Ageing Well Strategy for Haringey 2019 – 2023

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Revision History

Name	Version	Date	Summary of changes
Yewande Sangowawa	V2.0	17.09.19	Alterations to figures numbering throughout the document
Yewande Sangowawa	V3.0	26.09.19	Alteration to Ageing Well high level actions – start/end date and owners
Paul Allen	V3.1	29.09.19	Final alterations to Strategy
Yewande Sangowawa	V3.2	03.10.19	Additional information on Long Term Conditions included
Paul Allen	V3.3	08.10.19	Final amends to sections

Summary

A number of health and care partners as well as patients, residents and carers have come together to produce this Ageing Well Strategy for Haringey and to commit to a common vision: ***"We will work together to support people with frailty to live and age well".***

The Strategy is a plan adopted by the multi-agency Borough Partnership and supports one of 4 population groups – older people – the Partnership identified as a priority to support. The Partnership will also oversee delivery implementation, outcomes and impact of the Strategy and report to the Health & Well-Being Board. It is closely aligned to national and local policy direction, including the Borough Plan and NHS Long-Term Plan, particularly those sections of the latter which relate to integrating health and care services at a Borough and local footprint.

The scope of the Strategy chiefly focusses on ensuring our older population can 'age well' and what this means for people with frailty (or those who could become frail in the medium-term). This population is predominantly, but not exclusively, aged 65+ - but we also include the needs of specific groups of people more likely to become frail at a younger age in its scope. We know there are at least 13,500 people aged 65+ with some degree of frailty living in Haringey. This represents half of the 65+ population, and one-third (8,700) have mild frailty, with 5% (1,350) having severe frailty. It is important to ensure these individuals are supported and can support themselves to maintain or improve their health, well-being and independence. The number of older people is set to increase in Haringey over the next 10 years, with the number of 85+ year olds increasing by 5% per annum. This is welcome but will place future pressures on health and care budgets and capacity of the system. For example, only 18% of the population have moderate or severe frailty, but they use 30%+ of all available health and care resources due to their complex needs.

In response, partners have agreed to develop a three-year programme and action plan (a Roadmap) setting out how we will make the changes we need to implement the Strategy. The Roadmap is included in the Annex. Every year, we will look back at what we've achieved to see if it's making a difference and refresh our plans. We've taken a 'life course' approach to the structure of the Strategy:

- Ageing Well, i.e. how we can adopt healthier and fulfilling lifestyles as we age;
- Living Well with Long-Term Conditions, including dementia: A separate strategy will be developed for LTCs, but this section gives a view about the general approach taken. A specific section in the Ageing Well Strategy discusses Living Well with Dementia;
- Living Well when Becoming Frail: This describes the need for targeted help and support when individuals become frail, typically those with mild frailty;
- Living Well when Frailer: This describes the needs of people with more complex needs and how we will provide a coordinated response to best manage these needs. These individuals are those most likely to need a coordinated, often statutory sector, support
- Planning for, and Nearing, End of Life: This describes how as partners we will support people to die with dignity in the place of their choosing;
- Supporting People to Recover after Illness or Crisis including crisis and short-term support in, and discharge from, hospital or to avoid hospitalisation;

- Supporting Carers to continue in their caring role and have a life of their own.

Introduction: Our Aims And Principles

" We will work together to support people with frailty to live and age well"

A number of health and care partners have come together to produce this Ageing Well Strategy for Haringey and to commit to the above statement. The Strategy complements Haringey's existing strategies or plans about its population health and well-being, such as Haringey's Health & Well-Being Strategy and the Borough Plan, as well as individual partners' own plans, such as Haringey's Clinical Commissioning Group (CCG) commissioning intentions.

Partners who have collaborated on this Strategy under the remit of Haringey's Health and Well-Being Partnership include the London Borough of Haringey, Haringey CCG, Whittington Health NHS Trust, North Middlesex University Hospital NHS Trust, Barnet, Enfield & Haringey NHS Trust, Federated 4 Health (Haringey's GP Federation) and a number of voluntary sector and charitable organisations, such as Bridge Renewal Trust, Public Voice, the 50+ Forum and North London Hospice. Patients, residents and carers have helped us design the Strategy. We are very grateful for their contribution, time and knowledge.

As part of its development, partners decided to set out goals and principles we felt were important in making improvements to which this Strategy aspires. Working together, partners will commit to:

- Having a common way of identifying people with frailty as early as possible;
- Carrying out timely and shared assessments to understand people's needs;
- Involving the individual and their carers – their friends and families - in care planning and in promoting self-care;
- Working together with people and their carers to plan and deliver care and treatment and thus reduce the risk of someone needing more intensive and/or crisis-driven interventions later;
- Delivering care in the setting and living environment most suitable to the needs and wishes of people and their carers;
- Providing a timely, co-ordinated and multi-disciplinary response, where this is needed, to manage care, treatment and independence tailored to an individual's need;
- Improving people's functional ability to undertake daily living activities important to them;
- Respecting and protecting patients and carers from harm, neglect or abuse;
- Assessing and delivering care to support advance care planning for the last phase of life;
- Developing a single shared care record/plan available to patients, carers and care providers.

This Strategy will set out how we build on what we know is working well in Haringey and identifies a number of improvements we can make to move us towards our aim and aspirations.

What Success will Look Like

A number of Council and CCG strategies set out to improve the health, well-being and quality of life of the population within, and across, the Borough. The Ageing Well Strategy supports these aims through promoting a structured approach to helping as they become older and may become more dependent on others often due to the impact of multiple health conditions as they age.

This Strategy recognises there will need to be a number of key improvements to our current system. These improvements include how we will translate the goals and principles in the Aims section into reality. For example, we will know our Strategy is successful if we are able to identify people more readily who may need help earlier, provide better and more targeted information and advice to them, better assess their needs and work with and across partners to plan and deliver care in a coordinated and timely way.

The Strategy's implementation will support a number of outcomes older people tell us are important to them regardless of their level of need. This includes being as healthy, well and independent as they can for as long as possible and feeling well-supported to do so: for example, they can recover as far as possible after illness or crises. However, older people tell us they also value other outcomes, such as feeling they can contribute to their families and wider community, whilst their housing environment is also important to them.

Helping people to achieve these outcomes in the short-, medium- and longer-term will be beneficial to them and reduces their risk of having health or social crises. In turn, this will reduce pressures on our services, such as hospital A&E departments, because people's care can be better planned and delivered at home for more people in a more effective and efficient way.

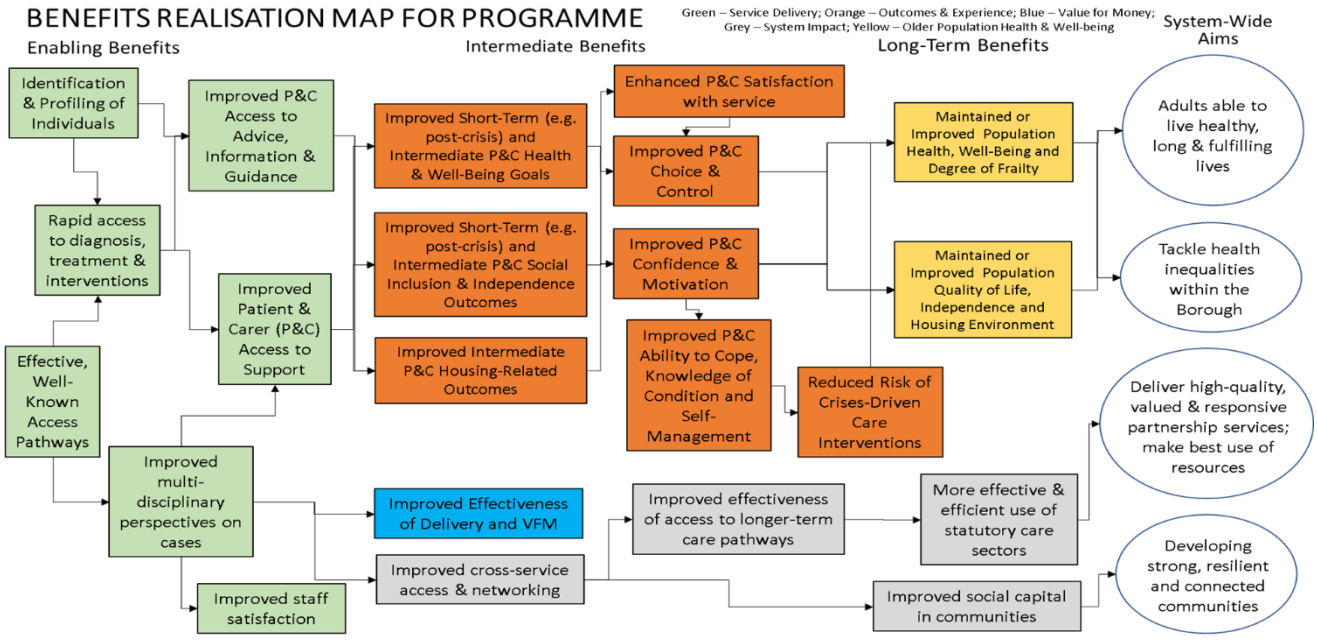


Figure 1 – Benefits Realisation Map for Strategy & Programme

Figure 1 combines all these types of outcomes to show what success might look like as a result of implementing this Strategy and how it relates to other strategies:

- A set of tangible service delivery objectives: improvements in access, planning and delivering the information and help that's available to people consistently across the Borough;
- Person-centred short- and longer-term outcomes about the expected benefits of this Strategy;
- Care system outcomes such as making best use of resources and improved value for money;
- An indication of how this Strategy contributes to wider strategic aims in Haringey.

A full set of system measures will be developed in 2019/20 to assure progress against the above outcomes is being made and that the Strategy implementation is having the impact intended.

Our Model of Networked Care

We are currently finalising our intended model of care for people as they age, including those that acquire long-term conditions and frailty, with both front-line professionals and older people. Our summary of this model will show the practical differences in care and support against which the success of the Strategy can be judged. We plan to make sure that individuals benefit from:

- Ensuring information, advice and guidance is simpler to access and more consistent between partners. Where needed, those with health and care needs will have access to community navigators to help steer them through a care and support system to solutions that's right for them;
- Simplified initial access points for health and care support for individuals, their families and professionals so that they get access to the right support they need quickly;
- Ensuring the assessment, care planning, delivery and review process is better tailored around an individuals' needs more effectively closer to home and in a way that's described in our principles;
- A range of high-quality services are available to them in the community that are tailored to their needs, so that individuals can decide with others which solutions are the ones right for them;
- Working in an increasingly multi-disciplinary and multi-agency way as individuals' needs become more complex. This means an individual may be working with one or two professionals, such as a GP or community nurse, if their needs are less complex but that those with more complex needs will have access to a more comprehensive multi-disciplinary team with a care coordinator;
- Seamless pathways of care and support to return home or to a suitable alternative, such as supported living, following a spell in hospital. Our services will continue to help people recover and regain their abilities if that's what they need;
- All of the above solutions is delivered in such a way that we are promoting prevention, individuals' autonomy and independence, encouraging them to manage their conditions and situations.

Strategy and Programme Structure and Governance

Partners have agreed to develop a three-year programme and action plan (a Roadmap) setting out how we will make the changes we think we need to implement the Strategy. We will look back at what we've achieved at the end of every year to see if it's making a difference and to refresh our plans.

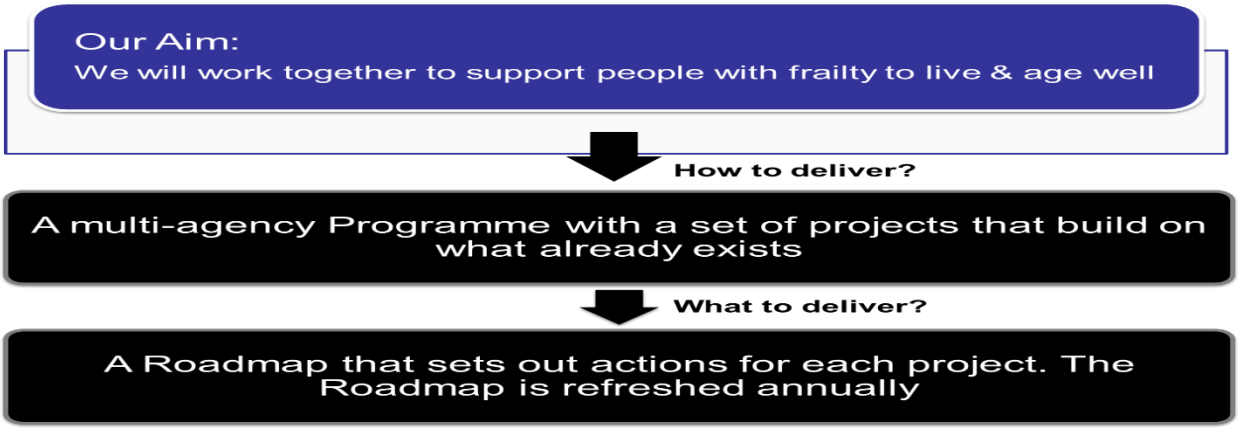


Figure 1 – Summary of Approach to Development and Implementation

A summary of the Roadmap for 2019/20 is included in Appendix 1.

Our Focus

The scope of the Strategy is far-reaching as it needs to consider:

- *Those who it will benefit* which is for the older population to 'age well' and what this means for people with frailty (or those who could become frail in the medium-term). This population is predominantly, but not exclusively, aged 65 and over - but we also consider the needs of specific groups of people more likely to become frail at a younger age;
- *The type of solutions* which focus on health and well-being prevention, such as keeping fit and active, and primarily on health, care and housing-related support for this older population;
- *How it integrates with other plans* to make sure the Strategy is aligned with national and local policy and plans, such as Haringey's Borough Plan or North Central London's Care Partners implementation of the NHS Long-Term Plan, and individual agency's own improvement plans. We have incorporated expectations of these strategies into our Ageing Well Strategy.

Governance

Haringey's Health & Well-Being Board has overall responsible for this Strategy and delivery of its Programme, as governance needs to be multi-agency to reflect the improvements we want to make to the integrated care model. The Board will discharge its responsibility through Haringey's multi-agency Borough Partnership that will be responsible for oversight of, and support for, delivery of the Strategy's Programme. This Partnership Board contains executives from the partners involved in forming this Strategy including patient/service user and carer representative groups.

The Head of Service for Integrated Care Commissioning (Older People & Frailty), a joint appointment between the CCG and Council, acts as the Programme Manager for the Strategy reporting on issues,

risks, progress and impact of implementation to the Board. The Programme Manager is supported to do so through a multi-agency programme group (Integrated Care Adults Group), which includes leads (from different agencies) responsible for different aspects of the Programme as well as patient/user representative groups. In turn, a number of multi-agency project groups support the work of the leads to make the improvements necessary.

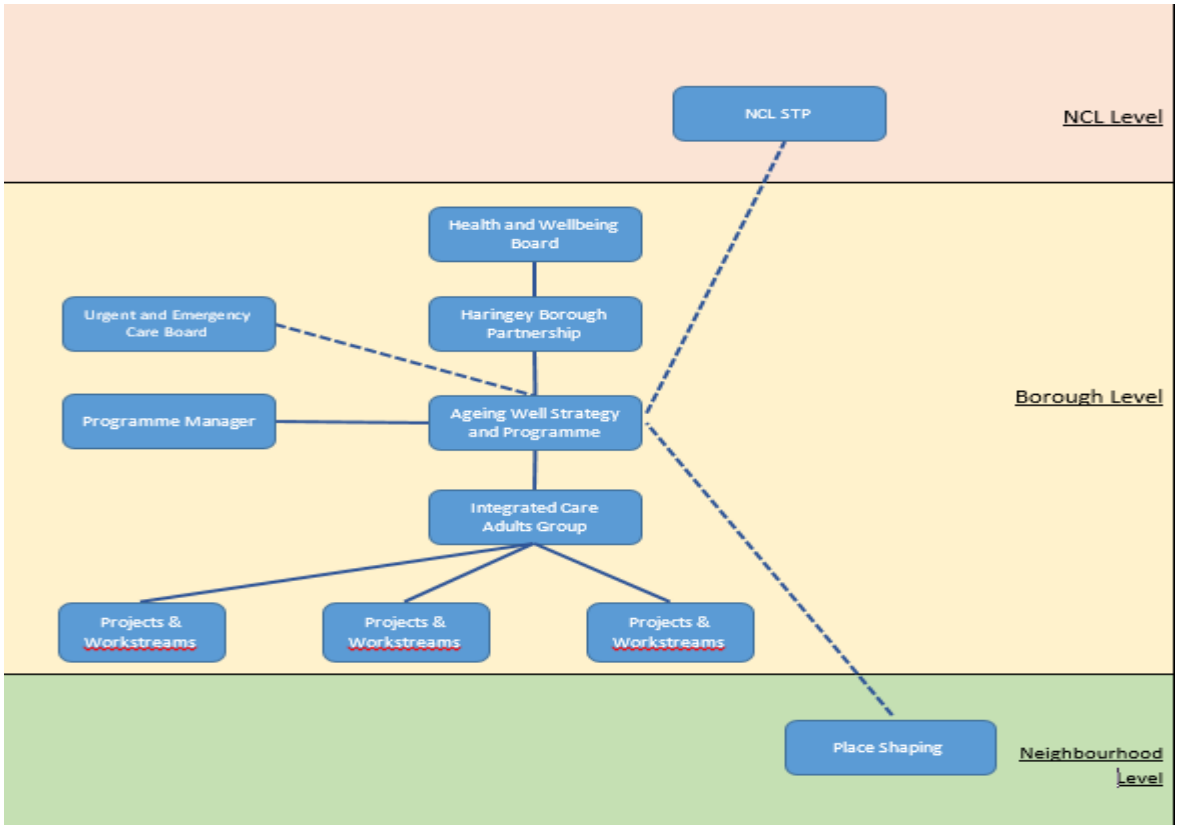


Figure 2 - Governance for Ageing Well Strategy in Haringey

An integrated care model needs to incorporate partners across North Central London, at Borough and local neighbourhood footprints. We need to align our plans across these levels:

- Haringey's Borough Partnership is one of 5 such partnerships in North Central London – one in each Borough. We are liaising with North London Health & Care Partners to ensure this Strategy aligns with NCL plans being revised in light of the expectations in the recently published NHS Long-Term Plan. Where it makes sense to do so, we are working across NCL to deliver these improvements, e.g. in progressing an IT solution for shared records;
- We are working closely with our local acute Trusts, Whittington Health and NMUH, Urgent & Emergency Boards to ensure our proposals are aligned with their plans. In practical terms, this will include ensuring our improvements align with similar to those planned for Enfield (NMUH) and Islington (WHT) and fully engage with our partners. A senior level multi-agency Transformation Leadership Group is overseeing development of those aspects of the integrated care model for older people that can be aligned across Enfield and Islington – a 'Frailty Network';
- We are working closely with partners at a neighbourhood level to deliver care closer to home for people with frailty, e.g. through our Integrated Care and Primary Care Networks discussed in this Strategy. These improvements support our wider partnership approach to working

collaboratively with local communities to make them stronger and more resilient. We are currently piloting our approach to partnership working in North Tottenham.

The Structure of the Strategy

Partners decided to take a life-course approach as a way of organising the Strategy and its Roadmap. Figure 3 below outlines a total of 8 projects in our improvement Programme:

- Five projects describe our life-course as we age (from simply needing to eat and drink well, take exercise and so on) through to supporting people if they develop a long-term condition, then becoming gradually more frail, and, finally, approaching the end of our lives;
- Another project focusses on making sure people are as well-prepared as possible and then well-supported should they have a health or social crisis, including needing to go to hospital, and that they can recover afterwards as quickly as possible;
- A project recognises the vital role family and friends (carers) play in supporting someone with health and care needs;
- A final section discusses some of the enablers to support staff deliver the improvements partners want. This includes issues like joint workforce development and IT development, which is being considered across North Central London (see Next Steps);
- The entire Strategy helps make sure we successfully develop and sustain age-friendly communities as a whole as part of partners' commitment to the Borough Plan. The Ageing Well Strategy, and partners' commitment to it, will help make this a reality, but the concept of age-friendly communities is much wider than the scope of this Strategy.

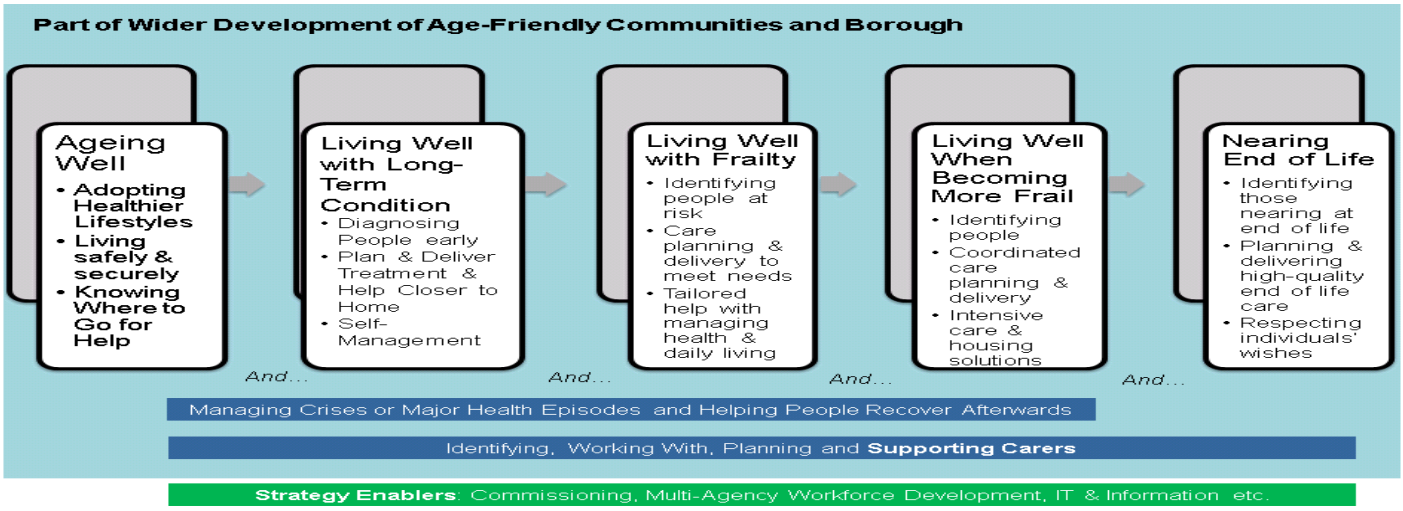


Figure 3 - A Life Course Approach to the Strategy

One of the Strategy's elements, **Living Well with a Long-Term Condition**, is the subject of a dedicated Long-Term Conditions (LTC) Strategy currently being developed within the CCG. However, a section in the Ageing Well Strategy outlines the improvements anticipated for people with LTC. However, one section of the current Strategy focusses on '**Living Well with Dementia**' given the importance of this condition on ageing well. We will make sure the Ageing Well and LTC Programmes are aligned so that we can provide joined-up plans for care and support to people with long-term conditions as they age, particularly for those who have more than one medical condition.

Each of the projects has its own section in this Strategy that sets out what's already in place, what our aspirations are in this Strategy and what our priorities for joint improvement are. A set of resulting improvement actions for each section are included in the Roadmap in Appendix 1.

Our Needs Now and in the Future

Figure 4 provides facts and figures about Haringey's older population, to which this Strategy is predominately aimed, and the services they utilise. There are 60,100 people aged 50+ living in the Borough, of whom 27,320 are aged 65+. These numbers represent 25% and 10% of Haringey's population. White British is the single largest ethnicity group in Haringey's older population (42%), with White Other making up another 24%, and Black and Asian ethnicities accounting for a further 18% and 10%.

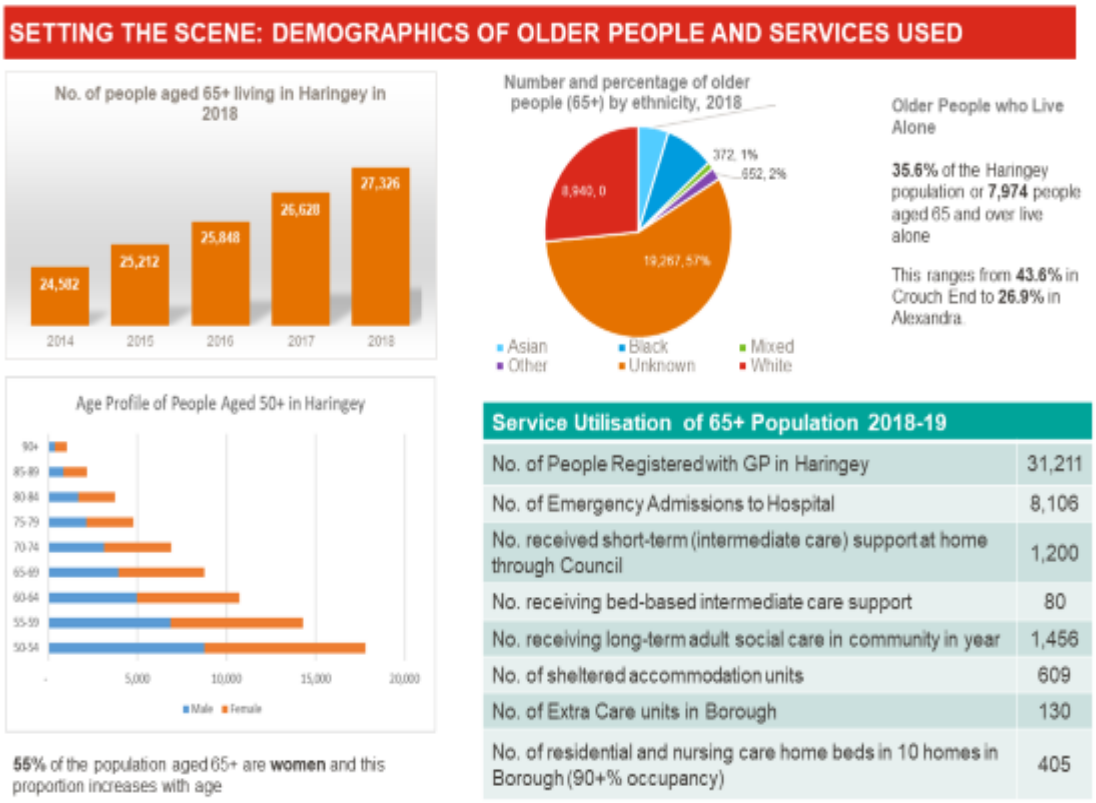


Figure 4 – Demographics and Service Utilisation for Haringey's Older Population

The population is ageing: it's estimated there will be 35,310 older people living in Haringey in 2028, an increase of 30% in ten years, with those aged 85+ increasing by 5% each year. As it's more likely older people will need more intensive health and care services than the general population, this is one reason why this Strategy is important.

Figure 5 shows there's a greater number of older people living in the west wards in Haringey. However, the more deprived wards are in the east and central wards (Figure 6). Average life expectancies for both men (81 years) and women (84) are the same as London. However, there's a big variation in overall and healthy life expectancies associated with deprivation in Haringey: people

in the 20% most deprived wards can expect to be in good health until, on average, 54 years, whilst their counterparts in the least deprived live in good health, on average, until 70.

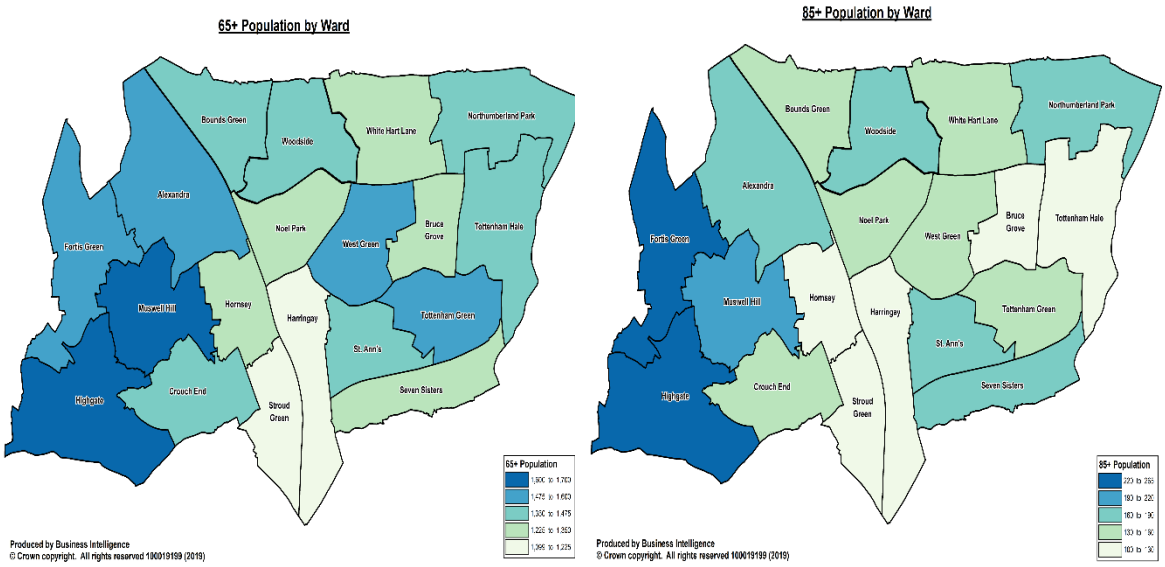


Figure 5 – Older Population in Haringey

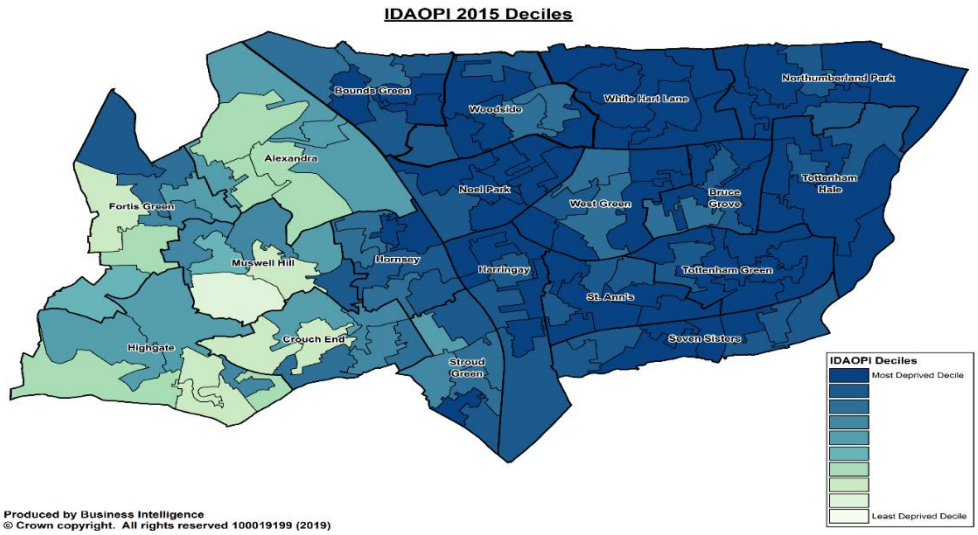


Figure 6 –Deprivation affecting older people index 2015 in Haringey

A vital part of this Strategy is to make sure older people are as in control over their own lives as autonomously as they can. We want to encourage and support people to lead fulfilling lives and develop meaningful social interactions and relationships as we know one benefit of making a contribution to the community is improved quality of life. This means that far from being passive recipients of health and social care, older people have a sense of purpose and feel valued by family,

friends, professionals with whom they work and their communities. To further this approach, older people have, and will be, active participants in shaping and taking forward this Strategy.

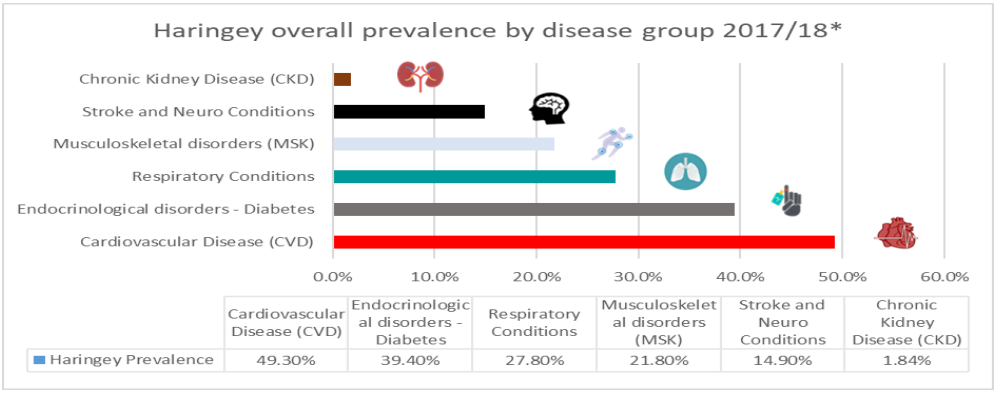


Figure 7 – Condition Prevalence in Haringey

We are developing a Long-Term Conditions (LTC) Strategy in parallel with this Strategy, and this will include a more comprehensive needs analysis. However, it does highlight that:

- A number of chronic conditions are known to impact significantly on individuals' health and life expectancy as they age in Haringey, including heart disease, diabetes and respiratory conditions. The LTC and Ageing Well Strategies have chosen to highlight 6 conditions (Figure 7) plus dementia on which Haringey needs to improve over the next few years;
- Individuals are more likely to have multiple long-term conditions ('multi-morbidity') as they get older: 30% of people aged 65-69 in Haringey have 2+ long-term conditions: this increases to 60% for those aged 85+: there's a greater risk people with multi-morbidity will be frailer.

The Ageing Well Strategy complements the LTC Strategy by focussing more precisely on the needs of (predominantly older) people with 'frailty', who often have multi-morbidities, and dementia.

Frailty

'Frailty' is not a single medical condition but rather a state of health. It refers to the impact of a combination of medical issues and symptoms on our body as we age - around 10% of people aged 65+ years are frail, but this proportion increases to 25-50% for those aged over 85.

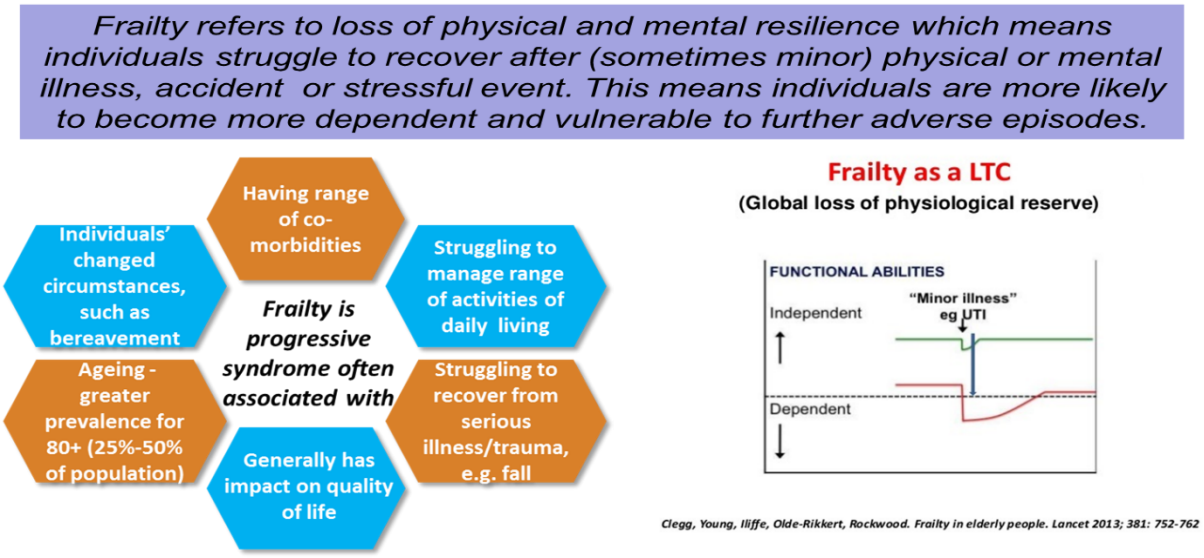


Figure 8 – Summary of Issues associated with Frailty

There are a complex range of medical, social and environmental factors that mean particular individuals are more or less likely to be frail. Figure 9 provides an insight into some of these factors. For example, there are conditions most often associated with frailty, such as musculoskeletal conditions like arthritis, respiratory conditions (e.g. Chronic Obstructive Pulmonary Disease) and falls/fractures, but the list in Figure 9 is by no means exhaustive.

Social factors are also known to influence whether someone is, or at risk of becoming, frail or frailer. For example, a recent national study[1] found older people who felt socially isolated were 75% more likely to become physically frail, whilst those living on low incomes are nearly twice as likely to be frail than wealthier individuals at the same age[2]. Trigger events such as bereavements and low mood are also known to impact on individuals underlying frailty and ability to recover after crises.

[1] Catharine R Gale, Leo Westbury, Cyrus Cooper, Social isolation and loneliness as risk factors for the progression of frailty: The English Longitudinal Study of Ageing, Age and Ageing, Volume 47, Issue 3, May 2018
[2] Watts PN, Blane D, Netuveli G Minimum income for healthy living and frailty in adults over 65 years old in the English Longitudinal Study of Ageing: a population-based cohort study BMJ Open 2019

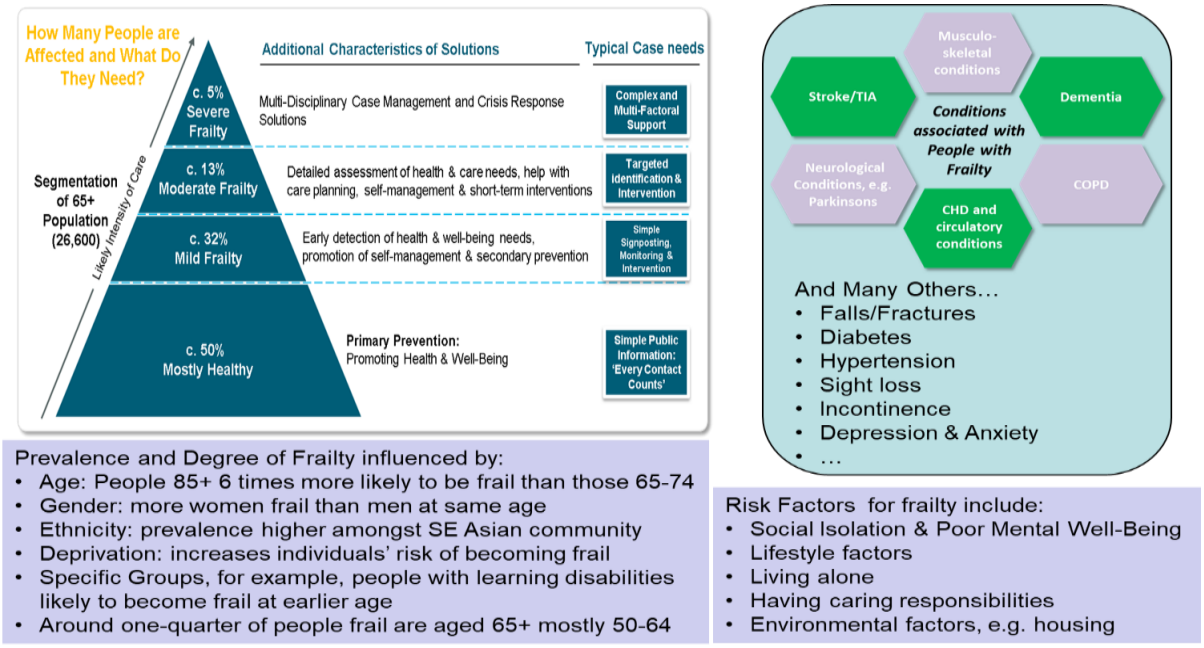


Figure 9 – Characteristics of People with Frailty and Response

People also have different degrees of frailty depending on their underlying needs. Figure 9 summarises the degree of frailty amongst the 65+ population in the Borough. It is estimated half of this population has some degree of frailty – **around 13,500 older people in Haringey**. One-third of the population (8,700) have mild frailty, with 5% (1,350) having severe frailty.

However, the 18% of people with moderate and severe frailty are estimated to utilise 40% of health and care resources, such as the costs of hospital admission and adult social care due to their underlying needs[3]. There is evidence locally and nationally[4] that up to 15% of older people who attend A&E could be better managed at home, such as people presenting with common respiratory conditions or urinary tract infections. In addition, we know some individuals, and those who care for them, could also be encouraged to better manage their conditions, or access help earlier, to avoid crises.

However, the same study suggested many older people presenting to A&E nationally are sicker and are more likely to need admission. One reason is that one-third of patients admitted to hospital as an emergency now have 5+ conditions, such as heart disease, stroke, diabetes, dehydration, hip fracture or dementia, and this proportion trebled in 10 years. Many patients are now older, with the proportion of 85+ patients admitted increasing by nearly 60% over the last decade. This mirrors our experience in Haringey in which we've seen a greater proportion of older people admitted to hospital once in A&E. Many are frail and could benefit from a more joined-up and multi-agency approach between hospital and community to coordinate and deliver their care, thus mitigating future crises.

[3] Vernon, M., Hopper, A. and Thompson, A.: NHS RightCare Frailty Pathway: An optimal frailty system

[4] Steventon, A., Deeny, S., Freibel, R., Gardner, T. and Thorlby, R., Emergency hospital admissions in England: Which may be avoidable and how?, Healthcare Foundation, May 2018. A local audit of recent A&E attendances indicated similar results

Haringey's Borough Partnership has developed a 'care cone' to summarise the level of need amongst Haringey's population and partners anticipated response to meet this need. Figure 9 uses this approach to describe the degree of support an individual will need will vary according to their underlying frailty. For example, those older people who are mostly healthy may simply need encouragement and signposting to preventative solutions to keep them as healthy, independent and connected as possible. Those with more severe frailty are likely to need complex and multi-disciplinary support facilitated through person-centred coordination of their care – as well as being encouraged and supported to be as healthy and independent as possible in their situations.

Although this Strategy chiefly focusses on older people, some people who are frail are under 65, mostly aged 50-64. It's estimated around one quarter of people with frailty are **under 65, i.e. 4,500 people in Haringey,** the majority with mild to moderate frailty, but up to 225 live with severe frailty. Particular 'at risk' groups amongst this younger population include:

- Those with chronic and enduring physical disabilities or severe mental health issues;
- Those with learning disabilities who are known to become frailer at a younger age than the general population, particularly those with Downs Syndrome;
- Those who are subject to severe and multiple disadvantage, such as those who may be homeless.

The solutions discussed in this Strategy apply to these groups and partners are working to ensure these solutions join up with specialist pathways, e.g. to support those with disabilities as they age.

Falls

As people get older and/or become frailer, they are more likely to fall. As well as the potential impact injury such as a fracture, older people who fall are also more likely to suffer longer-term consequences, such as a loss of independence, confidence and potential development of further long-term conditions or complications, all of which can lead to physical and mental deterioration and the risk of becoming frailer. It can also increase their risk of further falls and fractures.

The causes of a fall are often a result of the interplay of multiple risk factors associated with an individuals' underlying health conditions, medical history and its management, their environment and the event itself, e.g. the activity they were trying to undertake when falling. People with specific conditions, such as visual impairment, arthritis, Parkinson's disease, diabetes, stroke, delirium or dementia, are at greater risk of falls. Other risk factors include having a previous history of falls, muscle weakness, poor balance, alcohol consumption, incontinence and use of particular or multiple medication(s). Falls and fractures are included in this Strategy as they therefore often represent particular events or triggers that have an adverse effect on an older person's overall health and wellbeing and a sign of underlying or deteriorating health issues.

Figure 10 contains some facts and figures about falls and hip fractures in Haringey. It's estimated one in three people over the age of 65 and one in two over the age of 85 fall every year. Care home residents are 3 times more likely to fall than those living in the community and 10 times more likely to sustain a significant injury – this is often because these residents are particularly frail. The short- and long-term costs to the health and social care system of a fall are substantial, as they result in an

injury or fracture that often needs treatment and hospitalisation and in the need for further long term support.

Falls, together with low bone mineral density, are the main cause of hip fractures, a particularly devastating injury for the older population because nearly half of people with these fractures are not able to recover their ability to walk and half may require need care in a residential or nursing home.

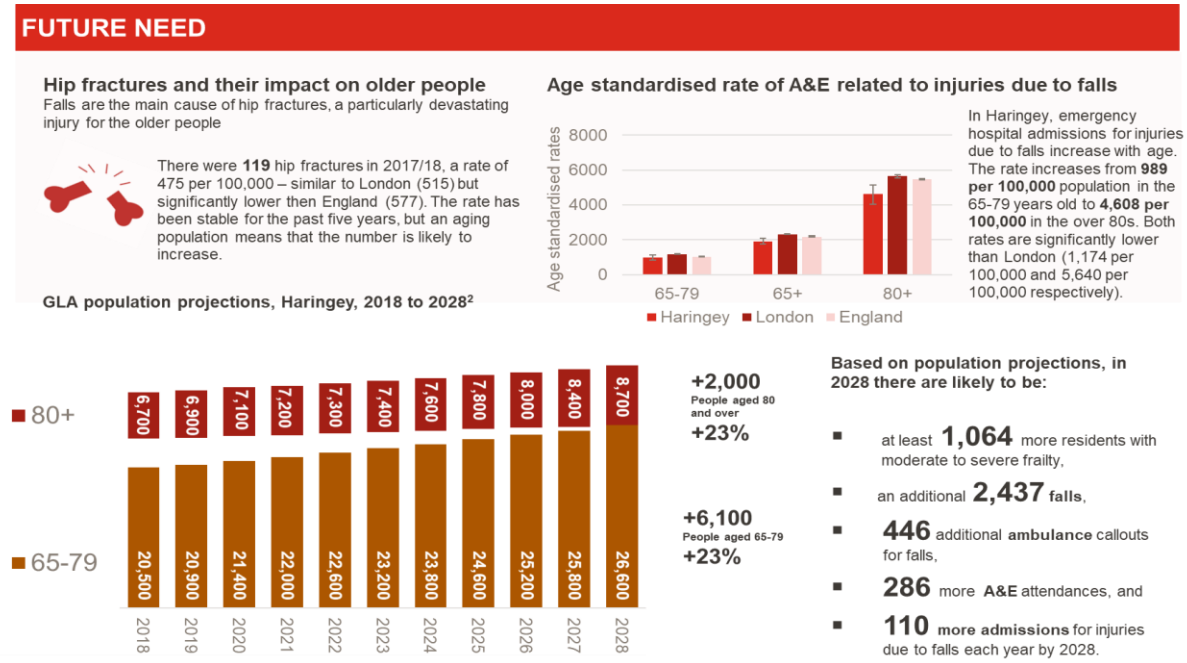


Figure 10 – Falls and Fractures in Haringey now and in the future

Tackling falls and fractures requires a whole system multi–agency approach. Reducing risk factors is crucial to preventing falls. Whilst the public, private and voluntary sector has a key role in reducing risk factors (e.g. reducing the risk of people falling in care homes or in hospital), older people can often reduce their own risks themselves by making sure there are fewer slips/trips hazards in their home and eating and drinking well, maintaining physical activity. Activities such as Tai Chi are known to be particularly effective in and improving strength and balance as people age. Haringey's Strength and Balance Scheme is a 12-week programme open to all residents at risk of falls or repeat falls and it aims to support people to undertake strength, balance, stamina and flexibility exercises. Similar activities are available in care homes.

Our aspiration is that all older people at risk of falling or those who have presented to services with a fall should be offered a falls risk assessment. Our Integrated Community Therapy Team (ICTT) in Whittington Health Trust undertake such assessments which recommend appropriate interventions to other professionals and individuals themselves, such as optimising an individual's medication regime, highlighting slips/trips hazards or recommending small items of equipment that can make a difference to people. ICTT will also refer people onto relevant services, e.g. where a risk of fracture due to low bone mineral density has been identified.

Dementia

'Dementia' is a term describing a set of conditions associated with the brain. They affect individual's memory, ability to undertake everyday tasks, communication, problem-solving and perception.

Some people may develop behavioural and psychological symptoms such as depression, anxiety or even hallucinations as their conditions develop. One in three aged 65+ will develop dementia as they age with the risk of acquiring the condition increasing as they get older. As Haringey will see a welcome increase in the number of older people over the next decade, there will also be an increase in the number of people affected by dementia.

Figures 11 and 12 contains some facts and figures about dementia. Alzheimer's disease is the most common form of dementia. A further 20% of people with dementia have vascular dementia, which is caused by reduced blood flow to the brain and is associated with conditions such as strokes.

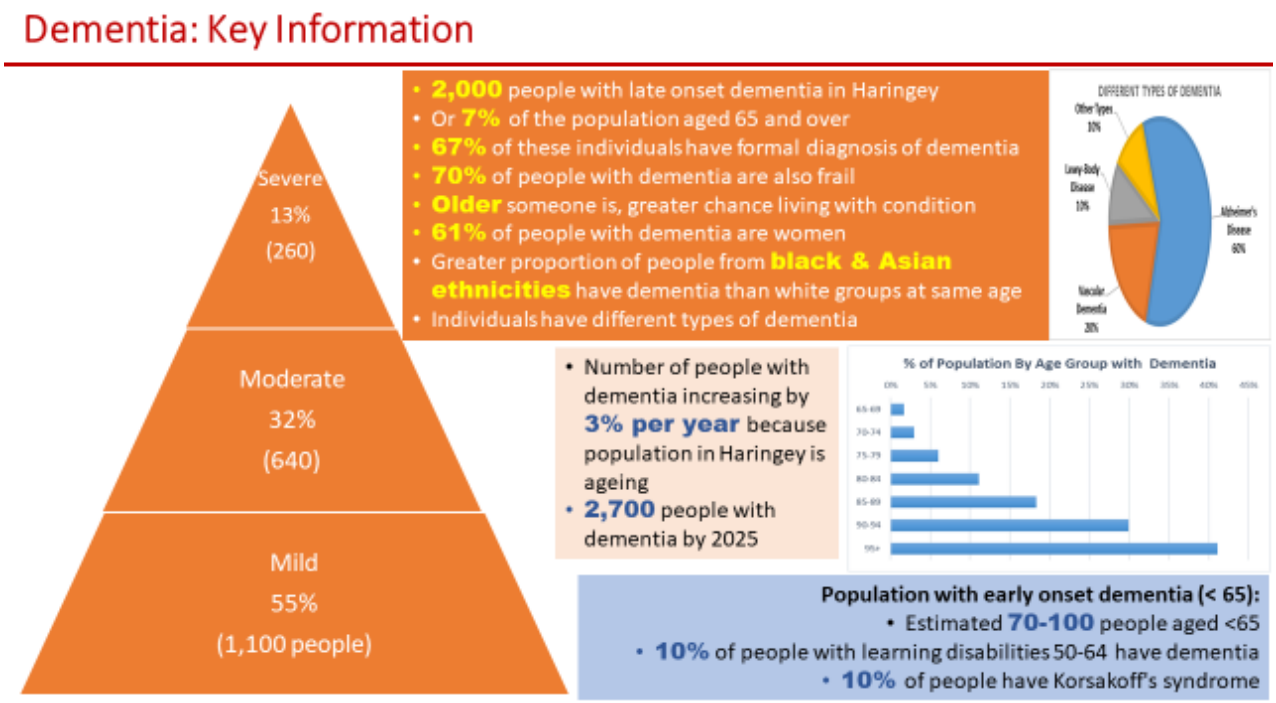


Figure 11 – Facts & Figures on Prevalence of Dementia in Haringey

Sadly, dementia is progressive condition, which means symptoms gradually get worse and we know that getting a diagnosis can therefore be devastating. However, people can live well with dementia for a number of years if they get access the treatment and support they need early enough, such as the right medication, helping people remember their life stories and continuing to be physically active. There's evidence leading a healthy lifestyle – being active, eating well and managing your weight – can reduce your risk of acquiring dementia. Conversely, particular medical conditions – such as high blood pressure and obesity – increase this risk, particularly for vascular dementia.

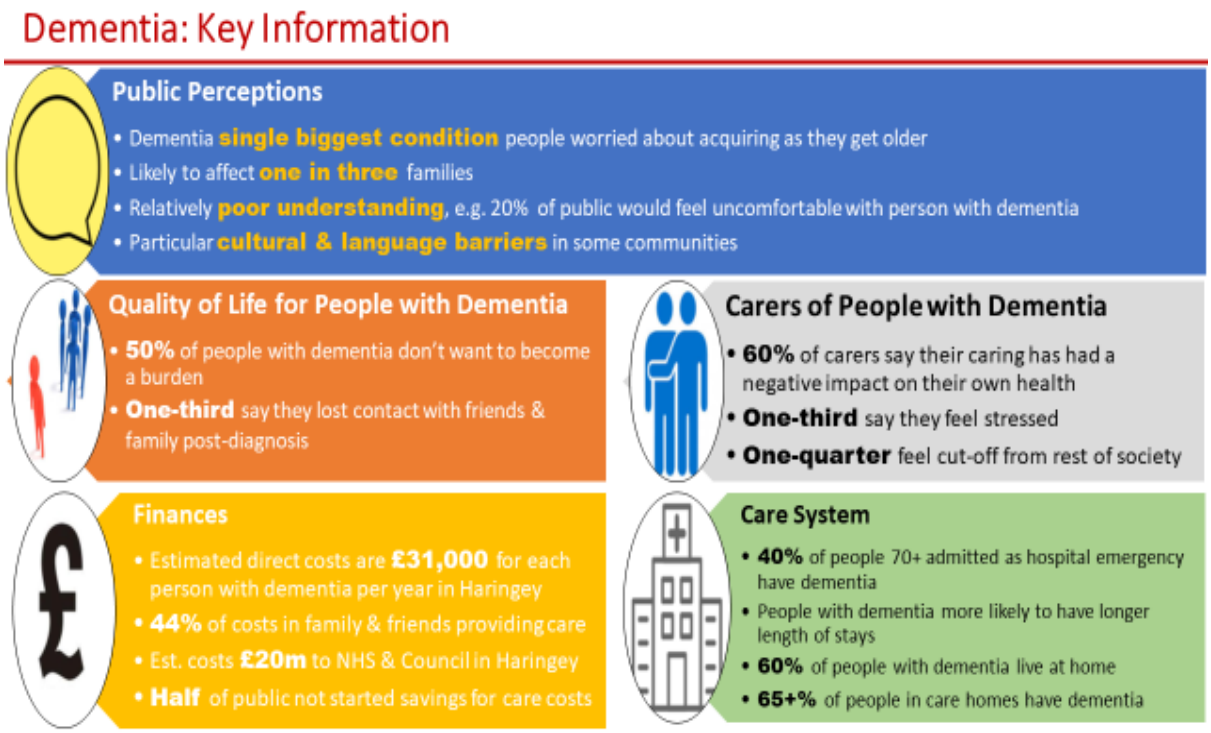


Figure 12 – Intelligence about Dementia

We know most people living with dementia often have other conditions and this means they are more likely to be frail. The impact on individuals and families may be compounded by personal circumstances, such as living alone. We want to encourage people with dementia and their families to plan for the future and avoid preventable crises, such as being admitted to hospital or care home or carers feeling unable to cope any more. Working together to support people to live well with dementia is vitally important and has its own section in this Strategy.

We also know there needs to be a step-change in how people think about dementia. Through our Dementia-Friendly Haringey, we want to mobilise our communities to play their part in tackling these issues as we know simple changes can make a big difference to people's lives.

Carers

'Unpaid carers' – family and friends who support someone with personal, social or health care needs ('cared for') – provide a vital contribution to supporting older people. It's estimated 60% of us will become a carer at some point in our lives, and the single largest group are caring for people with frailty, physical disabilities or dementia.

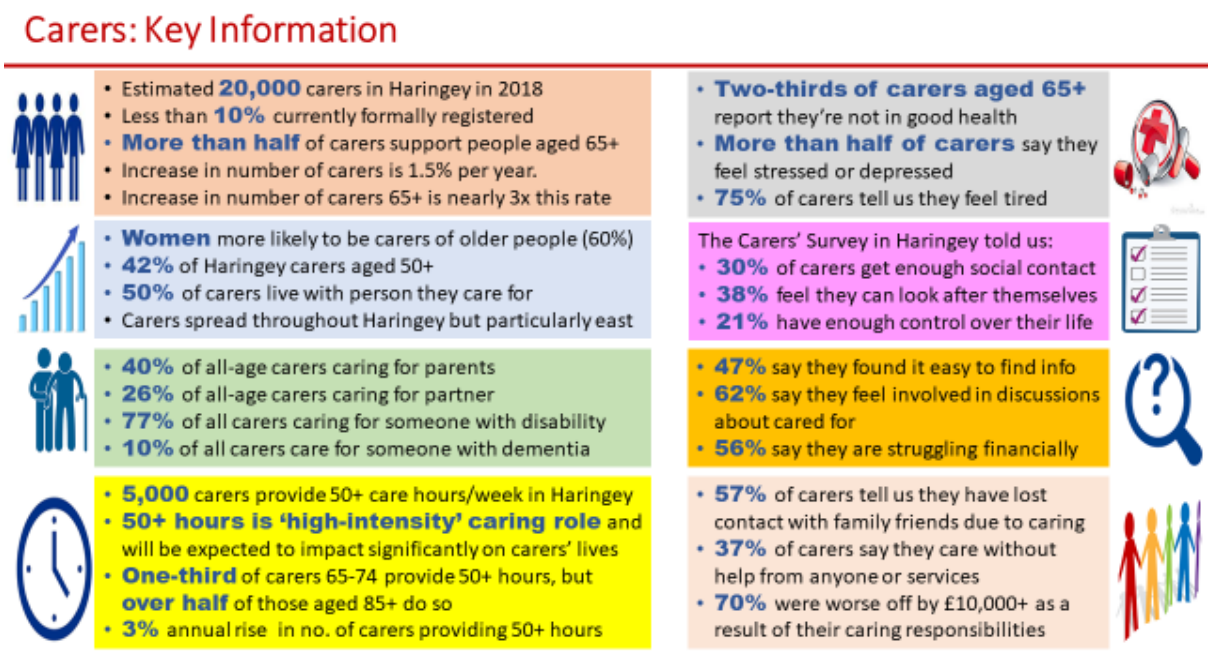


Figure 13 – Facts & Figures about Carers

Figure 13 provides some facts and figures about carers in Haringey. There are estimated to be 20,000 carers (for people of all ages) in Haringey and we need to improve the number of people formally registered as such on the Council's Carers' Register which is an important step to getting help.

For all age groups, carers at greatest risk of adverse outcomes are those providing more than 50+ hours informal care per week – around 5,000 people in Haringey. These individuals are at particular risk because their caring role impacts on their capacity to be in work, participate in social activities, and on their physical and mental health and well-being. Many of these carers are older and could be in poor health, e.g. the majority of carers aged 85+ provide 50+ hours care per week for someone else.

It's important we identify and support carers to continue in their caring role, particularly those with high-intensity caring responsibilities, those carers who are frail (and/or older) themselves and those living with someone with dementia. This support includes direct solutions to help people continue to care, for example providing respite care to the cared for to help carers to take a short-break, but also advice and help to improve their finances and access to benefits and to have a life of their own.

Services for Older People and What People tell us about them

A range of services already support the needs of older people, those with frailty or dementia and their carers. A list of these services broadly categorised into the structure of the Strategy can be found in Figure 13. These services provide a platform on which to build our plans for are integrated approach to supporting people.

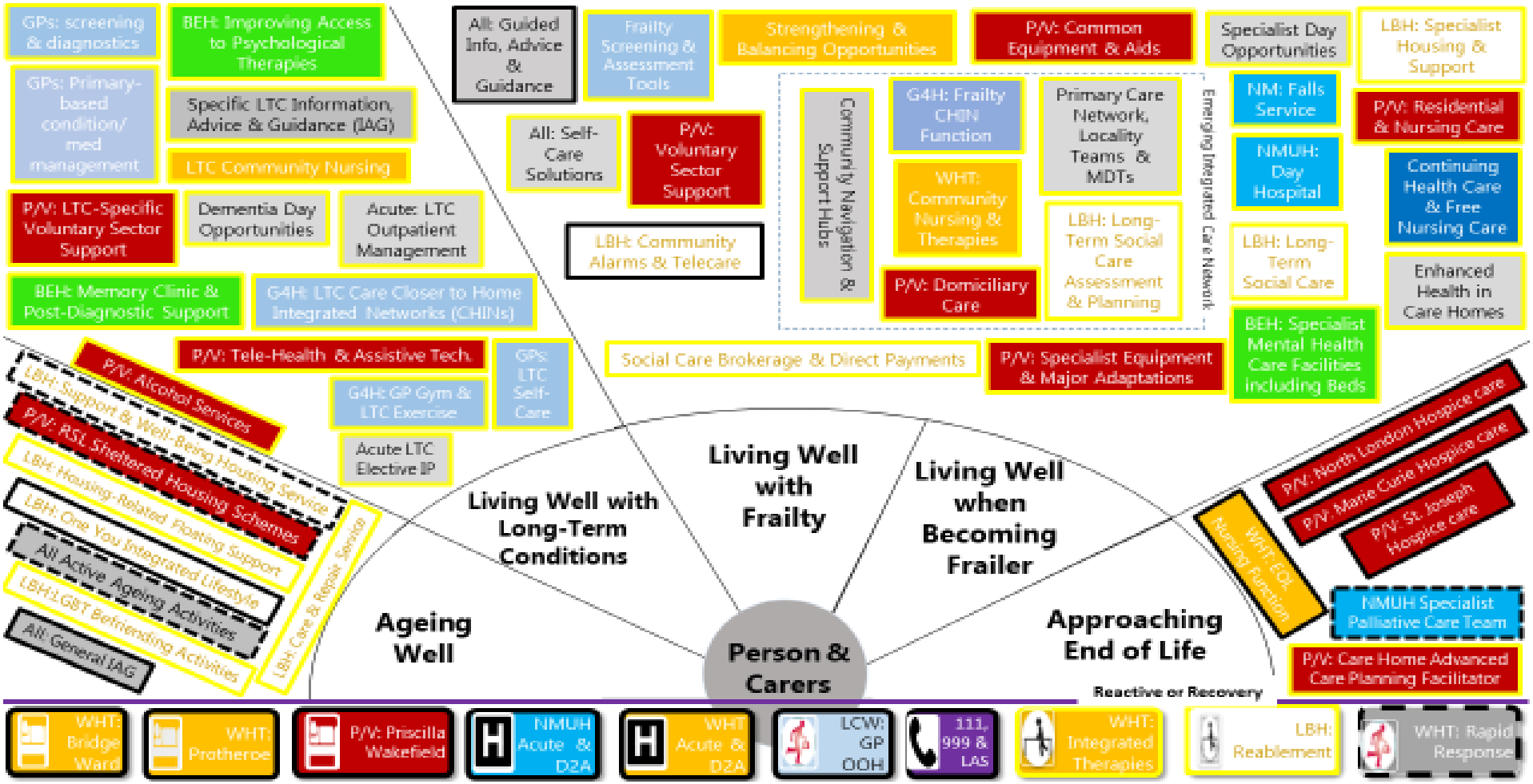
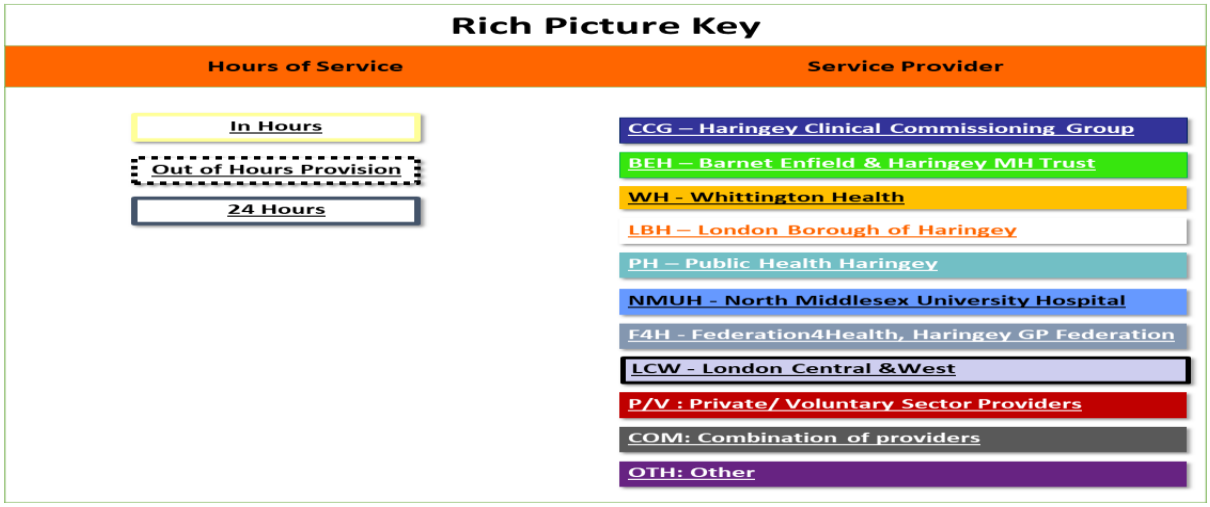


Figure 13 – Existing Services to Support People as They Age



We know many people value the support services offer but we have also listened to people about the things we could improve. Relevant sections of the Strategy discuss the services we have in more detail and our proposed improvements. Some common feedback from older people and carers include:

- Older people should be seen as an asset, rather than a burden, to the community. People could be encouraged to self-manage their care, be as independent as possible and to support others.
- Information about, and access to, services could improve and be more timely across the Borough. For example, only half of carers reported they found it easy to find out information and advice about services, support and benefits in the Council Carers' Survey;
- Many people valued the services they received. However, this was not true of everyone and there needs to be a greater level of consistency of support particularly within GP practices;
- Individuals' care and support could be more joined up and better coordinated particularly if the case was complex. At times, this support could be delivered in a timelier way to help them. Older people particularly welcomed the idea of more localised services with more time to discuss their cases and help to navigate the care system;
- People and carers could be better treated as 'experts by experience' and professionals could better listen and respect their views. For example, three-fifths of carers felt professionals consulted them in the care of the individual whom they cared in the Carers' Survey.

Ageing Well and Supporting an Age-Friendly borough

Current Position

An important part of our Strategy is to make sure older people can lead as healthy, fulfilling and independent lives as possible as they age. This will help reduce people's risk of acquiring, or worsening, their long-term conditions and becoming frail. But we also need to make sure Haringey is an age-friendly Borough, that is our communities and services that we all use can support people with particular needs as they age – sometimes simple changes can make a big difference to people's lives. This section of the Strategy focusses on both of these issues.

A range of solutions are already available in Haringey broadly aimed at supporting people to age well:

- Provision of information, advice and guidance across a range of national and local partners about the benefits of, and how to, adopt healthier and more active lifestyles in older age. We continue to encourage people to, for example, eat and drink well, take more exercise and stay connected and join in social activities they might enjoy as they get older;
- 'Living well' solutions particularly targeted at older people to age well. This includes, for example, providing them with opportunities to undertake social and physical activities they might enjoy such as Silverfit, which provides activities such as yoga, badminton and Nordic walking sessions for middle-aged and older people in Haringey. I's equally important solutions are in place for people less able to access such sessions: for example, many care homes provide chair-based exercises for residents. The London Borough of Haringey recently published 'Active Together', its Physical Activity & Sport Strategy for Haringey, to promote physical activities for all ages;
- There are many voluntary and community services and resources available that promote ageing well in Haringey, both statutory and commissioned services and those in the voluntary and community sector. For example, the North Tottenham pilot mapped over 100+ organisations providing a huge range of solutions to the diverse community in this relatively small area, many that relate to older people such as luncheon clubs. The 50+ Forum recently produced a directory of Haringey services older people might find useful and LBH's website has a similar list of such opportunities;
- Voluntary and public-sector partners are increasingly working together to create community and information hubs in local communal building or facilities such as libraries or sheltered accommodation. Connected Communities, one of our information hubs, for example, can help older people with housing, financial and benefits matters and we plan to expand their work geographically and in terms of the help and advice they can offer to better promote, for example, healthy lifestyles or support for carer. More generally, we are increasingly looking at how we can use all of our community assets – people, places and services – to better support older people, e.g. making the best use of green spaces, such as parks, allotments etc. so people can have the opportunity to be as physically active as possible;
- We want to build on the approach taken by Haringey's award of Dementia-Friendly Status to consider how the Borough could become more Age-Friendly (see Living Well with Dementia).

Despite all of these positive improvements, we know there's more we could do:

- Some people tell us they can find it difficult to find out about the resources and opportunities available, whilst others have difficulties accessing them;
- People tell us that sometimes the various opportunities and solutions are not as well-connected as they could be and professionals working with people, such as GPs, don't always know about these opportunities;
- There's likely a differing resources to help people age well in different areas of Haringey. Whilst this might simply reflect the needs of the population in particular neighbourhoods, there's an opportunity to build on these solutions.

Aspirations

Our aim is to ensure people to work together to support people to age well. We will do so through working with our partners, including older people and the community and voluntary sector, and this will include strengthening individuals, families and communities so that by 2022:

- Our places, services and communities will be better shaped around the needs of people as they age, including people who might need varying degrees of help to access them. We will have made significant strides towards implementing an age-friendly Haringey through strengthening individuals and communities and, as partners, we will support our communities to build their assets. This will include more older people volunteering in their communities;
- Our information, advice and guidance across partners provided will be more consistent and accessible to people who need it to help them age well and will be suitably tailored to the needs of these individuals. Consistent messages about how to do so will be delivered across partners who will be able to signpost people to others that could help them. Information, advice and guidance will be available locally across the Borough tailored to the community needs and using local facilities. This will be part of a wider information 'offer' for older people about their housing, finances, income and so on;
- More older people have adapted their lifestyles to make them healthier and more independent because they are more knowledgeable about the changes they can make, such as eating or drinking well, and it is straightforward for them to make simple adjustments to their lives;
- Health and social needs of older people and their carers will be better screened consistently across the Borough to support earlier access to advice, diagnosis or treatment through our local care and support partners working together. Support for older people will transition seamlessly between community and voluntary sector and statutory sector support as their needs change.

Key Priorities

Working with older people and their carers, our main priorities are to build on our solutions including those already in place, or could be mobilised, in local communities and services within them. This will mean:

- Improving our understanding and knowledge of existing services in communities. We will work with these communities and services to develop and nurture future capabilities, and support volunteering and peer support opportunities;
- Partners will increasing integrate and use available resources and facilities for use within the wider community, e.g. expansion of the 'community hub' concept within Homes for Haringey in which the wider community can use their facilities for activities. The aim is to have a network of 'ageing well hubs' across Haringey;
- Improve and streamline information, advice and guidance across partners working in local communities and tailor this around the needs of the population they serve. This should improve the range and utilisation of solutions available in communities as knowledge of them is more widely available to older people and those who can connect them to these solutions. They will also increasingly integrate with wider advice and help available through Connected Communities and others on issues, such as financial matters, also important for older people;
- Improve the screening of older people's health and well-being needs and make this more consistent within our GP practices and local integrated care networks; and ensure there's an integration between community and voluntary sector and statutory sectors as individuals needs change. This includes, for example, ensuring people can better plan for their future needs and know what to do if they are feel unwell.

High Level Actions				
#	**Milestones**	**Start Date**	**End Date**	**Owner**
	Improve the use of Housing Hubs/Community Hubs as community facilities/meeting place, with care navigators aiming to improve engagement Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar -21 PIII: Mar-22	Ageing Well Project Group
	Increase prevention and self-care, as well as self-referral to GP/system (as appropriate) especially in those with long term conditions. Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Join up existing services by improved signposting between services and by mapping of complementary services by GPs Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Normalise consideration of 'financial health', including sign posting to address financial concerns and encourage financial planning. Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Increase use of green spaces, allotments and interactions with nature to improve physical activity levels and wellbeing Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Improve awareness & uptake of volunteering opportunities (all ages) Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group

	Raise awareness/improve transport options for older people Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Actively promote carer's health and wellbeing Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group
	Provide guidance about the setting up of community lunch clubs Phase I: Initial Development Phase II: Further Development Phase III: Finalised Development	PI: Sept-19 PII: Apr-20 PIII: Apr-21	PI: Mar-20 PII: Mar-21 PIII: Mar-22	Ageing Well Project Group

Living Well with Dementia

Current Position

'Dementia' is an umbrella term for a range of progressive conditions affecting the brain. It results in a decline in multiple areas of brain functions, including memory, reasoning, communication skills and the skills needed to carry out daily activities. Its impact on individuals and their families may be compounded by other conditions and by personal circumstances such as living alone. A small number of people aged 50-64 years may develop early onset dementia. The intention is these individuals should have access to the same solutions as discussed below and in the wider Strategy. This is particularly important as some groups at particular risk, such as those with learning disabilities, are also at risk of being frail at an earlier age.

A range of solutions are already available in Haringey to treat people with dementia and help them and their families live as well as possible with the condition:

- The Alzheimer's Society awarded Haringey Dementia-Friendly Status to recognise the work of 60 organisations to raise awareness of dementia amongst the population to promote a dementia-friendly Borough. This alliance encourages organisations to make simple adjustments to their services to better accommodate people with dementia live as normal a life as possible. These organisations include health and care commissioners and providers, but also a wider range of services, such as arts and community groups, housing organisations, leisure centres, banks and schools;
- Individuals are screened for cognitive impairment initially within their GP practices and those cases of patients that need further investigation are referred to a consultant-led Memory Service for a formal diagnosis. This is important to ensure people receive the medical treatment and support that's right for their condition and circumstances. The Memory Service also provides short-term services to help people come to terms with, and adjust to living with, their condition. The Service will discharge the care of the individual to their GP practice to continue with their treatment;
- Individuals are already able to access a range of community-based support for people with dementia and their carers provided by the voluntary and private sector and Council. Some of these services provide advice, information and support for people to live well with the condition, whilst others are Council-funded services available to people (often with more advanced dementia and/or other needs) to help them live at home, such as dementia day opportunities at the Haynes Day Centre;
- We know that 70% of those with dementia are also frail and have multi-morbidities. The services discussed in other sections of this Strategy in relation to frailty, such as Care Closer to Home Integrated Network (CHINs) and Enhanced Health in Care Home models, provide support to a significant number of people with dementia in the community and in care homes who have other care needs;
- There are a range of services that support people with dementia who have more advanced dementia and/or behavioural issues. This includes nursing and residential care home provision in the Borough, as well as specialist mental health bed-based facilities for those with dementia.

We know individuals and families who use these services value the support on offer, but we recognise there are challenges which this Strategy can address. In particular:

- Using the Dementia-Friendly status of the Borough as a launch pad, we need to continue to raise awareness in the Borough about cognitive impairment and dementia, particularly across Haringey's diverse communities to ensure people are diagnosed as early to plan their subsequent treatment, care and support;
- We need to improve, and provide earlier access to, diagnosis, in particular ensuring that GP practices more consistently check the cognitive abilities of their patients;
- We need to improve post-diagnostic care and support more consistently for patients and families returning to the care

of their GP practices following discharge from the Memory Service;
- We need to strengthen our existing crisis resolution support to better support people and families better manage significant and unexpected changes in their health status or circumstances;
- We need to improve how services are coordinated to better support individuals and their families as their condition gradually advances and/or they become frailer including as they plan for end of life.

Aspirations

Our aim is to ensure people with dementia are diagnosed as early as possible and that they and their carers get the right treatment, care and support for them that will help them live as long, fulfilling and healthy lives as possible as they age.

In order to achieve this, we need to improve a range of services that work together to improve outcomes for people living with the condition – to improve our dementia pathway. Our services will form a coherent network that responsively support individuals and their families as their conditions and/or circumstances become more complex and that their views will be central to planning and delivery. We want to avoid people being diagnosed at an advanced stage with the condition or who present to services at crisis because there is support isn't available early enough. All of this will mean making sure we are making the best use of our collective resources.

Working with patients and carers, we intend to improve our dementia pathway. Key improvements include:
- Development of Dementia-Friendly Haringey in which more, and a greater range of, organisations commit to learning more about dementia and being better able to shape their services around the needs of people with dementia;
- Effective public awareness-raising about the condition, its impact and the importance of early diagnosis, particularly amongst those communities who are currently under-represented in terms of diagnostic rates. This awareness-raising will include how particularly older people can adopt healthier lifestyles to mitigate the risk of developing the condition;
- This awareness-raising will be strengthened through ensuring cognitive screening being part of the annual health checks available to older patients within their GP surgeries to better identify individuals with mild cognitive impairment or the early signs of dementia. In turn, the long-term development of primary care networks (in which GP practices will come together with partners to better support 50–80,000 populations in Haringey) will facilitate the sharing of good practice, working closely with the Memory Service. This will lead to timely diagnosis of more people at the early stages of the condition in which treatments can be most effective.
- The opportunity for people to have a navigator/coordinator from the time they are referred onto specialist service for diagnosis onwards. The navigator's role is to provide tailored advice, information, guidance, signposting and/or support coordinated across the care and support system, if the person wishes. This is particularly important to support individuals to initially come to terms with any diagnosis and to help them consider how to live as well as they can with the condition in the longer-term. The navigator will support planning for individuals and families within the Memory Service and provide continuity and coordination of support following the individual's discharge from the Service back to primary care. An individual's named navigator may change over time as their condition becomes more advanced and/or needs are more complex, but the individual and their carers should have always known who this person is;
- Part of the navigator and other professionals' roles will be to ensure individuals and families have a better understanding of the condition and how it, and the treatment and support provided, may impact on them and how they can live as healthy and fulfilling a life as possible. This includes how to mitigate crises and plan for the future;

- A tiered approach to community-based opportunities for people with dementia will be available in the Borough, ranging from access to more dementia-friendly universal services available to everyone (such as leisure centres or community groups), locality-based 'hub' models of more targeted support for individuals and a small number of more specialist day opportunities for people with advanced dementia. Life reminiscence and other approaches, building on what we know works, such as singing for the brain, will be more widely available through these opportunities. Part of this tiered approach includes establishing and sustaining peer support networks for carers;
- People will access specialist care and support to ensure we deliver a holistic and person-centred approach to care planning and delivery across sectors and disciplines. Examples include better coordinated care for people with dementia with moderate or severe frailty between primary, community health and secondary care and social care through locality-based integrated networks described in other sections of this Strategy; and access to psychological support solutions for people living with dementia and their carers;
- People with dementia and carers will increasingly benefit from both widely available digital solutions and more specialist technology, aids and adaptations to continue to live as independently and as safely as possible as the Council and other providers continue to improve their digital 'offer';
- More carers will be identified and benefit from a wider range of support opportunities as part of the planning for the support of the individual with dementia and will, in turn, get the help and support they need in their own right and to continue in their caring role; this will include wider access to respite care;
- Better coordination between services and their closer liaison with the person with dementia and carers often facilitated through the navigator/coordinator will help mitigate crises arising. However, effective resolution services will be available quickly if crises do arise, including to those individuals or carers needing unplanned hospital attendance or admissions and who need to return home in a timely and safe way;
- A geriatrician-led Enhanced Health in Care Home model will provide effective care for people with dementia living in residential or nursing care homes. This will support staff in care home to better manage the cases of particular residents with complex needs including those in the advanced stages of the condition;
- People with advanced dementia, including those with behavioural issues, will be benefit from assessment and long-term treatment beds within specialist mental health beds to help understand and treat them. Patient's referral, admission to, and discharge from, these facilities into the community will be well-coordinated between agencies;
- Professionals will provide opportunities for people living with dementia to consider their options about what will happen when their conditions become more advanced and their cognitive capacity to make decisions becomes impaired and/or they approach end of life. Individuals will have the opportunity to create their own advanced care plans to capture these choices and be confident that professionals will respect these wishes.

Key Priorities

Working with people with dementia and their carers, our main priorities are:

- Ensure we are able to better and more systematically screen and identify people who may have cognitive impairment and improve subsequent medical management of patients;
- Continue to improve diagnostic rates and reducing waiting times for medical diagnosis and subsequent treatment;
- Help people come to terms with diagnosis and improving post-diagnostic support to ensure people are able to continue their lives as long as possible including access to community navigators;
- Improve information, advice and guidance not just to individuals & families living with dementia, but also professionals' knowledge of available services and dementia pathways in Haringey (included in Becoming Frail);
- Implement a tiered approach to day opportunities for people with dementia and use of Haynes Day Centre and other facilities in as personalised way as possible depending on needs of individuals;

- Improve holistic care and support planning and delivery of care for people with dementia across agencies, particularly for those with more severe dementia and/or complex needs, who may also be frail;
- Improve care planning and support for people with dementia living in care homes and support for staff working in these care homes (included in Becoming More Frail Section);
- Better identify and support carers of people with dementia in their caring role (included in Supporting Carers);
- Continue to build Dementia-Friendly Haringey across different organisations

High Level Actions				
#	Actions for Priorities	Start Date	End Date	Owner
2.1	Continue to build on Dementia-Friendly Haringey and work across partners to engage more organisations, raise awareness amongst more staff and support more people to become Dementia Friends	May-19	Mar-22	Dementia-Friendly Haringey Leadership Group: specific targets to be set for each year
2.2	Improve and disseminate end-to-end cross-agency dementia pathways for people with dementia and their carers and develop outcomes framework to monitor progress	Apr-19	Dec-19	Dementia Reference Group
2.3	Work between HCCG, BEH MHT and Primary Care Networks to improve screening & diagnostic pathways for people with cognitive impairment	Jan-20	Sep-20	Paul Allen, HCCG/LBH as commissioner lead with providers
2.4	Work with Haringey's Primary Care Networks, BEH MHT other health partners to improve, and share good practice on, medical and clinical management of patients from diagnosis and onward management of patients • Phase I: Agreement on protocols & future management • Phase II: Implementation	P I: Dec-19 P II: Jul-20	P I: Jun-20 P II: Mar-21	Paul Allen, HCCG/LBH as commissioner lead with providers
2.5	Work with BEH MHT and partners to improve support available to people and carers to help them come to terms with diagnosis and begin to plan for the future	Sep-19	Mar-20	Uttara Mandal, BEHMHT
2.6	Establish network of appropriately trained community navigators across partners who can advise & support people with dementia and carers, to connect them with services and to be a contact and liaison point for them	Sep-19	Mar-20	Paul Allen, HCCG/LBH as commissioner lead with providers
2.7	Across partners, improve clinical and practice knowledge and skills in managing people with dementia and knowledge to support people through dementia pathways Phase I: Planning and development (2019/20) Phase II: Implementation across workforce (2020/21)	Nov-19	Mar-21	Dementia Reference Group lead to be identified
2.8	Improve access to day opportunities for people with dementia and carers, including those with more complex needs; work on developing a 'hub' approach so that workers in services for more complex needs can support staff in other services work with people with dementia Phase I: Planning and initial development (2019/20) Phase II: Implementation (2020/21)	Oct-19	Mar-21	Dementia Reference Group

2.9	Ensure wider frailty network under development, incorporating Integrated Care Networks and joint intermediate care, is able to plan, assess, manage and review the cases of people with dementia, particularly those with more severe dementia and/or complex needs Phase I: Planning and initial development (2019/20) Phase II: Full implementation of ICNs (2020/21)	Oct-19	Mar-21	Paul Allen, HCCG/LBH as commissioner lead with providers
NOTE Action relating to training community navigators who can advise on dementia can be found in *Becoming Frail*				
NOTE Action relating to cognitive screening check in routine GP annual health screening & reviews for those aged 75+ can be found in *Becoming Frail*				
NOTE Actions relating to improving and bring together available public information, advice and guidance about dementia and services to support them can be found in *Becoming Frail*				
NOTE Actions relating to ensuring Enhanced Health in Haringey Care Homes model adequately supports needs of people with dementia can be found in *Becoming More Frail*				

Living Well with a Long Term Condition

Current Position

Better management of people with long-term conditions will be one of our key priorities as a partnership. We want to move to a situation in which the health system is organised around managing individuals' needs holistically rather than services or specific conditions as they age. We also know that people with long-term conditions could be better managed in the community and want to enjoy a good quality of life free from frequent crises and unnecessary hospitalisation.

Prevention and early detection of a potential long-term condition is key to reducing the risk of people acquiring a LTC or this condition becoming worse. A range of high-quality community and secondary care services already exist and work closely with primary care to diagnose, treat and manage a wide range of conditions such as:

- Endocrinology: Diabetes
- Respiratory: Asthma and COPD
- Cardiovascular: high blood pressure etc.
- Musculoskeletal: Osteoporosis, Arthritis, etc.
- Chronic Kidney Conditions
- Stroke and Neuro conditions including Atrial fibrillation

People are living longer, with males now expected to live 80 years and females 85. Whilst welcome, increasing life expectancy can mean people will live longer with multiple long-term conditions ('multi-morbidity') and this can adversely impact on their health and well-being: multi-morbidity is associated with the wider determinants of health such as including unemployment, mortality and quality of life. Multi-morbidity is more common in deprived areas, and some of our Haringey population are at substantially higher risk of poor health and early death, particularly in the east of the Borough. We know nearly 70% of the total health and care expenditure in England is attributed to caring for people with long-term conditions, including multi-morbidity.

Some issues we know we need to improve on are:

- We could better promote and support people to adopt healthier lifestyles so they are less at risk of acquiring long-term conditions, such as high blood pressure or diabetes;
- More people living with particular conditions could be diagnosed and treated earlier; and we could improve the advice, information and support we provide about living with these conditions and what do if they are getting worse;
- We know there are variations across the Borough in screening, diagnosis and early treatment in care and support across the Borough that need to be addressed;
- The support provided for people between partners is not as joined up as it could be and this is a particular issue for people with multi-morbidity;
- The population with multi-morbidity continues to grow as people get older; but we know there are already constraints on capacity to respond within the current configuration of the health and care system.

Aspirations

Our aim is to offer care and services that enables the people of Haringey with long-term conditions to live longer and healthier lives with access to safe, well-co-ordinated and high quality services.

We want to ensure that as far as possible people with LTCs are able to maintain or enhance their quality of life through high quality services and supported self-management. Partners across North Central London (NCL), including Haringey Health and Well-Being Partnership Board, recognises the need to intensively challenge the way we support people with LTCs through a more Integrated, coordinated and holistic personalised person centred approach. To enable this, the LTC Strategy currently under-development will focus on four areas for delivery: **prevention, early detection, treatment and support.** The scope of this strategy will align with Haringey Mental Health Strategy as well as Ageing Well Strategy.

Our response is founded on working in partnership with stakeholders involved in patient care to transform how services are developed and delivered. We want people with LTCs and their carers to be at the heart of how we plan, design and deliver treatment and care; and we want to support professionals to work with individuals and together across the voluntary and public-sector sectors to improve services and health outcomes. This will enable us to integrate services further, move care closer to home and improve the information and support people can access, making use of resources available in communities to fully develop a more holistic way of delivering care and support.

We recognise the need to support and develop primary care to deliver services that address population needs in a sustainable way. Our newly established local primary care networks will work closely with our multi-disciplinary, multi-agency integrated care networks to identify, diagnosis, treat and support individuals with long-term conditions to meet their needs depending on their complexity (both networks are discussed in the next sections). These developments will be supported by key enablers such as making the best use of estates, joint workforce development and IT developments to better screen and track individuals' needs as they change over time and to identify those most at risk of acquiring specific long-term conditions, such as heart disease, or multi-morbidity.

We will work towards reducing unwarranted variation in care and better utilise our joint resources to make the best use of, or expand, current services whilst at the same time flexing resources to ensure we serve those parts of the Borough with residents at the highest level of risk.

Key Priorities

Short-term (Year 1)

In 2019/20, we will…

- Set out a multi-agency Long Term Conditions Strategy that addresses the population main health and social needs, and which includes relevant priorities from the NHS Long Term Plan
- Engage with patients and general public and agree strategic direction for the LTCs in Haringey
- Map all existing services and establish key priorities according to NHS RightCare recommended pathways and identify how we will take forward improvements
- Produce a LTC Roadmap to help us identify the actions we can take as partners to improve our 'offer'
- Improve diagnostic rates of key conditions within primary care, such as hypertension and diabetes; and better support people to manage their own conditions.

Long-term (Year 2 & 3)

From 2020, we will…

- Develop our LTC model and progress its implementation in line with our priorities including improved prevention, early diagnosis and self-management;

- Introduce new work streams and pathways, including integrating primary, community and secondary care further through development of our primary care and integrated care networks (see next sections);
- Align our priorities with existing NCL work
- Further progress our enablers within our LTC model such as work development and IT systems.

High Level Actions				
#	**LTCs strategy milestones**	**Start Date**	**End Date**	**Owner**
1	Decrease number of patients at risk of developing LTCs by improving prevention programmes and early detection	2019	Ongoing	Juliana Da Silva
2	Support GPs closing the gap between recorded prevalence and exception reporting through LCS and QIST teams	2019	Ongoing	Juliana Da Silva
3	Increase number of patients self-managing their LTCs through self-management programmes	2019	Ongoing	Juliana Da Silva
4	Align care/pathways across the Borough for all LTCs patients by redesigning current services model.	2019	Ongoing	Juliana Da Silva
5	Increase services offer at primary care level to avoid unnecessary pressures in secondary care outpatient services, A&E attendances and consequent admissions.	2019	Ongoing	Juliana Da Silva
6	Decrease variation and duplication of care provided to patients across Haringey	2019	Ongoing	Juliana Da Silva

Becoming Frail

Current Position

As they age, we know people are more likely to acquire one or more long-term and chronic conditions that affects their physical and mental well-being and daily living. Some will become frail, i.e. they lose physical and mental function and resilience. People can therefore find it more difficult to recover after illness, accident or stressful event and are at heightened risk of increased dependency, poor health or further adverse episodes.

This section discusses how people living with frailty can be identified as early as possible so they can be provided with advice and information about how to best to manage their health and social needs and the opportunities that may be available to them. The section goes on to discuss plans partners have developed to better support people with frailty, with the next section focussing on additional solutions for people with more significant needs.

Solutions that already exist in Haringey to help people live as well and safely as possible as they become frail include:

- Identification of people who may be frail either as part of pro-active management of patients within GP surgeries (for example, as a result of annual health checks or identified from case-finding tools based on national models for frailty) or because their frailty is recognised and assessed if they present to A&E;
- Provision of information, advice and signposting on websites or through trusted sources such as the Over-50s Forum. Examples include AskSara, an online system to provide guided user questions and answers to help people identify solutions, such as equipment, that could help meet people's needs;
- Simple items of equipment, aids and adaptations that's available to people to help them with daily living, such as medication dispensers, grab sticks or chair/bed adaptors. This also includes the Council's Safe & Sound service, that provides personal or housing alarms for people who may feel vulnerable and, if pressed, has a 24/7 response from service operatives;
- Primary care-based support for people with moderate frailty to undertake a comprehensive assessment (including a community navigator) of their health and social needs in preparation for future development of a wider integrated care network in local neighbourhoods. This medical assessment will result in a set of follow-on actions to be undertaken by their GP or other professionals to better manage their healthcare needs;
- Support from health professionals, such as district nurses and therapists, to help people manage their long-term conditions or recover after illness in their home as part of the care available via their GP;
- A range of community and voluntary sector opportunities to support people with frailty tailored to their needs and interests in a range of settings across Haringey and which includes support in people's homes;
- Support for residents who may be frail through Homes from Haringey and other Registered Social Landlords to ensure these residents have the support in suitable housing they need and are able to continue to pursue social opportunities important to them. These community facilities also act as 'hub' for the wider community;
- Voluntary sector community navigators, with their roles tailored to specific individuals' needs and circumstances, e.g. those who with mental health issues. Navigators work with people on a time-limited 1:1 basis to help them navigate the Council and NHS systems, understand their needs and connect them to the right solutions to meet goals important to them. Some of these navigators work in the community, but others are based within care settings, such as GP practices and hospitals;

We know many individuals who use these services value the support on offer but we know there are number of improvements that can be made. In particular:

- Not everyone living with frailty becomes known to services early enough to help and their needs are not always consistently recognised and addressed. This means people don't always get the access to the advice, help and support they need to improve their health, well-being and independence. We know these individuals are more likely to present to services later with more significant needs and/or at crisis, such as hospitalisation if their needs are not addressed early;
- The information, advice and guidance different agencies provide could be improved, joined up and better targeted at people with frailty;
- The process by which individuals find the right aids or equipment for them and the range of the equipment and technology available could be improved;
- One issue in the Borough remains the number of people who have falls due to their frailty – often these falls result in adverse outcomes for people and may result in them becoming more frail. The services we have to reduce the risk of falls or repeat falls could be improved and more people could benefit from them;
- Our existing community navigation services have proved popular and successful amongst people who are using them. We need to make these services are more consistently known amongst, and accessible to, people and professionals, such as GPs, so more people can benefit;
- We could provide a more joined-up response to planning and delivering and between agencies to the health and social needs of people with frailty in local communities and these could be better tailored to individuals.

Aspirations

Our aim is to work together to support people with frailty to live well. This. and the next, section (which focusses on supporting people with more complex needs) describe some of the key improvements we intend to make as people age to make the best use of collective resources. This will mean:

- As partners, we will use a single, simple screening tool across the Borough to assess the frailty and underlying needs of individuals as they present to services such as GP practices, hospitals or community health. This will help identify the differing degree of frailty people are likely to have and ensure more people at earlier stage of frailty can be identified and supported appropriately;
- Information, advice and guidance will be targeted to people who are likely to be frail and we will make the best use of solutions such as AskSara. Health, Council and voluntary sector staff, such as GPs or community navigators, will acted as trusted sources to ensure people are aware of this information and support them to access it. Individuals will therefore know a lot more about how best to manage their conditions for themselves and what to do if these conditions become worse suddenly;
- Older people's care and support will be managed through Local Integrated Care Networks. These Networks are groups of care professionals such as GPs, nurses, therapists, social workers and pharmacists working together to help identify and manage the health and social needs of people with frailty in local neighbourhoods.
- The Networks will incorporate our community navigators to support social prescribing in local GP practices and other facilities and connect people to solutions they may value. There will a wide range of voluntary sector opportunities targeted at people for frailty and tailored to their specific needs and interests;
- There will be a wide range of accessible technology, equipment, aids and adaptations available for people with frailty to help them manage their health and well-being and daily living as part of these solutions. The

'offer' will include the Council's Safe & Sound service with devices tailored to the specific needs of people with frailty;

- People's housing environments will be adapted to support people as they age and become frailer, and social housing facilities will be hubs to support the wider community;
- People's risk of falls or repeat falls will reduce as a result of improved knowledge and management of individuals' risks, their mobility through exercise referrals as part of a comprehensive falls service in the Borough.

Key Priorities

Working with people living with frailty, our key improvements are:

- Adopt a single, simple screening tool across all services in the Borough to assess the frailty and individuals' needs;
- Streamline our information, advice and guidance targeted at people who are likely to be frail;
- Improve awareness of staff across all sectors who are working with people with frailty about how to connect them to solutions from which they could benefit and to actively promote these solutions to individuals. This includes promoting and encouraging self-care, self-management and peer support amongst people with frailty;
- Improve and promote the range of equipment, aids and adaptations and digital solutions available to those with frailty and simplify access to these solutions, including the Council's Safe & Sound service;
- Expand and better join up our social prescribing and community navigation roles across the Borough and make sure they are part of our development of local Integrated Care Networks;
- Work with the voluntary sector to improve and better market the range of solutions targeted at people with frailty;
- Develop more adaptable social housing solutions to better support individuals as they age and expand use of their facilities to become community hubs;
- Improve the falls service and associated solutions in the Borough.

High Level Actions

#	Actions for Improvement	Dependencies	Start Date	End Date	Owner
3.1	Establish a single screening tool for use across all care and support services in the Borough to assess frailty and individuals' needs; and build use of these tools as basis to identify and review individuals' needs across sectors		July 2019	March 2020	Leadership Team
3.2	Work with Primary Care Networks to ensure cognitive screening and screening for frailty are part of the annual health checks for those aged 75+ and other vulnerable groups	*Living Well With Dementia*	September 2019	March 2021	HCCG Primary Care Team
3.3.	Across partners, improve and bring together available public information,	• *Living Well with*	PI: September 2019	PI: August 2020 PII: September	Paul Allen

	advice and guidance about living well with frailty, dementia, community navigators and services and support to help people do so; whilst promoting improved self-care, self-management and self-determination of these solutions Phase I – Develop and initial implementation Phase II – Full Implementation	• *Dementia* • *Becoming More Frail*	PII: September 2020	2021	
3.4	Work across Haringey's health and care partners to set out joint staff development programme, and share good practice, on: • Identification and management of people with frailty; • How to promote of self-care & self-management; • Improve staff knowledge on the network of services available for people and how to access them. Phase I – Plan and agree delivery of workforce development Phase II - Implementation workforce development		PI: October 2019 PII: April 2020	PI: March 2020 PII: September 2021	Leadership Team
3.5	Establish network of appropriately trained community navigators across partners who can advise & support people with frailty, dementia and carers and to connect them with services	*Living Well with Dementia*	July 2019	March 2020	Paul Allen
3.6	Work across partners to improve the 'community support offer' available to carers, people with frailty and/or who need early help: • Develop a joint Design & Outcomes Framework to map assets and develop future community services; • Make better use of identified existing services & facilities; • Use existing social housing facilities as community 'hubs' across Haringey; • Improve access to, and range of, community service including through stimulating development of peer support and community groups; • Pilot this approach within North Tottenham as part of place-shaping		July 2019	March 2021	Paul Allen / Gill Taylor / Marco Inzani

	solutions				
3.7	Evaluate existing Frailty Care Closer to Integrated Network (CHINs) and explore how to absorb its function to support people with moderate frailty into emerging Integrated Care Network model		April 2019	November 2020	Paul Allen
3.8	Review and improve falls pathways and associated solutions in the Borough, including the Falls Service, as part of the wider development of a Frailty Network Phase I – Develop and initial implementation Phase II – Full Implementation		PI: September 2019 PII: April 2020	PI: March 2020 PII: March 2021	Priyal Shah with Providers
3.9	Improve and better promote the range and type of equipment, aids and digital solutions available to those with frailty and more complex needs including the Council's Safe & Sound Service		October 2019	March 2021	Adult Social Care

Becoming Frailer

Current Position

This section discusses the needs and solutions for people who have more significant frailty and more complex needs. These individuals are likely to be in poor health, have problems with daily living (such as washing or getting around the house) and are at risk of further crises. Many may need a coordinated and often multi-disciplinary ongoing health and/or care response to plan and help meet their needs, including access to nursing, therapies and/or personal care. The aim is to support individuals for as long and as safely as possible in their own homes and maintain or improve their health, well-being and independence.

In addition to those discussed in the previous section, a range of solutions already exist in Haringey:

- A number of multi-disciplinary teams (MDTs) identify, plan, assess and organise long-term or ongoing care for people with more complex needs. For example:
  - MDT case tele-conferences between GPs, acute geriatricians and other health professionals discuss individual cases of patients recently discharged from hospital and who need medical follow-up;
  - The cases of people with more complex needs or severe frailty (identified through a range of health and social care professionals such as GPs) are managed within a Borough-wide multi-disciplinary Locality Team, a dedicated multi-agency team with a community matrons, social workers and therapists, who coordinate, plan, case manage and organise individuals' longer-term care;
- A range of support from health professionals, such as community matrons and specialist condition nurses, to help manage individuals' ongoing health conditions sometimes as part of a multi-agency team;
- Access to a range of specialist aids, equipment and major adaptations to help people to live in their home for as long as possible at home and meet their health needs;
- Access to adult social care assessment and care planning to decide how to meet an individual's personal and social care needs, with many eligible (thorough a national framework) to receive Council-funded Personal Budgets. Some people may choose to receive the Budget as a Direct Payment to arrange care themselves; whilst others may choose to work with the Council's Brokerage Team to arrange these services. The most common services people choose to support them to live at home are personal care, day opportunities and short breaks;
- Some people have such complex needs they need to have more specialised accommodation within the community. There are over 130 Extra Care flats in housing schemes in Haringey, which provide individuals with their 'own front door' but in which care and support is available 24/7. There are also 11 long-term residential and nursing care homes for older people, including those with dementia, across the Borough for those with the most complex needs.

We know many people who use services value the available support, but we know there are number of improvements that can be made:

- Our multi-disciplinary long-term care and support 'offer' for patients could be better coordinated and more people with complex needs could benefit from this integrated support. This includes more consistent management of these patients' medical needs across practices and better access to mental health support;
- Handovers between services, e.g. those between intermediate care to help people recover and long-term care could be made more consistent and people better supported to navigate what can feel like a complex process;
- Some people wait too long to access longer-term community health or adult social care across the Borough and we need to make sure our reviews of their care are more timely. Some of the available services could also

be better tailored to individuals' needs more consistently across the Borough;

- More people could benefit either from major adaptations to their homes to help them live there or access to more specialised housing;
- There is only limited number of nursing care home beds in Haringey which often means people with the most complex needs are often placed outside the Borough, and there can be delays to assess and review individuals for Continuing Health Care outside of hospital for some people.

Aspirations

Our aim is to work together to support people with frailty, including those who are have more complex needs, to live well. As well as the actions identified in the previous section, our key aspirations for those group of people are:

- People will benefit from responsive and consistent long-term community health and care services they need, eliminating unnecessary delays or duplications within the health and care assessment, planning, delivery and review process in a more person-centred way;
- People will benefit from a multi-disciplinary approach to coordinating the planning and delivery of health and care needs for more people through development of our Local Integrated Care Networks. Each person with complex needs will have a named professional, such as a GP, community matron or social worker, to act as a coordinator and each person will have an integrated care plan summary that is assessed and reviewed routinely;
- The joint support provided will incorporate greater access to mental health services, including specialist advice, information and support to individuals and other care professionals from specialist mental health workers;
- The recently formed Primary Care Networks in Haringey will develop as part of our Integrated Care Networks. PCNs mean local GP practices will collaborate to share good practice and expertise, and deliver proactive, personalised and coordinated medical services to specific groups. People with significant frailty are one group who will benefit from this improved 'offer';
- There will be a greater range of care services tailored to meet individuals' outcomes and needs in the community that they can access directly or be helped to do so;
- People with complex needs will be supported at home because they have greater access to specialised digital technology and major adaptions to help people manage health condition or in their environment; and a greater range of specialist living solutions;
- Residential and nursing care home staff will be better supported to manage the cases of residents through an Enhanced Health in Care Homes model, which will see health professionals, such as GPs, geriatricians and community nurses, work within the homes on a planned and urgent basis to help manage the cases of more complex residents and develop skills amongst care home staff to better manage cases.
- More people who need it will be accommodated in nursing care home in, rather than out of, Borough.

Key Priorities

Working with people living with frailty, our key improvements are to:

- Streamline access to and join up existing community health and social care services to improve assessment, planning, delivery and review of care and support for more people with complex needs across the Borough;
- Developing a more multi-agency approach to care coordination through development of local multi-agency

Integrated Care Network in parallel with development of Primary Care Networks to manage the cases of people with frailty;

- Improve our mental health 'offer' to older people with frailty, including tailoring our Improvements to Access to Psychological Therapies (iAPT) services to this group, and ensuring information, advice and support about mental health issues is available to them and other health and care professionals;
- Work with care providers to ensure they have a more consistent and outcomes-based focus to their work with people with more significant frailty and this is more joined up with other professionals working with the individual, e.g. in an Integrated Care Network; and that there is adequate provision of available high-quality services across the Borough;
- Explore how we could improve and promote a greater range of digital technology to those with more significant frailty, such as tele-care and tele-health monitoring;
- Ensure there's greater access to major adaptations available to individuals' homes; and re-provide a greater range of specialist living solutions through working with Registered Social Landlords to expand Extra Care facilities and using 'step-down' flats to better support people who need to recover;
- Roll out our planned Enhanced Health in Care Homes model to support care homes in Haringey;
- Re-provide one of our nursing care homes as a partnership between the Council and NHS to increase nursing care bed capacity in the Borough.

	High Level Actions				
#	**Milestones**	**Dependencies**	**Start Date**	**End Date**	**Owner**
4.1	Across partners, work towards developing local multi-agency Integrated Care Networks (ICNs) across Haringey: • Further develop further multi-agency health, social care and voluntary sector team models and care pathways in localities to support Primary Care Networks; • Improve agency's joint capacity and responsiveness to address to assess, plan, deliver & review needs of patients; • Deploy multi-agency team as part of North Tottenham place-shaping pilot to better support people with more significant frailty who need care coordination; • Integrate work of Locality Team, joint Intermediate Care and Care Closer to Home (CHINs) into emerging ICNs <u>Phase I</u> – Develop and agree ICN <u>Phase II</u> – Implement ICN		PI: August 2019 PII: October 2020	PI: September 2020 PII: September 2021	Leadership Team
4.2	Work with GP Federation and other partners to develop Haringey's Primary Care Networks and integrate ICNs and PCNs to improve care				GP

	pathways for people with significant frailty and/or high-risk patients Phase I – Develop and initially form 8 PCN Phase II – Full implementation of PCN functions		PI: April 2019 PII: October 2019	PI: September 2019 PII: September 2021	Federation with Partners
4.3	Roll out multi-agency Enhanced Health in Care Homes model to support care home staff & residents including those with dementia.	Living Well with Dementia	April 2019	March 2020	Paul Allen with Providers
4.4	Work with Registered Social Landlords towards increasing the range of supported living solutions such as Extra Care or 'step-up' flats as a means of supporting people in the community		September 2019	September 2021	Aphrodite Asimakopoulou
4.5	Council to work with partners to explore re-providing Osborne Grove as a nursing care home to increase capacity of available beds		April 2019	September 2022	Charlotte Pomery
4.6	Work with partners to re-provide locality-based community social care, such as home care, available to everyone with significant frailty, including Council-funded services. Phase I – Develop Phase II – Testing in North Tottenham and evaluating impact Phase III – Full Implementation if successfully evaluated		PI: July 2019 PII: April 2020 PIII: April 2021	PI: March 2020 PII: March 2021 PIII: March 2022	Charlotte Pomery
4.7	Improve support for mental health & well-being issues for people with changed and/or significant frailty through improving access to therapies such as IaPT Phase I - Develop and initial improvement Phase II – Full implementation		PI: October 2019 PII: April 2020	PI: March 2020 PII: March 2021	Tim Miller
4.8	Improve Continuing Health Care pathway including CHC processes and timescales for assessments and reviews for older people with frailty Phase I - Develop and initial improvement Phase II – Full implementation		PI: July 2019 PII: April 2020	PI: March 2020 PII: March 2021	Nigel Evason

	Note Action relating to information, advice and guidance and promote improved self-care, self-management and self-determination can be found in *Becoming Frail*

Approaching End of Life Care

Current Position

End of Life Care (EOLC) is the comprehensive care of those with serious or life-threatening illnesses with a focus on the improvement of quality of life through alleviating pain and suffering ('palliative care').

Older people and adults approaching end of life receive care and support from the Specialist Palliative Care Team, GPs, District Nurses, acute hospitals and hospices. The care and support may include (but is not limited to) assessment and management of physical, psychological and spiritual symptoms to reduce symptoms, suffering and distress; analysis of complex clinical decision-making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment; and providing specialist advice and support to the wider care team who is providing direct core level palliative care to the person. Our Advance Care Planning Facilitator project within care homes enables residents to discuss and express their wishes in relation to the type of care they would like to receive in the future and has recently been aligned with our Enhanced Health in Care Homes model (see previous section).

A recent review of services suggested the following improvements to the care and support 'offer':

- There is limited palliative care capacity. Access to the service could be improved at an earlier stage.
- Integration and coordination between specialist palliative care services and community teams could be improved to provide a multi-disciplinary approach.
- Training in end of life care, advanced pain management and communication skills should be provided to a wider range of community staff.
- Need to augment Advanced Care Planning to better support patient preference and wellbeing.
- Increase uptake and use of Coordinate My Care (CMC) within primary care and wider community teams.

Aspirations

Our aim is to improve the quality of life and wellbeing towards end of life and provide holistic planning and delivery of care and support to the patient and the people close to them. Health and care partners in North Central London will develop an NCL-wide EOLC Strategy, but this section focusses on priorities for Haringey. By 2022, we expect to achieve the following (subject to discussion and agreement with key EOLC partners in Haringey and NCL):

- With patients, families, local authorities and our voluntary sector partners at both a national, regional and local level, including specialist hospices, Haringey residents will be offered personalise cared to improve end of life care planning and delivery. This will be underpinned by an End of Life Care strategy.
- By rolling out training to help staff identify and support relevant patients, we will introduce proactive and personalised care planning (Advance Care Planning) for everyone identified as being in their last year of life.
- With support from Primary Care Networks and Quality Improvement Support Teams within Primary Care, quality of end of life care will be improved with a corresponding increase in the number of CMC records.
- Through support of the wider community and voluntary sector, social, befriending and bereavement support will be expanded.
- Through review of data, we will gather a better understanding of, and reduction in inequalities in End of Life Care, for vulnerable groups, for example, people who are homeless, people from Black, Asian and Minority Ethnic groups, people living with mental health conditions, Learning Disability, dementia.

Key Priorities

Short-term (Year 1)

- Develop a North Central London End of Life Care Strategy in collaboration with partners across the sector.
- Embed the expanded Specialist Palliative Care Service in the Community (started Q4 2018-19) to increase capacity.
- Learn from the Advance Care Planning Facilitator (ACP) project in the two care homes and decide on future provision.
- Review Hospice at Home Nursing service provision. The service is aimed at enabling people approaching end of life to be cared for and die in their preferred place of care.
- Improve EOLC in Primary Care as part of the Quality Improvement project (GP contract).

Long-term (Year 2 & 3)

From 2020, we will

- Improve the number and quality of Coordinate My Care records (which is a marker for ACP) in Haringey.
- Improve education, training and facilitation on Advance Care Planning and End of Life Care for wider community staff.
- Review models of hospice commissioning to create a sustainable solution for commissioners and hospices.

High Level Actions

#	Milestones	Start Date	End Date	Owner
5.1	Embed the expanded Specialist Palliative Care Service in the Community (started Q4 2018-19).	Jan 2019	May 2019	Priyal Shah / Patrick Schrijnen
5.2	Learn from the Advance Care Planning Facilitator (ACP) project in the two care homes and decide on future provision.	March 2019	May 2019	Priyal Shah
5.3	Review Hospice at Home Nursing service provision.	April 2019	July 2019	Priyal Shah
5.4	Develop North Central London End of Life Care Strategy.	April 2019	December 2019	Priyal Shah / Patrick Schrijnen
5.5	Improve EOLC in Primary Care through Quality Improvement in EOLC	April 2019	March 2020	Priyal Shah
5.6	Update on this project once North Central London EOLC strategy has been decided	Jan 2020	March 2020	Priyal Shah / Patrick Schrijnen

Major Health Episodes, Crisis and Recovery

Current Position

'Major health episodes or health or social crises' refers to a sudden, significant deterioration in a person's physical, mental and/ or social needs resulting either from planned surgery or from unforeseen illness, accident, injury or significant life event or circumstance (e.g. bereavement). This is a particular risk for people who are already frail. 'Recovery' refers to those interventions in which an individual can regain physical, mental and psychological capacities and independence post-crisis, often after a spell in hospital. Helping people with frailty recover is therefore particularly crucial in helping them maximise their health, independence and quality of life.

A range of high-quality short-term recovery and recuperation services (collectively called 'intermediate care') provide this support already exist in Haringey. Access to these intermediate care services is managed via a Council-run Single Point of Access (SPA) to support patients' hospital discharge if they need ongoing care and support. The SPA simplifies hospital discharges for people, offers therapeutic triage to support decision-making and facilitates same-day and next-day discharges to all residents needing this service. The SPA's 'discharge to assess' response increasingly makes sure decisions about people's long-term care needs are made out-of-hospital and after people have recovered (mostly at home), greatly improving residents' experience of support as well as their medium and long-term rehabilitation and health outcomes.

As part of the referral services locally as part of the NHS 111 system, Haringey has an effective Rapid Response service that operates seven days per week, providing short-term care and nursing interventions to Haringey residents in crisis in their own homes within 2 hours of call-out (or same day if less urgent) as an alternative to prevent people having to go to A&E unnecessarily. A highly successful pilot of the trusted assessors for care homes model, alongside additional clinical support to residential and nursing homes, has been running for some time, improving patient experience by both facilitating hospital discharges and reducing admissions. The CCG and Council already commission a range of bed-based solutions for people to recover or recuperate depending on the complexity and nature of their medical and functional care needs.

These services provide an excellent base from which the integrated intermediate care offer in Haringey have also improved. The SPA, for example, will screen individuals who need short-term help post-crisis, e.g. following hospital discharge, into the right care solutions to help continue their recovery over several weeks. This might mean, for example, access to therapeutic interventions to help them get about within their home via the Council's Reablement service or more medically-orientated home- or bed-based rehabilitation, with the latter in specialist facilities across the Borough.

Despite these positive outcomes, we know there are some issues to address:

- More people could benefit from our intermediate care services particularly those that could be referred before they may need a hospital episode ('step-up'), those with particularly short-term and intensive nursing needs at home and those who may need continuing health care in the community in the longer-term. This may also include expanding the times some services operate;
- We could better bring together some of the staff working in our intermediate teams to streamline assessment and planning processes for individuals with whom they work;
- We know we could improve the forward and onward planning post-intermediate care for some individuals based on good practice we have developed around MDT planning in other parts of the system.
- We need to support joint service development through delivery of key enablers such as more joined-up

commissioning between the Council and CCG and further development of joint IT and information-sharing solutions.

Aspirations

Our aim is to ensure that older adults experiencing major health episodes or crises receive treatment and social support in the most efficient and effective way possible. We aim to prioritise care outside acute hospital wherever possible, to maximise opportunities for Haringey residents to remain as independent as they can for as long as they can, and to support them to remain in their homes for as long as possible.

We are proud of the current services that help recover, but we know we could do more to improve and better align our joint intermediate care services and the capacity of community organisations to respond effectively to more complex clinical and social care and support needs at home. This will entail ensuring collaboration and joint accountability, seamless handovers between acute and crisis teams and longer-term care management teams, and the capacity to respond rapidly to individual's changing circumstances. Our services will form a coherent network that responsively supports all individuals and their families as their conditions and/or circumstances become more complex.

It will also mean a shift in resourcing from acute to community services as we are able to support more people with more complex needs outside of hospital. We will:

- Improve the care and support of older patients within our hospitals more generally from A&E onwards;
- Better join-up Health and ASC teams planning and delivering intermediate care together and planning next steps, including for a wider group of people, such as those who need short-term intensive nursing input or convalescence. This will mean staff, such as therapists, in different agencies will work more closely and jointly assess and review patients and streamlining individuals' access to services;
- Continued good management of hospital discharge for patients (e.g. transport, discharge before lunch, discharge summaries, early discharge planning, choice policy and so on). We will deliver 'home-first' approach to all hospital discharges and move-on from bed-based intermediate care placements, i.e. assume the first preference is that people can return home even if they need care and support to do so;
- Provide a 'trusted assessor' model for hospital patients who need to be discharged, or need to return, to a care home, and link this to Enhanced Health in Care Home model which we are rolling out to Haringey care homes (see Becoming More Frail);
- An improved focus on triage and redirection to community services from A&E (including statutory and voluntary sector interventions) – this will allow more people to return home quickly after a minor episode and reduces the risk of being admitted to hospital unnecessarily;
- Increased hours of operation of some of our intermediate care services to make sure they are more accessible throughout the day and week for Haringey residents;
- Integrated Health and ASC IT records and information-sharing will be available to support joint work and transition of cases between hospital and intermediate care and between intermediate care and any long-term support services the individual needs, respectively.

Key Priorities

In 2019/20, we will…

- 'Scale up' the existing trusted assessors for care homes input from pilot to full service.
- Ensure full utilisation of the trusted assessors for care homes service in acute hospitals.
- Develop and implement the community trusted assessor model between therapies and social work; and in doing improve the overall joint intermediate care 'offer' in Haringey. This includes expand the scope of and consolidate the Haringey Single Point of Access.
- Pilot the transfer administration of simple medications from district nursing to reablement.
- Implement early discharge planning.
- Implement the discharge choice policy.
- Ensure more patients are able to benefit from existing intermediate care services, including 'step-up' patients, those who need intensive nursing input and those who may be eligible for long-term health care

From 2020, we will…

- Move the administration of simple medications to all community care providers.
- Offer 7-day GP support to care homes as part of the GP contract;
- Implement joint Health and ASC records for intermediate care.
- Significantly reduce delays to hospital discharge caused by TTAs, transport and discharge after lunch.
- Integrate Health in the Haringey Single Point of Access.
- Implement improvements to the flow of residents between intermediate care and long-term care.
- Implement urgent diagnostic and treatment 'hubs' in the community.

High Level Actions				
#	**Milestones**	**Start Date**	**End Date**	**Owner**
6.1	Improve NHS-and Council Joint Intermediate Care pathways incorporating: • Integrated Point of Access across agencies and improved handover (e.g. from hospital) into intermediate care; • Trusted therapies assessment model between NHS and Council and streamlined access & management of people using pathway; • Improved handover to onward management of cases post-intermediate care across Integrated Care & Primary Care Networks; • Establish supporting infrastructure to support joint working, e.g. workforce development, information governance, IT etc. Phase I – Develop and initial implementation Phase II – Full Implementation	P1 - July 2019 P2 - April 2020	P1 - March 2020 P2- September 2021	Anita Marsden / Alison Kett
6.2	Work with partners to deploy Trusted Assessor model to support hospital discharge of patients to care homes in Haringey at NMUH and WHT and link with new Enhanced Care Home Model	April 2019	January 2020	Robert Cass

6.3	NMUH and WHT hospitals to work with partners to improve management of people with frailty from A&E attendance to discharge including: - interfacing with revised intermediate care and Integrated Care and Primary Care Networks for patients with delirium - improving access to intermediate care pathways as part of 'step-up' strategies to avoid or mitigate crises Phase I – Develop and initial implementation Phase II – Full Implementation	P1 - July 2019 P2 - April 2020	P1 - March 2020 P2 - September 2021	Richard Robson / Clarissa Murdoch
6.4	Develop an 'intermediate care nursing model' to support people with frailty who need recuperation after crisis or hospital episode	July 2019	December 2019	Robert Cass
6.5	Improve nurse-led rapid response and virtual ward functions to better support people approaching at crisis at home or to return home from A&E Phase I – Improvements with the existing resources Phase II – Potential expansion of model	P1 - July 2019 P2 - April 2020	P1 - March 2020 P2 - March 2021	Leadership Team
6.6	Work across partners to improve seven day and out-of-hours services to better support patients and increase urgent GP appointment and diagnostic capacity, including through development of Primary Care Networks Phase I – Explore options for improvement Phase II – Phase implementation of improvements	P1 - October 2019 P2 - April 2021	P1 - March 2021 P2 - March 2022	Leadership Team
6.7	Work to improve mental health crisis resolution services for older people with dementia with BEHMHT Phase I - Develop and agree improvement Phase II - Full implementation	P1 - October 2019 P2 - April 2020	P1 - March 2020 P2 - March 2021	Paul Allen / Tim Miller
6.8	Work across partners to improve emergency care planning arrangements for people with frailty involved in Frailty Network and sharing of information between partners Phase I - Develop and agree improvement Phase II - Full implementation	P1 - October 2019 P2 - April 2020	P1 - March 2020 P2 - March 2021	Leadership Team

Supporting Carers

Current Position

We know that (unpaid) 'carers' – family and friends of someone who has personal, social or health care needs (the 'cared for') – provide a vital and often unrecognised contribution to supporting people with health and care needs. We know 60% of us will become a carer at some point and the single largest group of people for whom they care are people with frailty. Most of these carers are themselves older and often have their own health issues, with the majority of more elderly carers (85+) having intensive caring responsibilities for someone else such as a spouse or close relative.

A range of support already exists in Haringey for carers to help them in their caring roles and to lead as health, well and fulfilling a life as possible. This includes:

- Information, advice and signposting on websites or through trusted sources such as the Over-50s Forum. The Council and CCG commission Carers FIRST in Haringey to provide first response, information to, and registration for, carers, as well as linking carers up to a range of opportunities to stay in touch and be supported. This includes providing tailored advice, advocacy and help to carers navigate the care and benefits systems and help to better plan their caring role, such as connecting them to services they might value. There are currently 1,000+ carers of all ages registered with Carers' FIRST. Frequent queries relate to financial support for carers such as eligibility for the DWP Carers Allowance;
- Some voluntary local groups and activities are available to support carers and often those they care for. These are tailored to specific needs, for example, local groups of carers of older people are enabled to come together and socialise via Carers FIRST;
- Carers benefit from the Council's free Emergency Carers' Alert Card scheme. This is a small card with a unique PIN and contact details to the Council's Safe & Sound Service, LBH's 24/7 Community Alarm Service Its purpose is for the Safe & Sound to mobilise the emergency plan they hold for that carer, e.g. who to contact to continue in the caring role, emergency support etc., in the event of someone ringing the contact number and quoting the relevant PIN;
- Health and care professionals consider the views and role of carers in joint assessment, planning and delivery of services to meet the care and support needs of the person cared. However, carers can also request a separate Carers' Assessment (or review) of their needs from the Council to look at their needs as a carer and how caring affects them. Some carers may be eligible for Council-funded support following assessment and planning;
- Council-funded planned or emergency respite care supports carers to take a short break from their caring role with professionals supporting the individual during the day or overnight either within an individuals' home or in a suitable housing environment, such as Extra Care or residential or nursing care;
- North Middlesex Hospital have a Carers' Passport Scheme for carers who are regular visitors to ward which has a range of advantages such as free parking and flexible visiting hours. whilst those they care for are in hospital and

We know many individuals who use these services value the support but we know improvements could be made:

- More carers of people with frailty could be better identified and registered in Haringey, and the advantages of registration could be better promoted. Registration is particularly important, for example, to make sure more people are subsequently able to access emergency planning with the Safe & Sound service;
- Care planning and delivery between agencies to the needs people with frailty and their carers could be better joined up - and more consistently accommodate carers' views as 'experts in the care of those they care for' and to support them in their own right;
- Information, advice and guidance that different agencies provide could be better coordinated and targeted at the needs of carers of people with frailty and their likely needs. This includes advice about income maximisation for

carers;

- A greater range of local support activities, including peer support, better tailored to carers could be developed and promoted across the Borough;
- More carers could benefit from support to address their own physical and mental health and well-being particularly in terms of social isolation and anxiety as part of a more joined up 'offer' for carers;
- More people could benefit from Carers' Assessments and subsequent help with planning their caring role;
- There's significant demand on respite care which could therefore help more carers and those for whom they care;
- The needs of some group of carers, such as such as those caring for people with dementia or elderly carers, could be better understood and supported.

Aspirations

Our aim is to work together to support carers of people with frailty to live well and continue in their caring role. To achieve this, we need to identify carers early, and as their circumstances change, help them find solutions tailored to them. The key improvements we intend to make which will make the best use of collective resources include:

- Organisations available to all will be encouraged to make simple changes to services to become more 'carer friendly';
- We will work together to identify carers, including those within high-risk groups, and better promote the benefits of registration. A wider range of organisations, including GP practices, hospitals, voluntary sector organisations and pharmacists, will more consistently promote the carers registration and support solutions across the Borough;
- Information, advice and guidance targeted at carers will be well-coordinated across multiple organisations as part of the wider network of information available locally. This will include access to information and support to improve carers' employment or finances to maximise household incomes;
- Carers will have good access to community navigators to help them identify their goals and connect them to solutions they might value. This, and the parallel development of multi-disciplinary Integrated Care Networks (ICNs), will provide a local response to meeting individuals' needs; both community navigation and ICNs are discussed in other sections;
- A range of local community services will increasingly become available to support the needs of carers including peer support opportunities. This will mean navigators or others can refer carers to improve their physical health and well-being, improve social inclusion and mental well-being or financial or employment opportunities, tailored to individuals' circumstances;
- Health staff working in Integrated Care and Primary Care Networks will address carers' physical and psychological health needs consistently across the Borough. This will include advice and support to better manage underlying cared for or carers' own health conditions and what do if they feel unwell. Older and frailer carers or those with particular intensive caring roles will be well-supported as part of a coordinated care response across these Networks;
- A greater number of Carers' Assessments will be undertaken to support carers to better plan their caring role and consider how to manage in a crisis targeted at those most at need. A range of home- and facility-based respite solutions will be available to carers;
- A range of digital technology will be available to support carers' role or help them 'keep in touch' if they live remotely.

Key Priorities

Working with carers, our key priorities are:

- Staff across multiple care organisations will be better trained to identify and work with carers including treating them as 'experts by experience' for those they care for. This will lead to jointly agreed and more personalised plans and care delivery, and help them carers plan their caring role and involved in managing the care of those they care for;
- Business intelligence will support us to target specific high-risk groups of carers of people with frailty and work towards improving the 'offer' of support for these individuals. Improvements will be developed with carers to better support these high-risk groups, such as those who are supporting people who have dementia, significant multi-morbidities and those with intensive caring roles;
- Streamline our information, advice and guidance better targeted at carers of people with frailty so that we have consistent messages across different organisations about the support on offer for carers;
- Work with a range of organisations, particularly health, care, housing and voluntary sector services, to promote carers' registration and free emergency planning with the Council's Safe & Sound service and Rapid Response;
- Incorporate the need to help carers navigate around the care and support system into the expectations of our Borough-wide development of social prescribing/community navigation, and as part of Community First development;
- Expand the range of community and voluntary sector solutions available to carers as part of the wider work on improving these solutions for vulnerable people, including through place-shaping work starting at North Tottenham;
- Improve the health and well-being 'offer' available to carers through their GP practice and as part of their Primary Care and Integrated Care Networks particularly for those with the most intensive caring roles;
- Expand the number of professionals who can undertake assessment of carers and plan with carers to support their role through development of the Integrated Care Networks;
- Expand the range of carers' respite opportunities in the Borough.

High Level Actions

#	Priority Actions	Start Date	End Date	Owner
7.1	Work across Haringey's health & care partners to set out joint staff development programme, and share good practice, on: • Identification, registration and working with carers of people with frailty; • How to promote 'carer management of person cared for' and looking after yourself; • Improve staff knowledge on the network of services available for carers and how to access them including helping them plan support; • Improve ability to undertake joint carers/cared for and specific carers assessments, planning & reviews <u>Phase I</u> – Plan and agree delivery of staff development <u>Phase II</u> - Implementation of staff development	Oct 2019 April 2020	March 2020 March 2021	Sebastian Dacre and Paul Allen
7.2	Establish a business intelligence tool to consistently identify where there are carers known (or potentially 'hidden	July 2019	March 2020	Charlotte Pomery / Community First

	carers') across Haringey, particularly high-risk groups			working with providers
7.3	Expand range of carers' respite opportunities in the Borough	October 2019	March 2021	Sebastian Dacre
NOTE Action relating to helping carers navigate around the care and support system into Haringey-wide social prescribing/community navigation can be found in *Becoming Frail*				
NOTE Action relating to screening for carers as part of the annual health checks & reviews for those aged 75+ can be found in *Becoming Frail*				
NOTE Actions relating to improving and bring together available public information, advice and guidance about caring and support can be found in *Becoming Frail*				
NOTE Actions relating to community and voluntary sector solutions available to carers as part of the place-shaping work starting at North Tottenham can be found in *Becoming More Frail*				

Our Next Steps

This Strategy has discussed how we will build on the solutions we already have in place to develop an integrated model of care to support people as they age more effectively and consistently in Haringey. It explains what our priorities for improvement will be for 2019/20 and beyond to make this happen.

We have set up a number of multi-agency projects to ensure the improvements we need to make are progressed and that they make a difference to individuals' lives and how we manage our health and care system. To help us, we are developing a set of outcome-based measures based on the benefits realisation map in this Strategy – and will continue to listen to feedback from individuals and carers.

We will also work with other health and care partners in North Central London to put in place a number of enablers for the Strategy. These include:

- *Joint Governance, Leadership and Network Collaboration* to help ensure our projects are delivered effectively and the right resources and infrastructure are available to support development;
- *Joint Commissioning and Finance* to help ensure the proposed improvements build on our revised approach to collaborative commissioning and financial management between partners;
- *Joint IT and Information Sharing, Reporting & Analytics* to help ensure the IT and informatics infrastructure needed to support these improvements, such as shared care records, is delivered;
- *Joint Workforce Development* to ensure our workforce is supported to work together in a more person-centred way; and that professionals know what their own responsibilities are, and who to contact when, to support individuals and carer;
- *Joint Estates Management* to help we make the best use of our buildings and facilities to develop a network of support closer to home for individuals and carers;

Our plans will therefore incorporate these enablers as part of the Roadmap.

Our intention is to update our Roadmap of actions and improvements annually over the next 3 years. We will therefore report progress on the Strategy's development, with a revised Roadmap and the impact on key outcomes, to the Health & Well-Being Board and Borough Partnership over this period.