go live in spring 2018. Implemented interim changes to the HAIL carers support service to better maintain and utilise the carers register. Full retender of newly specified carers' support service complete and new service due to launch in March 2018. Reviewed processed and identified opportunities to make better use of online registration.	The next Carers survey will be at the end of 2018 and we expect the changes to have made an impact on the way that carers view adult social care: Carers support service recommissioned with an updated service specification, new service due to launch in March 2018. By end of March, the council will roll-out comms about new carers offer, covering: • Identification and registration • Assessment and support planning • Carer Support Service • Community-based support	The next Carers Survey is likely to be after March 2018, therefore we will not have updated data until this time. However, additional data on informal care is expected to be available in the upcoming residents survey (early 2018).
e	Time credits - volunteering	1182 Members by the end of 2017/18	The number of time credits members is increasing over time. In quarter 2 (2017-18), there were 1187 members, meeting the 2017/18 target of 1182.	Engagement with voluntary organisations increasing availability of Time Credits opportunities. Promotion of Time Credits concept to residents, championed by Bridge Renewal Trust as strategic partner.	Exceeded target of 1182 members by March 2018 and expected to continue to increase membership through continued promotion of the Time Credits Network.	

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3	**Earlier support to maintain health and wellbeing**					
a	**Reablement**	**80.9% of older people still at home 91 days following discharge into reablement services (in line with BCF Target)**	80.1% of clients still at home 91 days after discharge into reablement. This figure reduced from a high of 91.4% in 2015/16 but more than double the number of users have received Reablement in 2016/17, so the outcomes are still robust.	January 2016 review of Community Reablement Service. May 2016 new service specification expanded the throughput of Reablement, reducing the exception criteria around health conditions such as COPD, deteriorating neurological conditions and recent neurological events. Strengthening links with hospital discharge through rollout of Discharge to Assess pathways from hospital. In 2016-17, there was a 98% increase in the number of clients receiving reablement within the same Community Reablement Service resource. Conservative estimates that Reablement has avoided £1.1m of long-term care this year.	Expect to meet the BCF target of 80.9% success for Reablement. Begin to monitor the primary health diagnosis to measure the impact of medical conditions on outcomes. Continue to work closely with Acute Trust partners on Discharge to Assess and medically optimised as we may see an increase in readmission due to the impact of earlier discharges if not medically stable. We will require immediate response by PCT, GP's and Nursing to manage deteriorating medical needs in the community and reduce risk of conveyance. Explore further options for expanding take-up of Reablement directly from the community front door.	Validated figures for 2017/18 will not be available prior to March 2018 so will need to be monitored in the next corporate plan period.

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b	**Falls aged 65 and over**	**1772 per 100,000ppn by 2017/18**	There has been a 3% reduction in the rate of non-elective admissions for falls related injuries between April and November 2017 compared to the same period in 2016/17. There have been 2 fewer non elective admissions for falls related injuries between April and November 2017. This equates to a 1% reduction in actual admissions	A workshop on falls prevention and response was held in July 2017 across Haringey, Islington and Camden. Six areas for recommendation were developed: the development of a falls pathway; developing falls prevention skills within organisations; improving the identification of people at high risk of falls; improving data sharing and communications; improving awareness of falls; and improving patient and public involvement in the falls pathway. Haringey will be considering how it takes these recommendations forward. Further Workshop carried out in January 2018 has identified clear work streams for development of falls pathway for Haringey and Islington patients. Identified development includes definition of Falls pathway and creation of a common falls assessment.	Haringey will be working with Camden and Islington to prioritise and implement the recommendations form the falls workshop.	
c	**Residential admissions**	**Age 18-64: reduction of 3 admissions (rate of 8.1) (2016-17)**	There has been an increase in residential admissions for 18-64 years old, **13 admissions** in the year to date, compared to 8 at the same point last year.	Implemented a policy of finding alternatives to residential for younger adults, including supported living and community homecare. Expanding the availability of Supported Living options. Value for money, including outcomes for the service user, is a key consideration in the decision making process and each care package is considered by a multi-disciplinary Care Authorisation Panel.	Expand and free-up additional Supported Housing units for clients to step-down from residential or for new clients to avoid residential admissions. De-registrations of existing residential providers for LD and MH clients are continuing, with two completed in 2017/18 to date and possible completion of further deregistration in-year.	Given the changing market and the time required to further expand Supported Living accommodation, the council has exceeded the number of new admissions from last year and cannot meet the target of a reduction of 3 admissions from the 2016/17 level.
d	**Non-elective admissions to hospital**	**Target of 3.03% reduction in actual admissions by 2016-17.**	There have been 15,103 non-elective admissions between April and November 2017. This is a 0.45% reduction in actual admissions compared to the same period in 2016/17 or 69 fewer admissions. There have been 5403 non-elective admissions per 100,000ppn this is a 1.69% reduction in the rate of admissions compared to the same period last year.	Haringey has started to reduce non-elective admissions though a combination of community admission avoidance schemes, including increasing care coordination through the Locality Team and increasing numbers through rapid response, and linking to work within the acute trusts to directly avoid admissions.	Haringey will continue to build on and monitor the performance of its admission avoidance services some of which will be included within the redesign of intermediate care.	Current performance is below the 3.03% reduction target and it will be challenging to meet the target by March 2018. However, Haringey's small reduction is in a national context of significant increases in non-elective admissions.

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4	**Responsive, high quality services**					
a	**Quality of Care Homes**	**To be in line with the London rate of 78% by 2018/19.**	Haringey currently has 65% of care rated as Good, and 0% rated as Outstanding as at October 2017 This is significantly less than the National picture, where 77% of care homes are rated as Good and 1% as Outstanding.	There have been six closures of residential homes in the past year, with some providers moving instead to develop supported living options. The QA team has a detailed monitoring and support plan for all homes that remain open and that are non-compliant. Commissioning are also actively supporting some homes to move to supported living status as in some cases this gives improved value for money. This is expected to have an impact early in the next financial year.	Implementation of new performance and outcomes monitoring framework for providers from March 2018.	Current performance is lower than the national level, where 77% of care homes are rated as Good and 1% as Outstanding. Over the last 18 months Haringey has seen no significant movement in this measure. It is unlikely that we will achieve the London average by March 2018 due to the timescales for closure or conversion and the capacity in the market locally and regionally. However commissioning QA activity has supported some improvements in improving, including support for care home closure where necessary.
b	**Delayed Transfers of Care**	**3.52% reduction in the rate per 100,000 population of DToC's (3,156) by 2016-17**	Between April and November (the most recent verified and reportable data) the rate of DTOC delayed days per 100,000ppn was 2242 this is a 1% increase in the rate of delayed days. There have been 4913 actual delayed days attributable to Haringey patients. This is a 3% increase on the same period in 2016/17 which equates to an additional 143 days.	Haringey DTOCs in 2016/17 reduced from 2015/16 at a time when London and national averages increased. Remodelling of the discharge process in hospitals has included establishing a social work intervention team in acute setting to reduce unnecessary referrals and undertake joint planning. Discharge to Assess has been piloted and pathways 0,1 and 2 are fully operational at NMUH and Whittington. A Single Point of Access in place for all hospital discharges. The average number of delayed days attributable to Social Care specifically (as a subset of all DtoC) was also below the target set with NHS England for September, October and November 2017. E.g. In October there was an 89% reduction in social care DTOCs. In November there was 48% reduction in social care DTOCs compared to the same period last year.	Work to address inconsistent data capture and reporting across different acute providers, including joint validation. Discharge to Assess Pathway 3 (complex discharges) to be fully operational, which will impact on some challenging DTOC cases. Haringey is leading on roll-out of Discharge to Assess across North Central London.	The more complex discharges are recognised nationally as particularly complicated to resolve. In Haringey the attempt to increase these complex discharges has unearthed a number of interdependencies across all partners that need to be resolved. These are recognised by partners and new ways to address are being progressed.

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c	**Satisfaction with care and support**	**Increase to 62% by 2018 (to be in top quartile)**	Haringey's performance has improved slightly in 16-17 with 61.3% overall satisfaction.	Satisfaction with care and support in Haringey is now above the performance of both London and Comparator Boroughs. Improvement has been consistent since 2012. Practice forums and redesign forums have focussed on how practitioners ensure that the process of undertaking assessments is clear to staff and that information is shared, the mosaic system reflects the procedures staff will be following and that where there is a need for advocacy or capacity assessments these are undertaken and service users and carers are involved in the process as required or appropriate	Changes to mosaic work flow system and embedded forms are completed. Redesign forums have produced clear protocols for staff around the function of the new teams and management structure. Audits tools modified to reflect best practice and embedded in management actions	
d	**Long term health conditions**	**55.6% of people with enough support (in line with the Better Care Fund)**	Survey results published in July 2017, using surveys collected between January and March 2017, show that 56.1% of people feel they receive enough support. there has been a 2.3% increase in the proportion of patients reporting that they have received enough support to manage their long term health condition.	Three Haringey **Care Closer to Home Integrated Networks (CHINs)** workshops have been carried out successfully, with excellent attendance and expression of interest from GPs and health/social care providers. **Locality team** managers have also been supporting the bed-based intermediate care Multi-Disciplinary Team at Protheroe House and Priscilla Wakefield Locality teams have continued to develop person-centred integrated working by implementing crisis care plans and 3 and 6-month telephone reviews. **Self-management support** 102 patients completed the Generic Self-management programme. This is 36% above the baseline target. 78 participants completed the Diabetes self-management programme this is 22% above the expected number of course completers. The Generic Self-Management Programme has carried out 1 Health Care Professionals Course delivered to 32 workers **MDT Teleconferences** The team is in discussions with Whittington IT to support electronic recording and dissemination of discussion notes and action lists – they will be viewable on Care Centric, that is, community (RIO) and GP (EMIS) users will be able to view the notes. The team has reached an agreement with MDT co-ordinators across NCL to facilitate MDT discussions for cross-borough patients (patients registered with	Set-up of the first Care Closer to Home Integrated Networks (CHINs) to coordinate delivery of acute, primary and social care. Locality Team is aiming to see a much large number of service users through referrals routes from a range of health and social care services other than just relying on GP referrals. Continue to support the self-management of people living with diabetes and other Long Term Conditions Continue to prioritise MDT discussions for patients who attend A&E multiple times and those who have complex discharges Working with London Ambulance Service to obtain data on frequent callers and link this to the MDT teleconference and Locality Teams.	No new data for this measure is due out until after March 2018 and we are above our BCF target for this measure.

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				a GP in a neighbouring borough.		
5	**Vulnerable adults safeguarded from abuse**					
a	**Feeling safe and secure**	**Maintain a satisfaction rate of 89% by 2017-18**	Haringey's performance has continued to improve with 89.2% saying that services have made them feel safe and secure.	Haringey is above the average for its Comparator borough averages for 2016-17, and is within London's Top Quartile. Mosaic work flow system amended to reflect and record best practice and enable effective reporting Audit tool developed and being tested	Roll out of safeguarding responsibilities across all teams. Recruitment to full safeguarding team including manager post. Embed auditing of cases to test best practice and identify areas of practice for development. We are currently running the survey and results will be ready for evaluation in April 18.	
b	**Safeguarding enquiries**	**There is still discussions around how best to report this objective. Aim at present is to maintain target of 67% of safeguarding concerns addressed through preventative work.**	There has been discussion within the NCL group to establish a way of reporting this key indicator, ADASS are developing a dash board for implementation and once in place will be used to inform reporting for this objective.	There is considerable fluctuation over time in the number of Section 42 enquiries, and this is consistent with experience in other boroughs. Improved use of preventative work at the initial concern stage has been one key driver of lower numbers of concerns proceeding to Section 42 and although the rate has fallen below our stated range, this reflects proactive safeguarding prevention and intervention.	Continue to monitor the rate of Section 42 referrals, alongside trends in the number of concerns raised and the proportions receiving preventative input. Agree target to be achieved, or maintained in light of knowledge that of all concerns raised 2/3 (67%) safeguarding concerns are addressed through preventative work, 27% go on to a S42 and 6% result in a NFA.	Achieving a rate of S42 enquiries within the narrow band 50-55 is challenging and an alternative approach may be required, e.g. using a rolling 12-month average. Also, the lower rate of Section 42 has been evidenced as reflecting increased safeguarding prevention and early intervention. Work is underway to develop a more meaningful performance measure
c	**Safeguarding outcomes**	**Increase the percentage of people who say the outcome was partly or fully met to 90% by 2017/18**	Haringey's performance has shown significant improvement over time since Q1 2015/16, increasing the percentage of those whose outcomes were partly or fully met from 43% to 93% by Q3 2017/18.	Amendments to mosaic work flow to effectively capture stated outcomes of people coming through safeguarding team Mandatory steps added to mosaic work flow to ensure process is being adhered too and data captured for effective reporting	Dedicated safeguarding team member in place within First Response Team to ensure that referrals to safeguarding at the first contact identify outcomes as part of initial triage. Effective audit to ensure best practice is being adhered too and the mandatory steps in the workflow have aided the reporting and evaluation of data and therefore the ability to report on the achievement of our objectives.	