AGEING WELL STRATEGY ROADMAP 2019/20 AND BEYOND

SROs: Rachel Lissauer, Director of Commissioning, Haringey CCG

SRO: Charlotte Pomery, Director of Commissioning, LBH

Programme Lead: Paul Allen, Head of Integrated Commissioning (Frailty & Integrated Care)

Project Start: Oct-19

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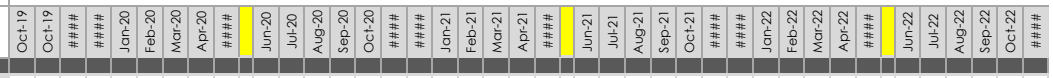
NO.	TASK	ASSIGNED TO	START	END
1	**Ageing Well**	Mary Orhewere		
1.1	Improve the use of Housing Hubs/Community Hubs as community facilities/meeting place, with care navigators aiming to improve engagement	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.2	Increase prevention and self-care, as well as self-referral to GP/system (as appropriate) especially in those with long term conditions	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.3	Join up existing services by improved signposting between services and by mapping of complementary services by GPs	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.4	Normalise consideration of 'financial health', including sign posting to address financial concerns and encourage financial planning	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.5	Increase use of green spaces, allotments and interactions with nature to improve physical activity levels & wellbeing	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.6	Improve awareness & uptake of volunteering opportunities (all ages)	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.7	Raise awareness/improve transport options for older people	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.8	Actively promote carer's health and wellbeing	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
1.9	Provide guidance about the setting up of community lunch clubs	Ageing Well Project Group	Sep-19	Mar-22
	Phase I: Initial Development		Sep-19	Mar-20
	Phase II: Further Development		Apr-20	Mar-21
	Phase III: Finalised Development		Apr-21	Mar-22
2a	**Living With Long-Term Conditions**			



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NO.	TASK	ASSIGNED TO	START	END
2a.1	Work in partnership with PHE to decrease number of patients at risk of developing LTCs by improving prevention programmes and early detection	Juliana Da Silva	Jul-19	Mar-20
2a.2	Support GPs and PCNs closing the gap between recorded prevalence and exception reporting through LCS and QIST teams	Juliana Da Silva	Jul-19	Mar-22
2a.3	Support patients self-managing their LTCs through self-management programmes by working closely with providers. Extend the self-management support to all LTCs and patients with multi morbidity across Haringey.	Juliana Da Silva	Jul-19	Dec-19
2a.4	Align care/pathways across the Borough for all LTCs patients by redesigning current services model.	Juliana Da Silva	Jul-19	Mar-22
2a.5	Increase services offer at primary care level to avoid unnecessary pressures in secondary care outpatient services, A&E attendances and consequent admissions.	Juliana Da Silva	Jul-19	Mar-22
2a.6	Work with wider commissioning teams and providers to review current services provision and decrease variation and duplication of care provided to patients across Haringey.	Juliana Da Silva	Jul-19	Mar-20
2a.7	Complete services mapping exercise related for the 6 identified areas for improvement, which includes an overview of type of services we should be providing to our population according to NHS Right Care Pathways.	Juliana Da Silva	Apr-19	Jul-19
2b	**Living With Dementia**	Paul Allen & Dementia Reference Group		
2b.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	Dementia-Friendly Haringey Leadership Group	May-19	Mar-22
2b.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	Dementia Reference Group	Jun-19	Jun-19
2b.3	Work with BEH MHT and Primary Care Networks to improve diagnostic pathways for people with cognitive impairment	Paul Allen, HCCG/LBH as commissioner lead with providers	Jan-20	Sep-20
2b.c	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	Paul Allen, HCCG/LBH as commissioner lead with providers	Dec-19	Mar-21
	• Phase I: Agreement on protocols & future management		Dec-19	Jun-20
	• Phase II: Implementation		Jul-20	Mar-21
2b.d	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	Uttara Mandal, BEHMHT	Sep-19	Mar-20
2b.e	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	Paul Allen, HCCG/LBH as commissioner lead with providers	Sep-19	Mar-20
2b.f	Across partners, improve clinical and practice knowledge and skills in managing people with dementia and knowledge to support people through dementia pathways	Dementia Reference Group lead to be identified	Nov-19	Mar-21
	Phase I: Planning and development (2019/20)		Nov-19	Jun-20
	Phase II: Implementation across workforce (2020/21)		Jul-20	Mar-21
2b.g	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	Dementia Reference Group	Oct-19	Mar-21
	Phase I: Planning and initial development (2019/20)		Oct-19	Jul-20
	Phase II: Implementation (2020/21)		Aug-20	Mar-21

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NO.	TASK	ASSIGNED TO	START	END
2b.h	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	Paul Allen, HCCG/LBH as commissioner lead with providers	Oct-19	Mar-21
	Phase I: Planning and initial development (2019/20)		Oct-19	Jul-20
	Phase II: Full implementation of ICNs (2020/21)		Aug-20	Mar-21
2b.i	Ensure Enhanced Health in Care Homes model available to support Haringey's care homes adequately supports needs of people with dementia and that care home staff have adequate training on dementia	Paul Allen, HCCG/LBH as commissioner lead with providers	Jul-19	Mar-20
3	**Becoming Frail**			
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	Leadership Team	Jul-19	Mar-20
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	HCCG Primary Care Team	Sep-19	Mar-21
3.3	Across partners, improve and bring together available public information, 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	Paul Allen	Sep-19	Sep-21
	Phase I – Develop and initial implementation		Sep-19	Aug-20
	Phase II – Full Implementation		Sep-20	Sep-21
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.	Leadership Team	Oct-19	Sep-21
	Phase I – Plan and agree delivery of workforce development		Oct-19	Mar-20
	Phase II - Implementation workforce development		Apr-20	Sep-21
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	Paul Allen	Jul-19	Mar-20
3.6	Work across partners to improve the 'community support offer' available to carers, people with frailty and/or who need early help:	Paul Allen / Gill Taylor / Marco Inzani	Jul-19	Mar-21
3.6.1	• Develop a joint Design & Outcomes Framework to map assets and develop future community services;			
3.6.2	• Make better use of identified existing services & facilities;			
3.6.3	• Use existing social housing facilities as community 'hubs' across Haringey;			
3.6.4	• Improve access to, and range of, community service including through stimulating development of peer support and community groups;			
3.6.5	• Pilot this approach within North Tottenham as part of place-shaping 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	Paul Allen	Apr-19	Nov-20
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	Priyal Shah with Providers	Sep-19	Mar-21
	Phase I – Develop and initial implementation		Sep-19	Mar-20
	Phase II – Full Implementation		Apr-20	Mar-21
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	Adult Social Care	Oct-19	Mar-21

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NO.	TASK	ASSIGNED TO	START	END
4	**Becoming Frailer**			
4.1	Across partners, work towards developing local multi-agency Integrated Care Networks (ICNs) across Haringey:	Leadership Team	Aug-19	Sep-21
4.1.1	• Further develop further multi-agency health, social care and voluntary sector team models and care pathways in localities to support Primary Care			
4.1.2	• Improve agency's joint capacity and responsiveness to address to assess, plan, deliver & review needs of patients;			
4.1.3	• Deploy multi-agency team as part of North Tottenham place-shaping pilot to better support people with more significant frailty who need care coordination;			
4.1.4	• Integrate work of Locality Team, joint Intermediate Care and Care Closer to Home (CHINs) into emerging ICNs			
	Phase I – Develop and agree ICN		Aug-19	Sep-20
	Phase II – Implement ICN		Oct-20	Sep-21
4.2	Work with GP Federation and other partners to develop Haringey's Primary Care Networks and integrate ICNs and PCNs to improve care pathways for people with significant frailty and/or high-risk patients	GP Federation with Partners	Apr-19	Sep-21
	Phase I – Develop and initially form 8 PCN		Apr-19	Sep-20
	Phase II – Full implementation of PCN functions		Oct-20	Sep-21
4.3	Roll out multi-agency Enhanced Health in Care Homes model to support care home staff & residents including those with dementia.	Paul Allen with Providers	Apr-19	Mar-21
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	Aphrodite Asimakopoulou	Sep-19	Sep-21
4.5	Council to work with partners to explore re-providing Osborne Grove as a nursing care home to increase capacity of available beds	Charlotte Pomery	Apr-19	Sep-22
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	Charlotte Pomery	Jul-19	Mar-22
	Phase I – Develop		Jul-19	Mar-20
	Phase II – Testing in North Tottenham and evaluating impact		Apr-20	Mar-21
	Phase III – Full Implementation if successfully evaluated		Apr-21	Mar-22
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	Tim Miller	Oct-19	Mar-21
	Improve Continuing Health Care pathway including CHC processes and timescales for assessments and reviews for older people with frailty	Nigel Evason	Jul-19	Mar-21
	Phase I - Develop and initial improvement		Jul-19	Mar-20
	Phase II – Full implementation		Apr-20	Mar-21
5	**Approaching End of Life**			
5.1	Embed the expanded Specialist Palliative Care Service in the Community (started Q4 2018-19).	Priyal Shah / Patrick Schrijnen	Jan-19	May-19
5.2	Learn from the Advance Care Planning Facilitator (ACP) project in the two care homes and decide on future provision.	Priyal Shah	May-19	May-19
5.3	Review Hospice at Home Nursing service provision.	Priyal Shah	Apr-19	Jul-19
5.4	Develop North Central London End of Life Care Strategy.	Priyal Shah / Patrick Schrijnen	Apr-19	Dec-19
5.5	Improve EOLC in Primary Care through Quality Improvement in EOLC	Priyal Shah	Apr-19	Mar-20

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NO.	TASK	ASSIGNED TO	START	END
5.6	Update on this project once North Central London EOLC strategy has been decided	Priyal Shah	Jan-20	Mar-20
6	**Recovering From Crises or Illness**			
6.1	Improve NHS-and Council Joint Intermediate Care pathways incorporating:			
6.1.1	• Integrated Point of Access across agencies and improved handover (e.g. from hospital) into intermediate care in line with D2A processes			
6.1.2	• Trusted therapies assessment model between NHS and Council and streamlined access & management of people using pathway;	ınita Marsden / Alison Ke	Jul-19	Sep-21
6.1.3	• Improved handover to onward management of cases post-intermediate care across Integrated Care & Primary Care Networks;			
6.1.4	• Establish supporting infrastructure to support joint working, e.g. workforce development, information governance, IT etc.			
	Phase I – Develop and intial implementation		Jul-19	Mar-20
	Phase II – Full Implementation		Apr-20	Sep-21
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	Robert Cass	Apr-19	Jan-20
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	Richard Robson / Clarissa Murdoch	Jul-19	Sep-21
	Phase I – Develop and intial implementation		Jul-19	Mar-20
	Phase II – Full Implementation		Apr-20	Sep-21
6.4	Develop an 'intermediate care nursing model' to support people with frailty who need recuperation after crisis or hospital episode	Robert Cass	Jul-19	Dec-19
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	Leadership Team	Jul-19	Mar-21
	Phase I – Improvements with the existing resources		Jul-19	Mar-20
	Phase II – Potential expansion of model		Apr-20	Mar-21
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	Leadship Team	Oct-19	Mar-22
	Phase I – Explore options for improvement		Oct-19	Mar-21
	Phase II – Phase implementation of improvements		Apr-21	Mar-22
6.7	Work to improve mental health crisis resolution services for older people with dementia with BEHMHT	Paul Allen / Tim Miller	Oct-19	Mar-21
	Phase I - Develop and agree improvement		Oct-19	Mar-20
	Phase II - Full implementation		Apr-20	Mar-21
6.8	Work across partners to improve emergency care planning arrangements for people with frailty involved in Frailty Network and sharing of information between	Leadership Team	Oct-19	Mar-21
	Phase I - Develop and agree improvement		Oct-19	Mar-20
	Phase II - Full implementation		Apr-20	Mar-21
7	**Supporting Carers**			
7.1	Work across Haringey's health & care partners to set out joint staff development programme, and share good practice, on:			
7.1.1	• Identification, registration and working with carers of people with frailty;			
7.1.2	• How to promote 'carer management of person cared for' and looking after yourself;		Oct-19	Mar-21
7.1.3	• Improve staff knowledge on the network of services available for carers and how to access them including helping them plan support;	Sebastian Dacre and Paul Allen		

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NO.	TASK	ASSIGNED TO	START	END
7.1.4	• Improve ability to undertake joint carers/cared for and specific carers assessments, planning & reviews			
	Phase I - Plan and agree delivery of staff development		Oct-19	Mar-20
	Phase II - Implementation of staff development		Apr-20	Mar-21
7.2	Establish a business intelligence tool to consistently identify where there are carers known (or potentially 'hidden carers') across Haringey, particularly high-risk groups	Charlotte Pomery / Community First working with providers	Jul-19	Mar-21
7.3	Expand range of carers' respite opportunities in the Borough	Sebastian Dacre	Oct-19	Mar-21
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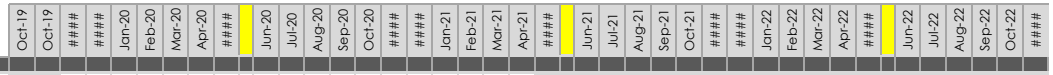

SIMPLE GANTT CHART by Vertex42.com
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About This Template

This template provides a simple way to create a Gantt chart to help visualize and track your project. Simply enter your tasks and start and end dates - no formulas required. The bars in the Gantt chart represent the duration of the task and are displayed using conditional formatting. Insert new tasks by inserting new rows.

Guide for Screen Readers

There are 2 worksheets in this workbook.

TimeSheet
About

The instructions for each worksheet are in the A column starting in cell A1 of each worksheet. They are written with hidden text. Each step guides you through the information in that row. Each subsequent step continues in cell A2, A3, and so on, unless otherwise explicitly directed. For example, instruction text might say "continue to cell A6" for the next step.

This hidden text will not print.

To remove these instructions from the worksheet, simply delete column A.

Additional Help

Click on the link below to visit vertex42.com and learn more about how to use this template, such as how to calculate days and work days, create task dependencies, change the colors of the bars, add a scroll bar to make it easier to change the display week, extend the date range displayed in the chart, etc.

How to Use the Simple Gantt Chart

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