Haringey Council

Report for:	Cabinet 11 February 2014	Item Number:	

Title:	Better Care Fund: Local Health and Social Care Integration Plan

Report Authorised by:	Mun Thong Phung, Director Adult Social Services

Lead Officer:	Beverley Tarka, Acting Deputy Director, Adult Social Services

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

1. Describe the issue under consideration

> *"To improve outcomes for the public, provide better value for money, and be more sustainable, health and social care services must work together to meet individuals' needs. The Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. The NHS will make available a further £200 million in 2014-15 to accelerate this transformation".*
>
> Spending Review (26/6/13), HM Treasury

1.1 This report presents for consideration and approval of Haringey's proposed Better Care Fund (BCF) Health and Social Care Integration Plan, hereafter referred to as the 'Integration Plan', prior to its dispatch to NHS England on 14th February 2014, for initial scrutiny. If required, a revised final version of this Plan must be submitted for ministerial sign-off no later than 4th April 2014.

1.2 The Integration Plan – see Appendix 1 - has been jointly produced by the Council (Adult Social Care) and Haringey CCG.

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2. Cabinet Member introduction

2.1 I am delighted to present this report to the Cabinet, which is dedicated to the proposition that the integration of health and social care will produce better results for local people and significantly improve their experiences of services while increasing value for money. The BCF and our Integration Plan are transformational. They are catalysts for change which, in an extremely tough public spending environment, will allow damaging reductions in service volume and quality to be minimised. The BCF provides a real opportunity to reshape and join-up provision across health and social care and the Plan describes the shared approach it is proposed to take to this task.

2.2 However, changing services and spending patterns will take time and the Integration Plan should be regarded as a two year operational plan, covering 2014/16, that forms part of a larger five year strategy for health and social care. The interests of Haringey's residents will, at all times, be at the heart of integration. There will be a relentless focus on the creation of real and robust integrated services leading to real benefits for people over which they will be able to exercise control, as far is practical and reasonable. The Integration Plan is designed to ensure that the BCF delivers these important objectives and to sustaining a well integrated and vibrant care economy that delivers great services for local people.

3. Recommendations

It is recommended that Cabinet:

3.1 approve the Integration Plan at set out at Appendix 1 in readiness for its submission to NHS England on 14th February 2014;

3.2. note that Haringey Clinical Commissioning Group's Governing Body has considered and approved the Integration Plan as set out at Appendix 1 on 30th January 2014;

3.3 note that the Health and Wellbeing Board has considered and approved the Plan at its meeting earlier today (11th February 2014).

4. Alternative options considered

4.1 National guidance makes clear that if Haringey is to access the BCF and realise the benefits of integration for local people it must produce and implement an Integration Plan. As a result no alternative option to the Integration Plan is presented. Maintenance of the status quo will perpetuate current inefficiencies in the provision of health and social care, fail to realise value for money gains and not improve people's experience of service provision. Moreover, it will place Haringey in breach of an important national policy initiative and result in the loss an exciting opportunity to reshape services through the use of the Fund.

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5. Background information

5.1 Closer integration of health and social care has been a recurrent goal of public policy for at least the past 40 years. Different solutions have been proposed including full structural integration into a single system. Other models are geared to overcome barriers and facilitate closer joint working and sharing of resources to give a seamless service. The successful integration of health and social care offers three potential benefits:

a) better outcomes for people, e.g. living independently at home with maximum choice and control;
b) more efficient use of existing resources by avoiding duplication and ensuring people receive the right care, in the right place, at the right time, and;
c) improved access to, experience of, and satisfaction with health and social care services.

5.2 The Coalition Government has taken up the challenge of integrating health and social care and wants the barriers between them swept away over the next five years. In the context of the intense financial and demographic challenges facing both services the BCF incentivises a decisive move towards integration. However, it is important to be clear what integration means.

Defining Integrated Care

5.3 In 2010 the Department of Communities and Local Government observed that people want joined up services and that it can be a source of great frustration when this does not happen. Integration means different things to different people but it has at its centre the building of services around individuals, not institutions. Work undertaken by National Voices confirms this view and it has formulated a definition of integrated care for which there is a strongly supportive national consensus. This definition holds that, from an individual's perspective, integrated care means:

> *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me".*
> http://www.nationalvoices.org.uk/defining-integrated-care-agreeing-narrative

5.4 This is the definition used in the preparation of Haringey's Integration Plan. It is explicitly person centred, has a good fit with personalisation and takes forward choice and control for individuals over their services. The definition also emphasises that integration is not about organisational arrangements; it concerns the experience of people who receive services. Consequently, the main organising principle of integration must be the personal perspectives of service users and patients.

Funding The Integration Plan – Details of the BCF

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5.5 The June 2013 Spending Review set out the details of the BCF, which is to be used to Fund the Integration Plan as follows:

2014/2015

a) £200m transfer from NHS to social care, in addition to;
b) £900m transfer already planned.

2015/16

a) £3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements composed of:
   i. £1.9bn NHS funding;
   ii. £130m Carers Break funding;
   iii. £300m CCG Reablement funding;
   iv. £354m capital funding (including c.£220m of Disabled facilities Grant), and;
   v. £1.1bn existing transfer from health to social care.

5.6 It is emphasised that the money invested in the BCF is not new with the majority of the Fund consisting of a financial transfer from health into the Fund. As a result, the BCF cannot be regarded as a *'windfall'*. It will create challenges within the health economy which will have to switch its pattern of investment with some of the funds placed in hospital provision having to be redirected into community based alternatives. This will have significant implications for the acute sector which are discussed in paragraphs 6.22 to 6.29, below.

5.7 In addition, the national guidance indicates that the BFC is to be subject to ringfencing to cover the new duties and associated costs imposed on local authorities by the Care Bill. £135m of revenue monies is tied to funding new entitlements for carers, the introduction of a national minimum eligibility threshold, the provision of better information and advice, advocacy, safeguarding and other measures. A further £50m of capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system. Advice received from the Local Government Association indicates that once we are informed of the impact ringfencing will have on Haringey the Integration Plan will have to be adjusted to reflect this in its section dealing with *'protecting social care services.'* This will not occur before the submission of the current iteration of the Plan.

5.8 However, the BCF cannot be characterised as a prop for social care. It, more accurately, reflects the need to provide help to people at home and earlier, before crises arise. The BCF is about using resources differently and more effectively by building on the range of existing integrated services that Haringey already has in place and establishing new ones.

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Haringey's Allocation of the BCF

5.9 In 2014/15 Haringey's allocation of the BCF funding will be £957,000, which will take the form of a Section 256 transfer from Haringey CCG to the Local Authority. This takes the total value of transfers for that year to £5.07m. This funding will be added to the existing Section 256 agreement with NHS England that was agreed by Cabinet at its meeting of 15 October 2013.

5.10 In 2015/16 the value of the BCF rises sharply to £18,061m consisting of:

	£000
Disabled Facilities Grant	£949
Social Care Capital Grant	£639
Transfer from CCG to BCF	£16,473
Total (2015/16)	**£18,061**

5.11 Guidance makes clear that the 2015/16 BCF allocation must be paid into a pooled budget. This will be by way of a one large or a series of Section 75 agreements. It will be important for the Council and CCG to commence negotiations on pool early in 2014/15, to ensure that these are in place when required. Before the Council can enter into any Section 75 agreements, Cabinet agreement will be required.

Our Approach To Integration - Stakeholder Engagement.

5.12 Led by Adult Social Care and Haringey CCG, the Integration Plan has been co-produced with service users, carers, professional groups, staff and NHS and care providers. In total, 211 service users, potential services users and professionals participated in a comprehensive engagement exercise. This avoided a one-size fits all approach consisting of workshops, focus groups and semi-structured one-to-one interviews. As a result, in line with the National Voices work we have been able to use the views expressed to construct a series of locally generated *'I'* and *'We'* statements – see Appendix 2. These summarise, respectively, what people want/need and how we propose to respond. The statements have informed the identification of the outcomes integration must deliver and thinking about the actions agencies will take to this end.

5.13 The establishment of reference groups (one has already been established under the auspices of the Older People's Forum) will embed on-going engagement at the heart of integration. Further details on the engagement exercise can be found in the Integration Plan at Appendix 1.

Our Approach To Integration – Building On What We Have Achieved.

In addition, the Integration Plan reflects a commitment to build on the integrated services Haringey already has in place, schemes worth approximately £5.91m which are making a valuable contribution to health and wellbeing in the Borough. However, while the Plan is unashamedly practical it is also aspirational. It spells out a strong, clear vision which describes how services will be taken forward and reshaped to offer local people the integrated services they tell us they want and need. In so doing the Plan is cognisant of the outputs from the CCGs Value Based Commissioning work which is designed to place the outcomes people value most at the heart of the commissioning process.

6. The Integration Plan

6.1 The presentation of the Integration Plan is restricted by the limitations imposed by the NHS England templates which must be used for its completion. The following synopsis of the Plan is provided in terms of the main headings of these templates.

Scope - The Service User and Patient Cohort

6.2 Integrated services will be inclusive. They will be available to all adults living in Haringey but, based on an analysis of the Joint Strategic Needs Assessment (JSNA) and GP Collaboratives profiles we will prioritise frail older people, and older people with dementia in 2014/15 and adults (of all ages) with mental health needs in 2015/16. These are the groups for whom integration will have the greatest and most immediate impact.

Vision for Transformation and Integration of Health and Social Care in Haringey

6.3 Haringey's Integration Plan is transformational. It calls for the reorientation of health and social care provision away from reactive to proactive services with the aim of providing people with the right care, in the right place and at the right time through a significant expansion of care in community settings. In so doing our intention is to reduce the need for acute interventions and, where such interventions become necessary, to return people to their homes as quickly and safely as possible. This is reflected in our vision which states:

> *"We want people in Haringey to be healthier and to have a higher quality of life for longer. We want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible."*
>
> (Haringey's Vision for Integration)

6.4 This vision is consistent with our definition of integrated care and to support it realisation the Integration Plan proposes a set of high level aims which will be operationalised through a series of interrelated objectives.

Aims and Objectives

6.5 The aims of the Integration Plan are:

a) ***Aim – Seamless Care and Support:*** To join-up systems for providing health and social care so that those receiving care and support experience seamless provision, regardless of who is providing it.

b) ***Aim – Person Centred and Personalised Services:*** To wrap care around service users and or patients, as unique individuals, with their wishes at the centre of care packages and pathways - they will be empowered to have their voices heard.

c) ***Aim – A Caring Community:*** To build the community's capacity to support its members, surrounding them with networks of support that combat loneliness and isolation.

d) ***Aim – The removal of organisational barriers:*** To remove organisational boundaries ensuring that they do not act as barriers to care, and are not noticed by service users.

e) ***Aim – The maximisation of Health and Wellbeing***: To maximise the health and wellbeing of individuals they will, wherever possible, be provided with integrated care and support in their own homes.

6.6 Collectively, these aims articulate partners' shared ambition to improve the results health and social care achieve for local people and their experiences of these important services. The objectives of the Integration Plan flow from its aims and are brief statements of the things we will do to realise its ambitions and to make its vision a reality.

6.7 In the language of the National Voices work, the objectives of the Integration Plan are expressed as a series of *'We'* statements:

a) ***Objective – Outcome focused:*** We will identify the outcomes that matter most to people and measure their attainment to learn and drive continuous improvement.

b) ***Objective – Policies, procedures and practices*****:** We will put in place policies, procedures and practices that enable, not hinder, the provision of integrated care with providers assuming joint accountability for achieving a person's outcomes and for showing how this delivers efficiencies across the system.

c) ***Objective – Monitoring attainment*****:** We will ensure that care is planned with individuals. Commissioners will monitor whether, or not, people are being successfully supported to attain the outcomes that they have set for themselves.

d) ***Objective – Integrated care plans:*** We will produce integrated care plans**,** cutting across health and social care, for all who need them. These plans will be accessible to their subjects and to the professionals they choose to share them with.

e) ***Objective – Prevention and proactive case management:*** We will undertake, by default, proactive and joined up case management to avoid unnecessary admissions to hospitals and care homes and to enable people to regain their independence as soon as possible after episodes of ill-health. This demands an emphasis on prevention and will result in services that are much more efficient, effective and more responsive to individuals' needs.

f) ***Objective – Prevention and increased support in the home and community:*** We will refocus services to offer increased support in the home and community to maximise the independence of people and enable them to self-manage their own health and wellbeing. This means responding proactively to the needs of individuals with, as above, an emphasis on prevention and working with the Third Sector to grow the range of community based solutions to people's needs.

g) ***Objective - Better information sharing:*** We will put in place better information sharing system that will allow key information about individuals' health care and support needs to be available to the social and health care professionals, subject to service users'/patients' consent.

h) ***Objective - Integrated community teams:*** We will introduce integrated community teams of social workers, nurses and therapists working closely with GPs and others to deliver joined-up care, reduce duplication and make the best use of skills and resources. Some of these teams will be based around groups of GP practices, while others operate across the borough and within hospitals in more specialist roles.

i) ***Objective - A single point of access***: We will put in place a 7 day week, 24 hour day single point of access to receive and respond to referrals from people living in the community, GPs and local organisations. The single point of access will streamline and make more accessible health and social care, offer signposting and meet the reasonable information needs of all who contact it.

j) ***Objective – Collaboration with GPs:*** We will work as closely as possible with GP practices and localise services, aligning them with Haringey's four GP Collaboratives.

Cultural Change and Challenge

6.8 Partners in Haringey recognise that the success of integration (the realisation of its aims and objectives) demands cultural change across the local health and social care system. To work well together health and social care organisations must develop a deeper mutual understanding and appreciation of the contributions they each make to the health and wellbeing of local people. They must also understand that they are parts of one whole integrated local health and social care economy and system.

6.9 Therefore, the integration of health and social care demands behavioural change as much as it requires organisations to adopt different ways of working. A shared culture has to be developed that allows the diverse professionals within health and

social care to work together efficiently and effectively. To this end the development of integrated teams, joint assessments, case coordination across disciplines and multi-disciplinary training are cornerstones of the Integration Plan.

Description of Planned Changes – A System Wide Transformation

6.10 6.10 The vision underpinning the Integration Plan is about nothing less than a systems wide transformation of health and social care in Haringey and the changes described are the means by which this transformation will be delivered. A multi-faceted change programme will identify priority areas for change that will be the subjects of immediate action. In addition we will commit to working on and developing other areas for action over the next 2 – 5 years, a period which aligns with the Coalition Government's medium and long-term agendas on integration.

6.11 This is an exciting, but complex challenge, but we have a clear sense of direction that is provided by the Integration Plan's vision, aims and objectives. We will use the BCF to establish a range of new integrated services and to enhance those already in place. In so doing we will focus on reducing hospital and care home admissions, promoting timely discharges, preventing dependency and maintaining independence and improving individuals' experience of services.

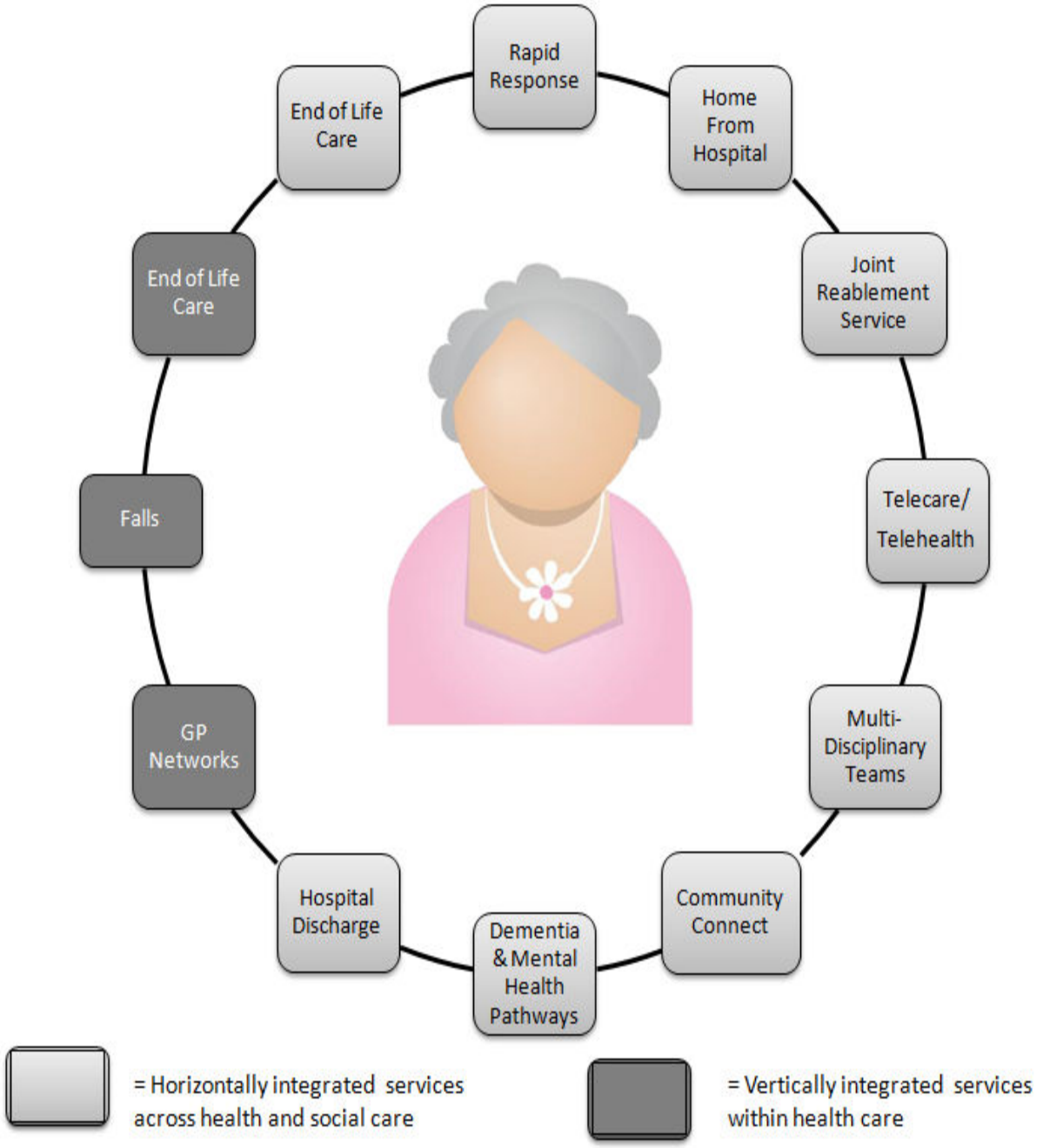
6.12 Furthermore, Haringey is able to base transformation on the solid bedrock of experience that health and social care partners already have of integrated services. The Integration Plan reflects our determination to learn from and make best use of this experience as we embark on a programme of change that broadens and widens the scope of integration, making integrated services the default form of provision. To reach this destination requires that health and social care undertake a journey that starts out by recognising where we are today, and where we will be in 2014/15 and 2015/16. These matters are considered in the next three sub-sections.

Building On What We Have Achieved - Where We Are Today

6.13 Haringey has already moved away from traditional service models that are segregated in terms of a health and social care divide. Services have increasingly been integrated across health and social care (called horizontal integration) and between different health care services (called vertical integration). Examples of these forms of integration are provided in Figure 1. The BCF provides health and social care partners with an opportunity to build on their shared achievements by extending the range of integrated services available to local people.

6.14 In the course of 2014/15 we will review the integrated services already in place and undertake the detailed planning that will underpin the enhancement of some of these services and the launch of new initiatives focusing on frail older people, end of life care, discharge planning and self-management. Work on shared information systems and joint assessment will also be carried forward. In all these areas we expect to see substantial progress in 2014/15 and new service options coming on stream with an increased emphasis on services for adults with mental health needs.

Figure 1. Example of Services That Are Already Integrated



Building on What We Have Achieved - where we will be tomorrow, 2014/15

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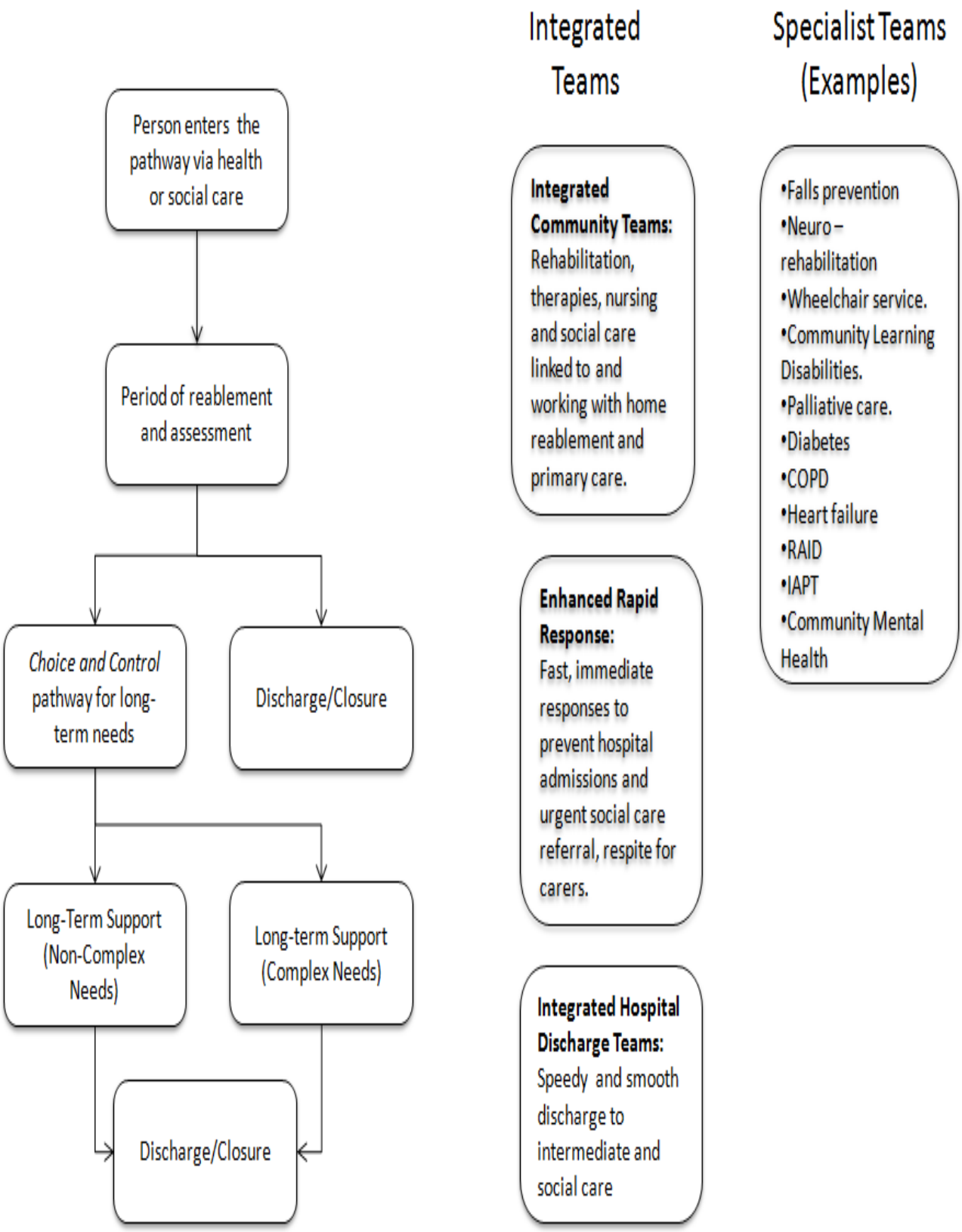
Building On What We Have Achieved - Where We Will Be Tomorrow, 2015/16

6.15 By the end of 2015/16 our default form of provision for most service users and patients will be will be integrated services. The proposed new service model is illustrated in Figure 2. The services described in this model will work alongside and complement those integrated services outline in Figure 1 with the key new service developments being:

a) ***Integrated Community Teams.*** These will have a core membership of social workers, community nursing staff and therapists and be based upon groups of GP practices.
b) ***A Single Point of Access*** (not shown in Figure 2) across health and social care for people living in the community.
c) ***Integrated Hospital Discharge Teams*** to promote and make arrangements for the safe discharge of people from hospital to their own homes or other settings. An important aspect of the teams' work will be ensuring that discharge procedures work well for people, as well as hospitals.
d) ***An enhanced Integrated Rapid Response Team*** to promote hospital discharges and prevent admissions by offering support in the home including respite to carers, at short-notice.
e) ***Specialist teams*** some of which will be integrated while other will not. These teams will operate on a pan-borough basis, supporting people with complex needs.

6.16 Collectively the integrated services, referenced above at Figure 1 and below at Figure 2, will provide a whole systems response to intermediate care, hospital discharge, urgent care, and community rehabilitation. They will also contribute to prevention and ensure that people are cared for at home, or close to their homes. The intention is for Haringey's residents to remain as independent as possible for as long as possible with a good quality of life.

Figure 2. What the Proposed Model Looks Like.



Establishing Ways of Working That Support Transformation – The Enablers

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6.17 Alongside the development of new services will be the development of new ways of work which will support and enable change. Previous discussion of the importance of cultural change provides a good example of such an enabler. However, this needs to be accompanied by changes to the health and social care infrastructure that will also take forward change. In addition, a robust governance structure (see paragraph 6.30 below) to superintend integration will be required, performance monitoring and the development of open information technology and information systems that support case coordination and joint assessment are vital. Work has commenced in these areas while the construction of joint commissioning strategies, shared procedures and processes and the development of other enablers will be actively pursued.

Timescales (Estimated)

6.18 **August - December 2013:**

a) Establish programme management approach and structure to the delivery of the integration of health and social care in Haringey.

b) Brief the Health and Wellbeing Board and CCG Governing body on the implications of integrations and the requirements of the BCF.

c) Commence engagement process, including providers, service users, patients, carers and public.

d) Agree service model and associated commissioning intensions.

e) Agree BFC investment intentions.

f) Adopt NHS numbers as primary identifier and commence discussions on shared IT solution for better data sharing.

6.19 **January - March 2014:**

a) Conclude engagement process.

b) Draft local integration plan completed.

c) Detailed joint commissioning strategy produced.

d) Reports to Health and Wellbeing Board, Haringey's Cabinet and Haringey CCG's Governing Body seeking their support of the local integration plan.

e) Submit first and final drafts of parts 1 and 2 of Haringey's Integration Plan.

6.20 **April 2014 – March 2015**

a) Complete detailed planning to implement concepts developed during co-design phase to achieve our aim and objectives.

b) Monitor financial flows to evaluate financial impact of possible models on different providers and on total cost to commissioners.

c) Review and roll forward existing Section 256 winter pressures schemes.

d) Manage the implementation and benefits tracking for the newly integrated services that are "live" and developing our next tranche of joint commissioning plans in line with local needs and the whole systems approach.

e) Plans to build on existing integrated schemes finalised (estimated May 2014).

f) Enhanced Rapid Response Team launched (estimated Oct 2014).

g) Revised and updated delivery plan for 2015/16 agreed (estimated Feb 15).

h) Negotiate and present to Cabinet and the CCG's Governing Body the Section 75 agreements in readiness for the 2015/16 pooled budgets.

6.21 **From April 2015**

a) Single point of access launched (estimated Apr 2014).

b) Roll-out of Integrated Community Teams commences (estimated Apr 15).

c) Roll-out Integrated Hospital Discharge Teams (estimated Apr 15).

d) Introduce regular annual customer satisfaction surveying to develop our baseline for user experience.

Implications for the Acute Sector

6.22 Haringey CCG is the Lead Commissioner for the North Middlesex Hospital. The majority of acute services for Haringey residents are provided by the North Middlesex Hospital and Whittington Health Integrated Care Organisation, which also provides community services.

6.23 Since 2011/12 there has been detailed dialogue between commissioners and acute Trusts focused on schemes, initiated both by Trusts and by commissioners, to reduce unplanned hospital admissions and A&E attendances. Projected changes in activity patterns have been detailed in Quality Productivity and Prevention (QIPP) Programmes produced by the CCG. Transformation Boards have been in place since 2012, at the level of Chief Officer and CEO of partner organisations, to enable strategic focus on these programmes of work.

6.24 The impact of the Better Care Fund on the delivery of NHS services will be greater focus from a joint commissioning perspective on the linkages between:

a) NHS community services including; district nursing, community matrons, integrated care and therapies and community palliative care
b) Services commissioned by Local Authorities including: reablement, social care assessment, domiciliary care provision and residential care
c) Services provided by acute Trusts with a focus on reducing unplanned admissions such as ambulatory care, facilitated early discharge, older people's assessment unit and day hospitals

6.25 The focus on pro-active case management, locality based services and 7 day/wk care will enable NHS savings to be achieved through:

a) Reduction in unplanned hospital admissions, releasing CCG spend and capacity within acute trusts. Acute capacity will translate into improved efficiency; improvements in performance on Referral to Treatment Time (RTT) and A&E 4hr target and reduced spend on ad hoc capacity to manage peaks in demand
b) Reductions in length of stay, representing savings to acute providers through improved efficiency, ability to manage peaks in demand and opportunities to repatriate patients
c) Reduced duplication of care provision if there are areas of overlap between community and social care provision addressed through common assessment and co-location of service
d) Reduced outpatient demand: better care planning and an emphasis on enabling self-management will aim to streamline, where appropriate, the numbers of outpatient appointments that patients are attending

6.26 There is high value to both acute providers and to commissioners of delivering on the Better Care Fund with its focus on preventative community provision, enablement and maximising efficiency between community providers.

6.27 How will the savings be realised:

a) Development of a shared transformation programme with identified savings targets for NHS commissioners and providers; and
b) Shared PMO monitoring of transformation schemes.

6.28 Risks associated with failure to deliver:

a) Continued upward pressure on CCG budgets with rise in unplanned admissions; and
b) Continued risk to Trusts' ability to manage peaks in emergency attendances and admissions.

6.29 If the Integration Plan fails to deliver improvements some of the Fund may need to be used to alleviate the pressure on hospital services. Our plans in this regard are outlined in the contingency plan contained in part 2 of this Plan.

Governance

6.30 Figure 3, describes the governance structure that will be put in place to maintain oversight of the Integration Plan and to ensure that it delivers required outcomes. The key features of this structure are:

a) ***Executive oversight and policy direction:*** Executive oversight and policy direction will be the responsibility the Health and Wellbeing Board, the Governing Body of Haringey Clinical Commissioning Group and the Local

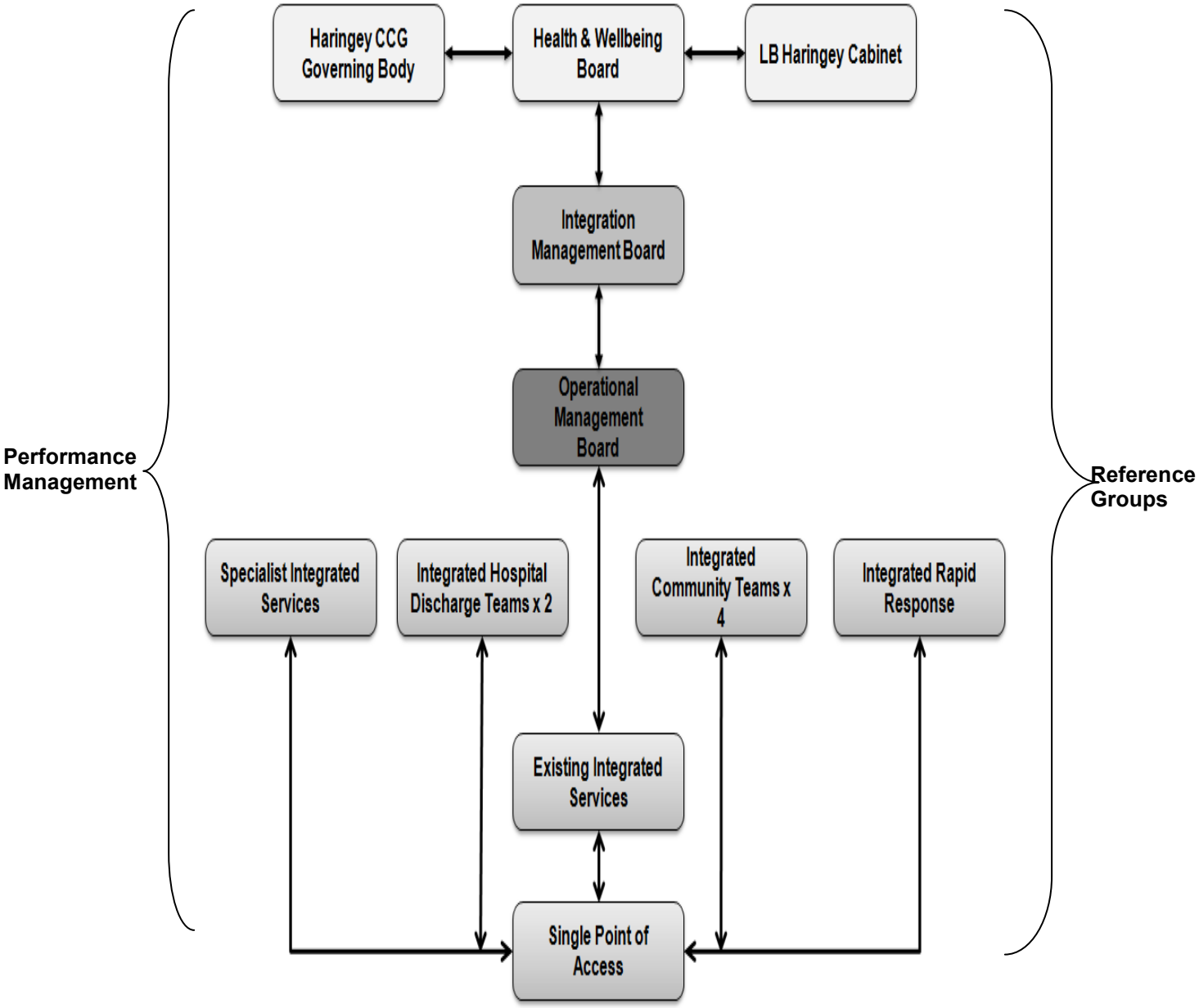
Authority's Cabinet as the senior executive bodies of the partners responsible for the integration of health and social care in the Borough. Ultimate responsibility for the delivery of this Integration Plan rests with the Health and Wellbeing Board which has, in line with guidance, been briefed on the BCF. The chair of the Health and Wellbeing Board will receive briefings in the course of monthly meetings with senior managers and the Director of Public Health will assist the Health and Wellbeing Board to discharge its governance responsibilities.

b) ***Strategic oversight:*** The Integrated Management Board is the senior health and social care commission group responsible for maintaining strategic oversight of integration, including strategic commission. It will plan spend, set priorities, monitor the delivery of key outcomes and make recommendations to the executive level bodies (the Health and Wellbeing Board, the Cabinet and the CCG's Governing Body), as appropriate. It is also the forum to which problems, that cannot be resolved operationally, can be escalated for solution. The Integrated Management Board will meet on an, at least, monthly basis, receive regular monitoring reports and be co-chaired by the Chief Officer of the Clinical Commissioning Group and Director of Adult Social Care

c) ***Operational oversight:*** The Operational Integration Board will maintain day-to-day oversight of business units (services). It will have an internal and external provider focus and work with them to identify and trouble shoot problems, ensure consistency of practice, promote learning and to progress service plans. In this way the Operational Management Board's oversight of micro commissioning will allow it to inform the strategic commissioning intentions framed by the Integrated Management Board.

d) **Business Units:** These are the integrated services providing people with care and support. They will be responsible for the services designated to them in keeping with good practice, policy and statutory requirements. Managers of business units will link to the Operational Management Board and provide such reports that may be reasonably asked of them.

e) ***Performance Management:*** This function will gather and coordinate performance data from the Business Units and Operational Management Board and distribute it across the entire governance structure. The data will provide that structure with the intelligence needed to inform decision making, policy formation, commissioning and the proactive management of integration. Performance Management will support excellence in data gathering and use by putting in place the systems and processes needed to capture and analyse required data, transforming it into useful information.



Executive oversight and policy direction

Strategic commissioning and oversight body.

Operational oversight body

Business units

f) ***Monitoring performance:*** All business units including the single access point, will be responsible for collecting their own monitoring data with the assistance of performance management colleagues. This will promote organisational and professional learning and support continuous improvement

g) ***Reference Groups:*** These groups, which will include Haringey's Older People's Forum, carers, third sector etc, will ensure that the voices of services users, patients, carers and other key stakeholders are heard and able to influence the governance and development of integrated health and social care provision in Haringey. They will also expose the thinking of statutory agencies to a valuable external constructive critical challenge. This will help quality assure our approach to integration while providing a conduit of communication between local people, professionals, the Third Sector and community organisations.

h) ***Two way communication:*** Good governance demands excellent and systematic two way communications between the different layers of the governance structure to 1) ensure information exchange: 2) enhance clarity of understanding across the system; 3) escalate issues and bring about their resolution, and; 4) avoid silo working.

6.31 It is important to note the role of Haringey Healthwatch, the representative of patients and the public, in the governance structure. Healthwatch will be in a position of significant influence as its Chief Executive is a member of the Health and Wellbeing Board and so able to feed into its discussions of the BCF and the ongoing integration of health and social care. It is envisaged that Healthwatch will also play an important role in establishing reference groups whose views it can represent to the Healthwatch and Wellbeing Board.

6.32 All parts of the governance structure are multi-disciplinary, bringing together an integrated health and social care approach to the governance of the Integration Plan and to the delivery of required outcomes. This is a pre-requisite for a vibrant integrated health and social care economy dedicated to delivering excellence to local people.

National Conditions

6.33 To access the BCF the Integration Plan must show how Haringey has or will meet prescribed national conditions:

a) ***Plans to be agreed jointly****:* This condition demands that the content of the Integration Plan be agreed between the Council and Haringey CCG. As a result the Plan has been prepared by officers of the Council and the CCG and must be agreed by Cabinet, the CCG's Governing Body and the Health and Wellbeing Board.

b) ***Protecting Social Care:*** Adult Social Care and the CCG have agreed a process that confines eligibility for protection to services health and social care partners agree delivers health and social care benefits. As a result the protection of eligible services is in the interests of both parties (i.e. health and social care) and builds on their considerable their experience of s256 transfers.

It will be a matter of negotiation to determine which eligible service will actually be protected.

c) ***7-Day Services To Support Discharge:*** All services commissioned through the use of the BCF will operate on a 7 day week basis. It will also be used mainstream some short-term funded 7 day week services (e.g. Rapid Response).

d) ***Data Sharing:*** The Integration Plan demonstrates Haringey's compliance with this condition by making clear that we have 1) adopted NHS Number as the primary identifier across health and social care; 2) that we are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards, and; 3) that required information governance controls are in place.

e) ***Joint-Assessments And Accountable Lead Professional:*** Health and social care partners in Haringey are committed to joint assessments and care planning with accountable lead professionals being allocated to ensure that all service users/patients receiving services from health and social care have a joint plan whose implementation is well coordinated. This function will be undertaken by appropriate health and social care professionals, as determined by the needs of individual service users/patients, using a common IT system and be supported by the use of a joint assessment tool to identify risk and required care and support. This tool has been developed and reflects established practice in our already integrated learning disabilities and reablement services. Care co-ordination and the allocation of accountable lead professionals will be part of our basic integrated service offer.

f) ***Agreement on the consequential impact on the acute sector –*** Paragraphs 6.22 to 6.29 above outline the ongoing work that is taking place with the acute sector to deal with any unwanted implications the BCF may have for the sector. The contingency plan, a sub-set of the Integration Plan, specifies the measures that will be taken should the need arise to protect the acute sector The view of the sector are important and meetings have taken place with its representatives and will continue to take place with them over the life-time of the Plan.

Outcomes and Metrics

6.34 The Integration Plan template sets out the metrics that will be used monitor impact of the Plan. The measurement of the metrics used (at least initially) should not be too demanding as it will rest on the use of data that is already collected. They are:

a) Delayed transfers of care (a nationally prescribed metric);
b) Emergency admissions (a nationally prescribed metric);
c) Effectiveness of reablement (a nationally prescribed metric);
d) Admissions to residential and nursing care (a nationally prescribed metric);
e) Patient and service-user experience (a nationally prescribed metric); and
f) Injuries due to falls in people aged 65 and over (a locally selected metric).

6.35 The Integration Plan provides full year delivery projections for each metric for 2013/15 and 2015/16. Health and social care partners' are collaborating to ensure the collection of the required data and to monitor against these targets.

Finance

6.36 Details of the financial aspects of Haringey's BFC Integration Plan can be found at part 2 of the Plan. Attention here is drawn to the summary of proposed expenditure of the BCF, provided in Tables 1.

Table 1. Summary of Proposed BCF Expenditure 2014/16: Estimated Spend

BCF Investment	Lead provider	2014/15 spend		2015/16 spend	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent
Older People and Dementia Pathway	London Borough of Haringey	475,000		475,000	
Mental Health Recovery Pathway	London Borough of Haringey	580,000		580,000	
Winterbourne Response	London Borough of Haringey	50,000		50,000	
Joint Commissioning	London Borough of Haringey/CCG	135,000		200,000	
Development and Enabling (Programme Management, Facilitating Integrated Locality Team Development, Initiating Integrated Care Planning, Staff Development, Scoping of Single Point of Access)	London Borough of Haringey/CCG		225,000	150,000	335,000
Integrated Locality Teams (Re-ablement, District Nursing, Community Matrons, Locality based social work teams)	London Borough of Haringey/Whittington Health			10,744,200	
Rapid Response - 7 days/wk	Whittington Health	340,000		500,000	
Step Down Care	London Borough of Haringey	625,000			
Reablement	London Borough of Haringey	2,450,000			
Reducing Delayed Discharges from hospital (Step-Down Care, Integrated Hospital Discharge Teams, Home from Hospital, Social Workers based in Hospitals 7 days/wk)	London Borough of Haringey	150,000		3,857,904	
GP Case Management and 7 day access	CCG	1,371,430		1,371,430	
Integrated End of Life Care Service	Whittington Health			1,379,389	
Additional Third Sector Investment	London Borough of Haringey	26,067		75,000	
Promotion of self management, measurement of patient engagement/activition, community development (Community Development Workers and Good Neighbours)	London Borough of Haringey	120,000		770,000	
Community Capacity Grant Schemes	London Borough of Haringey			639,000	
Promoting independence for people with disabilities	London Borough of Haringey			949,000	
Total		6,322,497	225000	21,740,923	335000

Note: benefits are put against the main contributor, but all schemes benefit

6.37 Table 1 provides an overview, by scheme and year of the planed expenditure and associated benefits of the BCF. The total spend must be equal to or more than Haringey's total BCF allocation which may be supplemented by any financial additions health and social care partners, including the Council, wish to make.

6.38 Approximately 25% of the BCF in 2015/16 is paid for improving outcomes. If the planned improvements are not achieved a contingency plan is required that specifies how this funding will be used to alleviate the pressure on other services. Table 2 shows the amounts of the BCF required to support these services to achieve the Integration Plan's key outcomes if targets are not fully met.

Table 2. Contingency Plan for Maintaining Services if Planned Improvements Are Not Achieved.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)	527,862	527,862
	Maximum support needed for other services (if targets not achieved)	527,862	527,862
Outcome 2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Planned savings (if targets fully achieved)	177,476	177,476
	Maximum support needed for other services (if targets not achieved)	177,476	177,476
Outcome 3 Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)	94,110	94,110
	Maximum support needed for other services (if targets not achieved)	94,110	94,110
Outcome 4 Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)	412,282	412,282
	Maximum support needed for other services (if targets not achieved)	412,282	412,282
Outcome 5 Patient / service user experience	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Outcome 6 Injuries due to falls in people aged 65 and over	Planned savings (if targets fully achieved)	61,230	61,230
	Maximum support needed for other services (if targets not achieved)	61,230	61,230

6.39 The relationship between the proposed investment of the BCF and the delivery of the outcomes as specified in tables 1 and 2, respectively, is summarised in Appendix 3.

Note: Awaiting national data to complete row for outcome 5.

6.39 The relationship between the proposed investment of the BCF and the delivery of the outcomes as specified in tables 1 and 2, respectively, is summarised in Appendix 3.

Making Integration and Whole Systems Transformation Happen

6.40 This report and the Integration Plan outline an exciting but very challenging, large and complex programme of change. Whole systems change of the type described is not easy and its accomplishment will require a highly focused and well managed approach with excellent partnership working between the Council and CCG.

6.41 The importance of good and effective partnership working between the Council and CCG is amplified by the extremely tight timescales attached to the BCF. These demand that we *'hit the ground running'* in 2014/15 in order to review existing integrated services and make all necessary arrangements for the launch of an expanded integrated service offer in 2015/16. There is no time to waste and if this is not done Haringey will not receive its full BCF allocation and will fail to deliver on a key government priority (i.e. the integration of health and social care that has all party support).

6.42. Therefore, a programme management approach is suggested to carry through the task of transformation and the Council and CCG will be appointing to a joint post to provide additional programme management capacity. Key areas of activity will be:

a) the establishment of the governance structure;
b) the development and agreement of a comprehensive programme plan;
c) the agreement of a method by which to deliver better information sharing with all technical and information governance issues solved;
d) the review of existing integrated services – see Figure 1;
e) the completion of plans to in place integrated teams – see Figure 2 - and launch of the single point of access;
f) the agreement of a joint commissioning strategy;
g) the update of the current Section 256 and agreement of a Section 75 pooled budget into which the 2015/16 tranche of the BFC must be paid, and;
h) the ongoing engagement with all stakeholders, but especially service users and patients and their carers and NHS and social care providers.

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6.43 In addition to the above priority areas of change health and social care partners in Haringey will commit to working on and developing other areas over the next 2 to 3 years.

6.44 Accompanying the integration of health and social care will be the development and implementation of a comprehensive communications strategy. This will assist the Council and CCG to respond to and manage the considerable media, public and professional interest the integration will generate.

Risks

6.45 It is acknowledged that whilst the BCF represents a tremendous opportunity to integrate and transform health and social care provision for the benefit of local people it also carries risks. These are listed in the risk log, below, together with their treated RAG ratings and mitigating actions. No risks are rated red, which would have the potential to seriously compromise delivery of the Integration Plan. All risks are rate amber and while all require attention none are considered insurmountable.

6.46 The risk log is a living document and will be kept under regular review to ensure that existing, new and emergent risks are actively managed to minimise the impact they might have otherwise have on the realisation of the benefits of integration.

Risk Log

Risk	Risk Rating (Treated)	Mitigating Actions
IF delays occur in launching BCF funded services THEN targets may not be achieved and outcomes realised.	Amber (Medium)	We will create and appoint to a joint (CCG and LA) post to provide the dedicated project management capacity need to plan and coordinate the launch of services.
IF political and organisational will across partner agencies cannot be aligned THEN integration will not take place.	Amber (Low)	We will brief and ensure that the HWB support proposals for integration. Health and social care leadersto champion and provide energetic support for integration. Work on integration to be joined-up across health and social care.
IF funding is not available to fund double running THEN gaps in service provision may appear as	Amber (Medium)	We will ensure that commissioning plans for new integrated services are fully funded and take

the transition is made to new integrated ways of working		into account decommissioning costs.
IF behavioural and cultural changes do not accompany efforts at integration THEN service provision across health and social care will not be seamless.	Amber (Low)	We will bring diverse staff groups together to build a new integrated professional identity reinforced by physical collocation, joint management structures and shared training.
IF we shift resources to fund new integrated services THEN current service providers, particularly in the acute sector may be destabilised	Amber (Medium)	• Our current plans are based on engagement with providers who are, broadly, supportive of the proposals to integrate health and social care in Haringey. • The development of our plans for 2014/15 and 2015/16 will be conducted within a whole system approach allowing for a holistic view of impact across the provider market with an emphasis on jointly defining the ultimate destination of transformation.
IF the BCF runs out before integration is completed THEN we will be unable to complete this task without more resources and disrupting provision to patients and service users.	Amber (Low)	We will impose strict financial monitoring to ensure the best and most efficient use of Haringey's BCF allocation
IF the introduction of the Care Bill results in a significant increase in the cost of care provision from April 2016 onwards that is not currently fully quantifiable THEN the sustainability of current	Amber (High)	• We undertake an initial impact assessment of the effects of the Care Bill and will continue to refine our assumptions around this as we develop begin to deliver integrated services

social care funding and plans will be impacted upon.		• We believe there will be potential benefits that come out of this process, as well as potential risks.
IF we fall to achieve the level of performance against the metrics contained in the BCF Plan THEN part payment of the BCF will be withheld.	Amber (Medium)	We will invest in business analyst capacity to ensure that the performance of all BCF funded schemes are robustly monitored allowing under-performance to be identified and proactively managed.

7. Comments of the Chief Finance Officer and financial implications

7.1 The Better Care Fund was announced by the Chancellor in the Autumn Statement and indicative allocations to Local Authorities were provided in December 2013. However the 2015-16 figures should not be regarded as confirmed as some aspects of the funding distribution formula may change. In addition we know that £1bn of the £3.8bn awarded nationally will be top-sliced and used to provide an element of performance award. Further guidance about the implications of this will be provided by the Department of Health at a later date.

7.2 It is important to be aware that the first half of the money is likely to be awarded on the basis of performance in 2014-15. Although we have no reason to believe that performance in Haringey will not be satisfactory, the targets are likely to be challenging and so there is some risk to the funding. Delivery of milestones and performance against targets will need to be closely monitored in year and action taken to redress any weaknesses in a timely fashion.

7.3 £4.1m of health funding was allocated to Adults in the 2013-4 budget and the expenditure plan was approved by Cabinet in October. It has been assumed in the MTFS that the additional £957k in 2014 will also be allocated to Adults. Plans to spend this money in order to meet the objectives of the funding have been discussed with the CCG and an initial high level allocation is set out above.

7.4 Further work between LBH and the CCG is needed to finalise some of the details for the 2015-6 fund but the high level areas for investment are set out above.

7.5 It is very important to understand that this is not new money but a realignment of existing budgets across the two organisations. Where new services are created or existing services extended (for example in the further use of 7 day working) then this can only be funded through disinvestment elsewhere including the reduction or stopping of existing health and social care services.

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8. Head of Legal Services and legal implications

8.1 This report seeks the Cabinet's agreement to the Integration Plan for the Better Care Fund, in readiness for its submission to NHS England by 14 February 2014.

8.2 In formulating the Plan, certain conditions must be met including the requirement to have regard to the Joint Strategic Needs Assessment for the local population and existing commissioning plans for both health and social care. Further, there are national conditions which must be met as set out at paragraph 6.33 of this report; and both national and local metrics for measuring success which will result in the release of further funding in 2015/16.

8.3 The Plan must be able to demonstrate patient service user, public and service provider engagement and how this consultation has taken place. A summary of the consultation that has been undertaken is provided at paragraph 5.12 of this report. An equalities screening tool has been undertake on the proposals addressed within the Plan which has concluded that there was no requirement for a full equalities impact assessment to be undertaken.

8.4 Funding in 2014/15 will take the form of a 'Section 256 transfer' from Haringey CCG to the Local Authority. Section 256 National Health Service Act 2006 permits NHS England to make payments to local authorities towards expenditure incurred or to be incurred by it in connection with any social services functions. The funding transfer is subject to a written agreement between the Council and the NHS England which is referred to as a Section 256 Agreement. This funding will be added to the existing Section 256 agreement with NHS England that was agreed by Cabinet at its meeting of 15 October 2013.

8.5 NHS England has set out that funding in 2015/16 will be by way of 'Section 75' pooled budgets. Section 75 National Health Service Act 2006 permits NHS bodies and local authorities to establish pooled funds for the provision of health-related functions. This funding transfer will be subject to further written agreement(s) between the Council and the NHS England, referred to as a Section 75 Agreement. These 'Section 75' pooled fund arrangements will require the approval of the Cabinet. These matters will be brought to the Cabinet for decision in advance of the 2015/16 tranche of funding, expected to be in the Spring of 2015. The CCG and the Council are free to extend the scope of their pooled budget funds beyond the allocation from NHS England.

8.6 The use of all funds provided under the Better Care Fund must meet the requirements of the guidance from the Department of Health to NHS England of 19 December 2012 (Gateway Reference: 18568). This includes the condition that the local authority agrees with its local heath partners how the funding is best used within social care and the outcomes expected from this investment, through a jointly agreed Plan. It is indicated that the Health and Wellbeing Board is the natural place for these discussions. This is further supplemented in both the letter from NHS

England and the Local Government Association (LGA) to the NHS and local government in August 2013; as well as in the Better Care Fund Planning Guidance issued by NHS England in December 2013, both of which state that plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

8.7 Both the CCG and the Health and Wellbeing Board have agreed the Plan, on 30th January 2014 and 11th February 2014 respectively, and the Cabinet is now asked to approve the Plan in order that it may be submitted for scrutiny by NHS England.

9. Equalities and Community Cohesion Comments

9.1 The proposed Better Care Fund Plan is designed to provide health and social care services that produce better results and a better experience for all local people. As a result it serves the interests of all protected groups, whose health and wellbeing it promotes, and is aligned with the Council's commitment to equalities. The Equalities Impact Assessments Screening Tool has been completed which indicates that a full Equalities Impact Assessments is not required at this time for the following reasons, as recorded in the in the Tool:

9.2 *"The BCF represents a fantastic opportunity to transform health and social care services for local people. Our aim is to use the fund to improve the results these important services achieve for local people and their experiences of using them. This means that the organising principle of transformation will be the personal perspectives of people.*

9.3 *Our intention is to use the Fund to ensure that health and social care provide a comprehensive seamless service offer with services being much more accessible and available to individuals when they need them. As a corollary of this 7 day week services will be established which place emphasises on prevention, reablement, the maintenance of independence, reducing delayed discharges and admissions to care homes and closer working with GPs. In addition integrated community health and social care and hospital discharge teams will be put in place as a 24/7 single point of access. These measures will lead to significant improvements in the efficiency, economy and effectiveness of services.*

9.4 *The BCF Plan stresses that at all times partners (the LB of Haringey and Haringey CCG) will be relentlessly person focused and seek to provide services which are personalised, offer choice and control and respect personal dignity at all times. It is a commitment that is, particularly, relevant to all protected groups and honouring their right to equality and excellence in service provision. Services currently being provided are not being reduced in any way and are in fact being enhanced and intended to produce positive outcomes for all service users without any detriment to any protected characteristics. On this basis, we do not think a full equality impact assessment is require"*

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10. Head of Procurement Comments

10.1 There are no current procurement issues within to the Integration Plan for the Better Care Fund, in readiness for its submission to NHS England by 14 February 2014.

11. Policy Implication

11.1 Policy on the Better Care Fund is being set out jointly by NHS England and the LGA. It is expected this funding will be used to significantly affect the pattern of local services, shifting resource and demand away from acute services focused on treatment and towards community based services, focused on prevention. The plan has the potential to have a positive impact on integration. While it is not all new money, pulling it together may well ensure better use of current funding.

11.2 This plan for the Better Care Fund is based on the work Haringey's CCG and the Council which have undertaken jointly to develop integrated commissioning and integrated services. The work supports the strategic approach adopted in Haringey's Health and Wellbeing Strategy: ' *A Healthier Haringey: We will reduce health inequalities through working with communities and residents to improve opportunities for adults and children to enjoy a healthy, safe and fulfilling life.*

11.3 The plan should be read together with the following documents:

a) Joint Strategic Needs Assessment

b) Haringey's Health and Well-being Strategy 2012-15 and delivery plans

c) Improving the health and wellbeing of people in Haringey: Clinical Commissioning Group (CCG)prospectus 2013

Key documents
NHS Guidance on Better Care Fund http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

12 Reasons for Decision

12.1 To maximise value for money (efficiency, economy and effectiveness) and deliver the best possible range of integrated health and social care service to local people and local communities in compliance with Haringey's Health and Wellbeing Strategy

13. Use of Appendices

Appendix 1a and 1. BCF Health and Social Care Integration Plan
Appendix 2. *'I'* and *'We'* Statements
Appendix 3. The Relationship Between Proposed Investments and the Delivery of Outcomes

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14. Local Government (Access to Information) Act 1985

14.1 Not applicable