VERSION: FINAL

Haringey

Better Care Fund Plan

Part One

2014-16

Contents

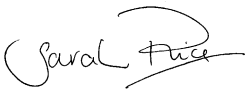
Better Care Fund planning template – Part 1

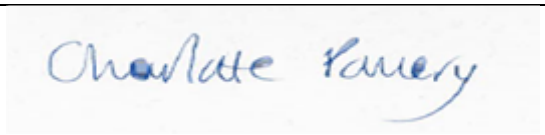
1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Haringey Local Authority**
Clinical Commissioning Groups	**Haringey CCG**
Boundary Differences	**N/A**
Date agreed at Health and Well-Being Board:	**19/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£0**
2015/16	**£16,473,000**
Total agreed value of pooled budget: 2014/15	**£6,925,000**
2015/16	**£22,074,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	 Haringey CCG
By	Sarah Price
Position	Chief Officer
Date	19/09/14

Signed on behalf of the Council	 Haringey Council
By	Charlotte Pomery
Position	Assistant Director of Commissioning
Date	19/09/14

Signed on behalf of the Health and Wellbeing Board	TBC Haringey Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Claire Kober
Date	19/09/14

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
LB Haringey "Joint Strategic Needs Assessment (JSNA)" 2012	Information on the health and wellbeing of people in Haringey. http://www.haringey.gov.uk/index/social_care_and_health/health/jsna.htm
LB Haringey "Joint Health & Wellbeing Strategy (JHWS)" 2012	Plan to improve the health and wellbeing of people in Haringey, based on three outcomes: 1. Every child has the best start in life 2. A reduced gap in life expectancy 3. Improved mental health and wellbeing http://www.haringey.gov.uk/hwbstrategy
LB Haringey "GP Collaborative Profiles." 2013	49 GP Practices in Haringey are organised into four Collaboratives: Northeast; Southeast; West and Central. The Profiles provide information on the demography and health and wellbeing for each collaborative.
NHS North Central London "Primary Care Strategy: Transforming the Primary Care Landscape in North Central London" January 2012	Strategy to improve the quality and capacity of primary care in North Central London. http://www.haringeyccg.nhs.uk/about-us/strategies-and-publications.htm
LB Haringey "Haringey Borough Profile" 2011	Detailed demographic and socio-economic profile of Haringey. http://www.haringey.gov.uk/index/council/how_the_council_works/fact_file/boroughprofile.htm
LB Haringey "Haringey Ward Profiles" 2011	Detailed demographic and socio-economic profile of the 19 Haringey wards. http://www.haringey.gov.uk/index/council/howthe_council_works/fact_file/wardprofiles.htm
London Borough of Haringey "2013/14 Commissioning Plan – Section 256 Social Care Funding." 2013	Plan for the use of health funding for social care services that produce positive health outcomes in Haringey.
Haringey CCG "Commissioning Strategy 2014/15 – 2018/19" 2014	Five year strategy for the commissioning of health services in Haringey.
Haringey CCG "Operating Plan 2014/15 – 2015/16" 2014	Two year plan on how national and local health priorities will be achieved in Haringey.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Haringey Better Care Fund Vision

ENABLING INDEPENDENCE THROUGH INTEGRATION

"By April 2019, 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."
London Borough of Haringey/Haringey Clinical Commissioning Group

Haringey is the fourth most deprived borough in London. The population of Haringey is younger than the national average but, following the national trend, the proportion of over 65s within the population is rising fast. The Haringey Joint Strategic Needs Assessment (JSNA) demonstrates that there is a nine year gap in life expectancy, for both men and women, between the west and the east of the borough. The east of the borough has the lowest life expectancy and contains Tottenham, one of the most deprived areas in the country.

The Haringey Health and Wellbeing Strategy (HWBS) builds on this evidence and identifies three key priorities:

a) Giving every child the best start in life
b) Tackling the life expectancy gap
c) Improving mental health and wellbeing

In line with the priorities of the HWBS, the BCF encompasses actions to tackle health inequalities and the life expectancy gap, through a focus on early interventions in Long Term Conditions, and improve mental health and wellbeing, through a focus on choice, control and empowerment. It is recognised that through the implementation of the BCF over the next few years, opportunities for integrated services for children will be explored further.

Based on evidence from the JSNA, and through consultation with stakeholders, a decision was made to focus the Haringey Better Care Fund (BCF) on frail older people (65+) for the first year of implementation. It is believed that this is the group for whom integration will have the greatest and most immediate impact in Haringey.

In Haringey there are 22,400 adults over the age of 65 years and 2400 over the age of 85 years (Census 2011). An estimated 74% of those over 65 years who are registered with a GP live with one or more long-term conditions (Haringey Health and Wellbeing Strategy).

Patients over 65 years are major users of emergency services and use the majority of hospital beds for unplanned admissions. The Haringey JSNA shows there have been high rates of emergency admissions due to circulatory diseases and this rate has been increasing. Emergency admission rates are significantly higher for men than for women for Coronary Heart Disease (CHD), heart failure and stroke and there is a clear social

gradient for all three conditions especially in deprived populations (JSNA Circulatory Diseases). More than 1 in 20 people in Haringey have diabetes. The standardised rates of emergency hospital admissions due to diabetic ketoacidosis and coma have increased markedly in the last few years and the reasons for this are not clear (JSNA Diabetes).

Older age groups are likely to suffer from poor mental health due to long term and limiting illness. The hospital admission rate for mental health (345 per 100,000 population) in the last three years in Haringey was higher than the London average. The majority of depression related hospital admissions occurred in those over 65 years of age.

Falls are the most common reason for accident and emergency attendance and hospital admission in the elderly. The JSNA shows there is significant upwards trend in older people who fell in the last three years especially in the over 85 years. For all emergency admissions in Haringey of residents aged over 75 years, 6.9% of are related to falls, 15.2% related to respiratory conditions and 19.1% related to cancer.

The use of urgent and emergency care is a clear indicator of the effectiveness of health and social care in supporting people's health and independence. Haringey is committed to implementing evidence based services that will address the over representation of older people in urgent and emergency care. Where possible illness and injury will be prevented and Long Term Conditions and Mental Health will be appropriately managed.

Haringey's BCF is transformational. It calls for the reorientation of health and social care provision away from reactive care, which is provided in acute and institutional settings to proactive care, which is provided in people's homes and community settings. The intention of the BCF is to provide joined up, co-ordinated health and social care services which reduce the need for people to go to hospital. When it is necessary for people to go to hospital they should be treated as quickly and safely as possible so that they can return home and return to independence.

The BCF vision is entirely consistent with the person centred definition of integrated care arising from the National Voices work:

"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."

Our approach to integration focuses on the assets of people marking a decisive move away from the traditional preoccupation with deficits. We will not define people by their disabilities and needs, but by their abilities, by their potential and by what they can do for themselves, with and without support. People will be helped to remain healthy and independent for long as possible and be supported to build lives beyond illness and disability through reablement and recovery. This approach will ensure that health and social care services in Haringey are person centred, provide great outcomes and positive experiences of care.

We know from our engagement work that this means putting in place a new and transformational service model based on integrated multi-disciplinary teams working closely with primary care and specialist services. It also means that we emphasise speed of response, early intervention, enabling independence, self-management and providing services in people's homes.

b) What difference will this make to patient and service user outcomes?

Public and Service User Outcomes

Through a series of eight public, patient, service user and carer engagement events in Haringey (with a total of 200 local people) to understand people's experiences of health and social care, a list of local priorities was developed:

i. **Access**: Haringey people lack knowledge of what health and social care services are available and lack clarity about which access points should be used to obtain services.
ii. **Safety**: This theme is related to the confidence people have in both the health and social care services and staff. Comments included "Services should be monitored and take stock of where we are and where we are going" and "Social workers should really know what they are doing and be sufficiently qualified".
iii. **Person Centred**: One respondent summarised this as "being treated decently and with kindness". Haringey people emphasised that their care and support are intensely personal services and the ways in which they are delivered have a direct impact on both the quality of people's experiences and on their general sense of wellbeing.
iv. **Information**: To exercise choice and control Haringey people need high quality up-to-date information which identifies available services and how to access them. They also stressed the need to protect personal information and for it to only be shared with their consent.
v. **Self-Care:** Haringey people are worried about being a 'burden' on carers and do not want services to take-over and do things for them, thereby, creating avoidable dependency. They want to maximise the amount of time they spend in good health and value services that help them to do things for themselves, supporting their independence.
vi. **Team Work**: Haringey people recognise that health and social care services that work together as one team, including the service user/patient, deliver a better experience and outcomes. Communication is seen as central to this: "I want people to speak to each other – pick-up the old telephone instead of unnecessary paperwork".
vii. **Wellbeing**: Older people in particular value services that promote wellbeing and reduce loneliness as expressed by one respondent "I want to see people, to have companionship, to have someone to talk to."

Haringey BCF will address these patient and services user priorities as follows:

a) **Integrated services will be easy to access**, through a single point of access. Health and social care pathways will be clearer and shorter with fewer 'hand-offs' including the use of a single assessment process and care co-ordination.
b) **Integrated services will be well managed** and provided by competent professionals and staff. Interoperable IT will support the work of staff to better manage patient and service user care.
c) **Integrated services will be person centred** and highly personalised to the experiences and views of the people who use them. Services will uphold peoples' sense of self-worth, focusing on peoples' assets and refusing to define people by their disabilities. Services will offer people as much choice and control as possible, which may include personal budgets.
d) **Integrated services will provide good and timely information**, from a variety of sources including the voluntary and community sector. Consent will be sought before any personal information is shared with other services and professionals.

e) **Integrated services will enable individuals to do things for themselves** through prevention of ill health, self-management of existing long term conditions and reablement towards independence when recovering from a period of poor health. Support will also be offered to carers, friends and families of patients and service users so that they can continue to care.
f) **Integrated services will work together as one team**, including the patient/service user, with clear and constant communication. Staff will come from primary, community, social and acute care services, as well as the voluntary and private sector, and include GPs, community matrons, district nurses, therapists and social workers.
g) **Integrated services will promote wellbeing and reduce loneliness** through the building of community capacity and caring networks in partnership with the third sector. Services will better align responses to physical and mental health needs.

These patient outcomes match recent strategic reports and analysis in Haringey which have identified that there is a need to improve communication and care coordination in the health and social care system as well as develop an integrated approach to providing care across the boundaries of primary and secondary care. Focus needs to be targeted on ensuring efficient systems; removing gaps and duplication with existing service provision and providing care in lower-cost settings with an increasing emphasis on primary and secondary prevention. This will enable patients to receive the right care in the right place, so that they are seen by the most appropriate professional to meet their clinical needs.

Population projections and future needs

Future projections demonstrate that based on current trends, clinical needs are expected to grow. In 2035 the population of over 65s (2010 ONS sub-national population projections) will account for 14.5% of the Haringey population (London 14.2%), increased from 11.4% in 2010. In the next ten years, Haringey will see a rise of 50% for the over 85 population. Given the increasing elderly population in the west of Haringey, there will be an expected increase in long-term conditions and associated higher use of community and hospital services

The number of people with more than one health condition such as Coronary Heart Disease (CHD), diabetes, asthma or dementia is set to rise significantly. The Haringey JSNA shows that prevalence of CHD and hypertension is likely to increase but will remain static for stroke. The prevalence for diabetes is estimated to increase to 9.4% by 2030. Approximately half of this increase is due to the changing age and ethnic group structure of the population and about half is due to the projected increase in obesity.

Accident and emergency attendances resulting from a fall have been predicted to double over the next 25 years. Falls are predicted to increase particularly in the age 65-69 age group and in the over 85 years.

To reduce these increasing pressures on acute services, and in particular urgent care and accident and emergency (A&E) departments, the BCF will focus actions that have the potential to halt or reverse their progression as well as planning to ensure future needs are met. The focus of the Haringey BCF on prevention will seek to the prevalence of preventable conditions. The focus on self-management of long term conditions, mental health and falls, initially with older people (65+), will seek to maintain the independence of a growing cohort of those most at risk. The focus on effective

hospital discharge will seek to meet the predicted increase in future needs.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Health and Social Care Service Changes

Integration will transform the way in which health and social care services are delivered in Haringey by April 2019. Services will respond to changes in the expectations, needs and experiences of the local population. **Figure 1** shows the whole BCF service pathway for Integrated Services for Older People, which has been developed with a range of stakeholders including public, patients/service users, carers, providers (including public and voluntary sector) and partners (including CCG and LBH staff).

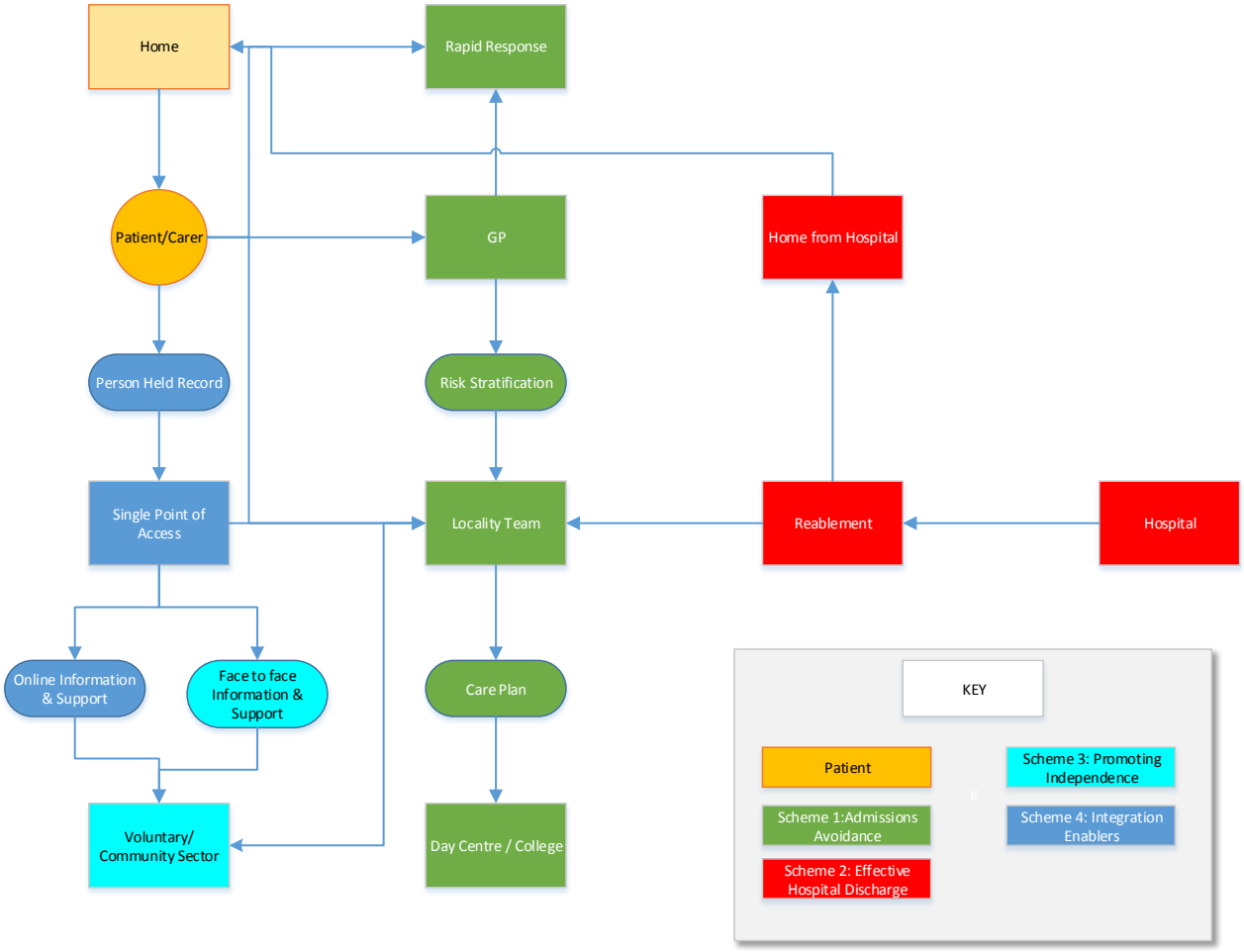


Figure 1: Integrated Services for Older People Pathway Summary

By April 2019, the vision is that there will be a cultural and behavioural shift where people in Haringey will regularly monitor their own health and wellbeing. A person held record which links to a range of data sources will be available for all residents. This will be able to track key indicators for health and wellbeing including physical health, mental health and the broader determinants of health e.g. information on education or benefits. The person held record will be able to flag early warning signs if there are any issues that require attention. The emphasis will be on people maintaining their own health, through using their own abilities, skills and potential and to know where to get support if this is not possible.

The majority of Haringey residents will know where to go for support to enable them to maintain their health and independence. They will be able to access support easily and quickly from a reliable and well maintained web-site 24 hours a day, 7 days a week. The website will provide tools that will assess peoples' needs holistically and then navigate them towards the most appropriate information and advice, which may include links to voluntary and community support services. Most people will be able to navigate this with no further support, but for a small proportion of people who need assistance this will be available via the telephone or face to face in a central hub where staff will have access to a similar set of holistic screening tools and links to a wide variety of services. For the majority of the Haringey population these simple actions will be enough to maintain a healthier and happier life.

For a small proportion of the local population more intense support may be needed to maintain health and independence. As well as providing an early warning to Haringey residents, the person held record (with the appropriate information governance to protect personal and sensitive information) will also provide an early warning to Care Co-ordinators within integrated health and social care Locality Teams. For residents with specific health conditions (e.g. Long Term Conditions (LTCs), Dementia, Mental Health) that make them more at risk of an unplanned admission to hospital, they will have access to a named Care Co-ordinator who will proactively monitor and review the resident's health and wellbeing.

Care co-ordinators will be employed within a variety of providers who can respond to the differing needs of individuals. These providers will be from a range of sectors that support health and social care including traditional NHS and Local Authority services such as Primary Care, Community Health Care, Acute Care, Mental Health, Social Care; and Voluntary, Community, Social Enterprises and Private sector providers. All providers will deliver high quality and safe services as part of a broader integrated pathway.

Care Co-ordinators will be employed by different providers but will work as part of an integrated Locality Team. They will each bring vital specialist medical and social care skills and expertise to help maintain the health and wellbeing of Haringey residents. They will also work generically as part of an integrated team so that they develop and maintain a relationship with their patient/service user, increasing efficiency and reducing duplication. By being within a specialist provider Care Co-ordinators will get the clinical and professional supervision necessary to deliver high quality and effective services. By working in an integrated and multi-disciplinary team Care Co-ordinators will ensure they have quick access to the expertise, skills and support of other professions needed for the care of their patients/service users.

Information from the person held records will also populate a risk stratification tool. This will enable GPs to identify registered patients at risk of an unplanned admission. This will ensure that the right people are assigned to Care Co-ordinators within the Locality Teams. Locality Teams will be based around clusters of GP practices, with every GP knowing the name of the Care Co-ordinators assigned to their patients. Patients/Service Users, GPs and Care Co-ordinators will work together to define and agree goals to improve health and wellbeing, which will be recorded in Care Plans, accessible within person held records.

Information and advice services and Locality Teams will work together to keep the majority of the Haringey population as healthy and independent as possible. Health conditions will be improved or stabilised where possible, maintaining acute services for

when they are needed most. When urgent care is needed, rapid response services will be used, where appropriate, in the first instance to provide care in people's homes. When conditions worsen and necessitate a hospital admission, acute services will be primed to act quickly and efficiently. A patient's discharge will be planned upon admission so that services are ready when needed. Reablement services will be delivered at the earliest opportunity to ensure that patients are returned to independence following a hospital discharge. Reablement services will link to Locality Teams so that patients can be monitored as long as necessary to reduce any risk of a readmission to hospital.

By April 2019 integration will take place at the operational and strategic levels with integrated teams, integrated management, integrated commissioning and integrated governance structures combining to provide local people with high quality, efficient and effective services.

This five year vision for integrated health and social care services in Haringey builds on an existing range of both horizontally integrated (between health and social care providers e.g. reablement services) and vertically integrated services (between different healthcare providers e.g. acute and community healthcare providers at Whittington Health). Existing services include:

- Rapid Response – urgent health and social care support for conditions (e.g. urinary tract infections, respiratory problems) to avoid a hospital admission, or facilitate the early discharge of those admitted.
- Dementia Day Centre – Support for carers of people with dementia e.g. weekend drop-in service
- Mental Health Recovery College – Courses for secondary mental health services users focused on recovery and wellbeing
- Reablement – Personal care and support for people with poor physical and mental health to restore independent functioning
- Step Down Care – Non-acute facility to support the timely discharge from acute hospital
- Home from Hospital Pilot – Short term volunteer led befriending and home visiting service for people aged over 50 who are discharged from hospital
- Neighbourhood Connects – Community development approach to support residents to make positive choices regarding health and well-being and reduce isolation
- Integrated Palliative Care – Five day a week, nurse led service for end of life patients and families, offering both health and social care input.

Monitoring and evaluation of these services provides a local evidence base for effective integration e.g. the Haringey joint reablement service has demonstrated that from March 2013-14 the majority of service users (64%) who complete a short period of intensive reablement support by trained reablement workers and therapy staff are returned to independence (Chart 1).

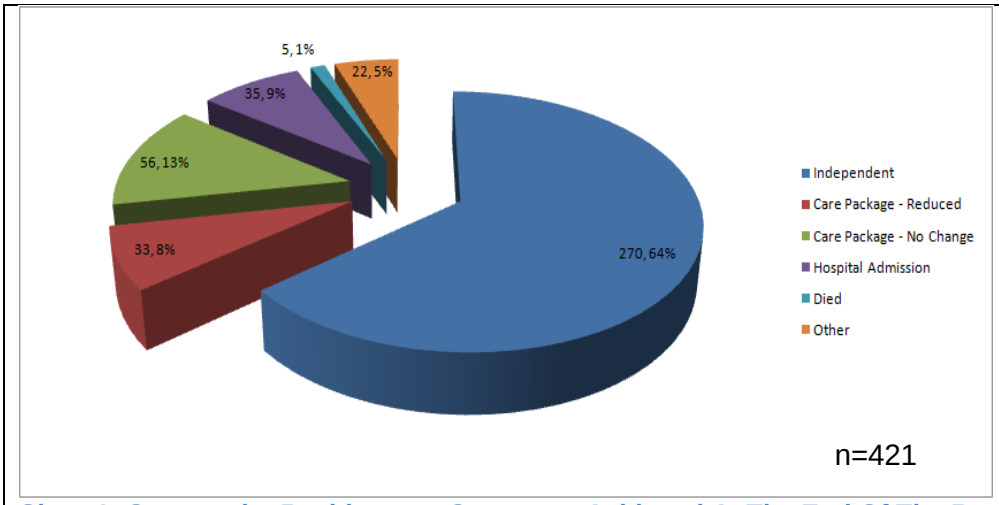


Chart 1: Community Reablement: Outcomes Achieved At The End Of The Reablement Period March 2013 – Feb 2014 (Source, LBH)

The Haringey BCF will review and evaluate all current integrated services to identify good practice and align them with the national evidence base. Services that are shown to be performing well and within current best practice will be expanded (from five days a week to seven days a week) and linked into the proposed BCF Pathway in Figure 1 to facilitate access through a single point of access. Services that do not meet expected performance measures and/or do not match current best practice will be co-designed and re-developed to ensure that they do, before being linked into the pathway.

As well as existing services, the Haringey BCF is proposing a new integrated service 'Locality Teams'. This service is in the process of being co-designed between health and social care agencies, with input from a broad range of stakeholders (including the public). This service will also be based on the national evidence base.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In this section we show through analysis of data how care can be improved by integration, starting first with the data for recent performance in Haringey. In 2011/12 the rate of emergency hospital admissions for all conditions in Haringey was 7,855.82 per 100,000 people (all ages). Table 1 below shows that Haringey was ranked 2nd best out of 10 similar London boroughs for emergency hospital admission rates for all conditions in 2011/12. Of comparable boroughs, Wandsworth performs best, and to match Wandsworth's rate of emergency hospital admissions in 2011/12 Haringey would have required a 3.8% improvement in its emergency hospital admission rates.

Geographical area	Indirectly standardised rate of emergency hospital admissions per 100,000 people per year (2011/12)	Rank
Wandsworth LB	7554.11	1
Haringey LB	**7855.82**	**2**
Greenwich LB	8027.99	3
Islington LB	8708.93	4
Lambeth LB	8973.03	5
Croydon LB	9299.78	6
Southwark LB	9571.50	7
Hammersmith and Fulham LB	9744.62	8
Lewisham LB	9753.01	9
Waltham Forest LB	10257.51	10
ENGLAND	8987.99	Haringey is significantly better that England average
London SHA	7955.43	Haringey is statistically not different from London

Table 1: Rate of emergency hospital admissions for all conditions per 100,000 people in Haringey and comparable boroughs (Source NHS information centre data taken from HES)

Chart 2 below shows the trend in emergency hospital admission rates in Haringey and 9 comparable London boroughs from 2007/08 to 2011/12. Between 2007/08 and 2011/12 the rate of emergency hospital admissions (all conditions and all ages) in Haringey has fluctuated, but has shown a general downward trend, with an average annual fall of 1.8%.

The measure used in this analysis is an overall measure of emergency hospital admission rates for all age groups and all conditions, however there are limitations in this analysis:

- It does not enable a comparison of admission rates in different age groups, or amongst people with different diseases.
- When comparing rates in different geographical areas it does not take into account

the different disease profiles of the areas.

- The most recent data available for comparison is 2011/12 and therefore does not provide a picture of current performance.

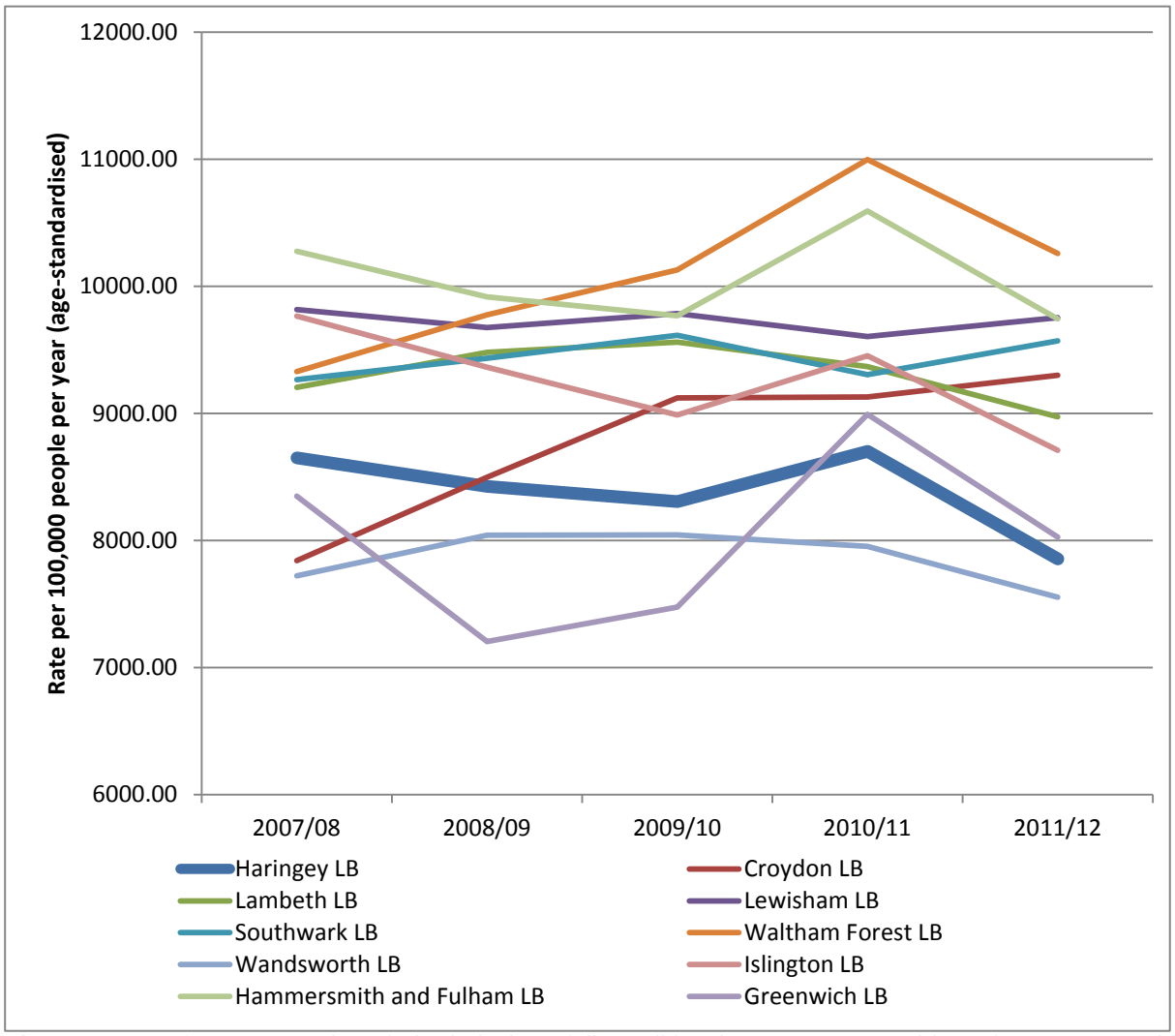


Chart 2: Rate of emergency hospital admissions (all conditions) per 100,000 residents in 10 comparable London boroughs. (Source: Analysis from NHS Information Centre data – taken from HES.)

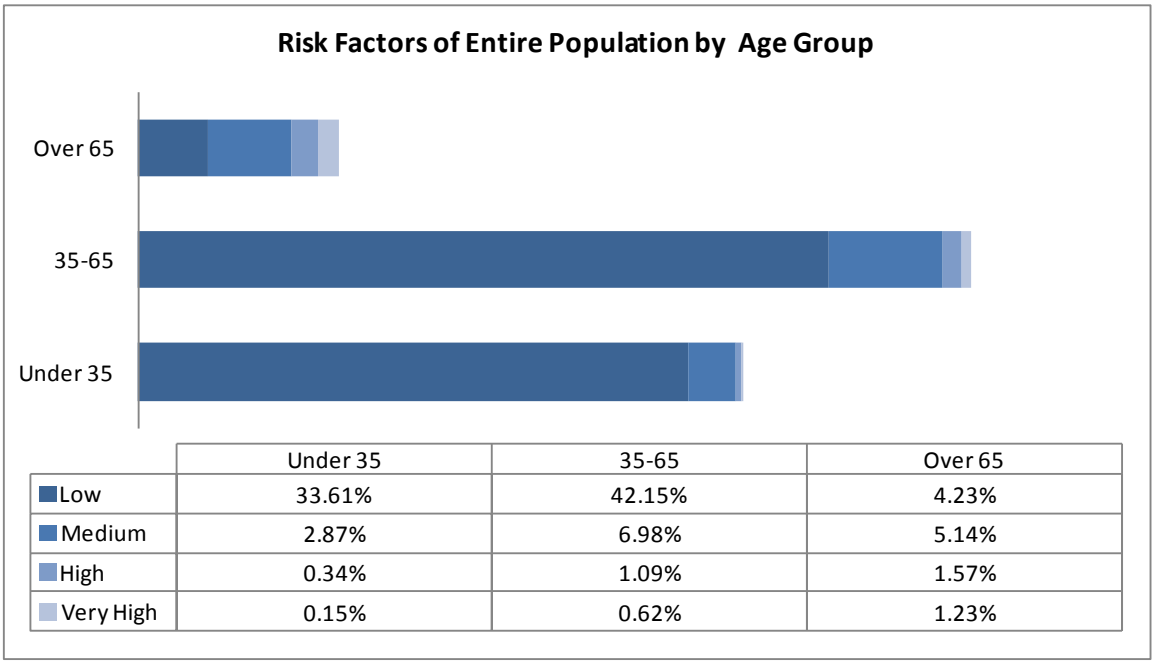
Due to these limitations more recent data from other sources is being used to develop a case for change in Haringey. Haringey CCG commissions the Health Intelligence risk stratification tool which predicts the likelihood of a person having a non-elective hospital admission within the next 12 months based on a number of variables including age, number of Long Term Conditions (LTCs) and number of non-elective admissions in the last 12 months.

Data from the tool was used to risk stratify the whole of the Haringey GP registered population. The age and gender profile of the GP registered and the Haringey resident population (taken from the census) are broadly in line. The largest age band is 25-49 and 13% of the population are over 65. There are 30,162 fewer people in the GP registered population compared to the resident population.

The risk stratification tool has four categories of risk, with the percentage of the GP registered population that are within the category: 2% are very high risk; 3% are high risk; 15% are medium risk; and 80% are low risk. In Haringey (report run on 12th August

2014) 6,745 people are high risk and 4,496 are very high risk, totalling 11,241 people.

Breaking down the risk categories by three broad age groups provides the following analysis (**Chart 3**):



	Under 35	35-65	Over 65
Low	33.61%	42.15%	4.23%
Medium	2.87%	6.98%	5.14%
High	0.34%	1.09%	1.57%
Very High	0.15%	0.62%	1.23%

Chart 3: Risk Factors of Entire Population by Age Group

The chart shows that the over 65s have a higher probability of being in the high and very high risk categories. Further analysis shows that over 65s make up 56% of the High/Very High Risk categories, whilst making up just 13% of the population. In addition of all the over 65s, 23% are in the High/Very High Risk categories. Over 65s are also over represented in terms of acute service usage (specified as outpatients, A&E and emergency admissions) accounting for 26% of activity.

The ethnic profile of those in the High/Very High Risk Category is broadly in line with the profile of the overall GP population, meaning that no group is under or over represented amongst the High/Very High Risk group. However it should be noted that Haringey has a very high ethnic mix with 86% of people coming from an ethnic background other than White British, which includes the two largest categories Mixed Ethnicity (18%) and Black African Caribbean (17%).

Table 2 shows the prevalence of health conditions amongst the Haringey GP registered population. As a proportion of the total GP registered population depression of the most prevelant condition, followed by (in order) diabetes, Chronic Kidney Disease (CKD), Chronic Obstructive Pulmonary Disease (COPD) and finally dementia. Taking these health conditions in total, 44% are attributable to depression.

Condition	Total number	Proportion of GP population	Proportion of Health Conditions
CKD	**4,126**	1.84%	11.32%
COPD	**2,086**	0.93%	5.72%
Dementia	**728**	0.32%	2.00%
Depression	**16,196**	7.21%	44.43%
Diabetes	**13,314**	5.92%	36.53%

Table 2: Prevalence of health conditions amongst the Haringey registered population

Taking these health conditions in total **Chart 4** again shows that the over 65s are over represented with these conditions.

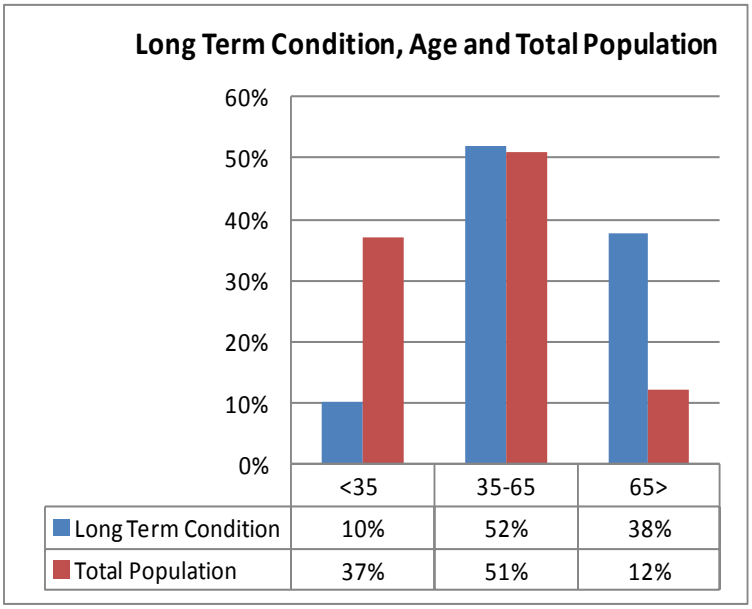


Chart 4: Distribution of Health Conditions by age band.

The risk stratification tool makes a coherent case for targeting the BCF on the over 65 age group in the first instance and for ensuring that mental health is given equal parity of esteem in the development of all schemes.

The focus of the BCF on integration connects with priorities that have a significant impact on the quality and outcomes of patient centred care. Working in a joined up way will improve the patient experience, achieve better outcomes and enable more efficient use of resources across partners. Priorities have been identified through patient and GP feedback of areas of concern, national focus (e.g. pressure ulcer reduction), analysis of reasons for emergency admissions (6 month review of care homes admissions) as well as a review of ensuring awareness of quality issues in Haringey CCG. The following priorities have a particular link to integrated working:

- **Discharge processes.** Ensuring that discharge processes from acute services are as joined up and proactive as possible to facilitate appropriate discharge at the earliest point. This should enable people to return home to independence with appropriate support, ready to be increased or decreased as required.
- **Ensuring robust quality assurance processes for all providers.** These are already robust in most areas but commissioners are also working to ensure that every organisation, including small community organisations, have clear processes for identifying areas for potential improvement and that this is monitored by Haringey CCG. Having a consistent framework for quality assurance across providers will contribute to increased integration and equivalent standards across sectors.
- **Insight and Learning Programme - Listening to feedback of patients, service users, carers and the community.** Ensuring that commissioners listen to, triangulate and investigate further and then learn from insights from patients, service users, carers and the community to drive quality improvements and further integration.
- **Care homes work.** Working with Haringey residential and nursing homes that care for those who are frail and elderly to drive quality improvement and avoid admissions to hospital. Ensuring that care homes operate as part of an integrated system of care for individual patients will maximise their benefit and reduce the risk of hospital

admissions. A number of focus areas have been identified including pressure ulcer management, falls prevention, End of Life Care work and Do Not Resuscitate (DNR) forms, emergency admission reviews and reviews of those cases where residents are frequently attending the hospital or who are living with long term conditions.

- **Pressure ulcer prevention.** Commissioners have initiated joint working across acute, community and care home providers to provide an integrated approach to reducing the prevalence and severity of pressure ulcers, which originate in the community (in peoples' homes or care homes). Colleagues in primary and adult social care will also support this work. Initial data is indicating that the prevalence and severity of pressure ulcers are reducing but further work is needed to target those at most risk including patients who are only known to Primary Care or who are only supported by a carer.

The target reduction of 3.5% of non-elective admissions in 2015/16 would result in 705 fewer admissions. The information detailed within the 'Case for Change' indicates that the majority of this activity will be within the older adult population (65+), targeting people with one or more Health Condition (either mental health and/or Long Term Conditions). Using this analysis, and the evidence base for integration, partners have developed responses based on increasingly joined up care around residents. In order to meet the reduction in admissions, Haringey has based its response on the national evidence base regarding Care Co-ordination; Reablement and Self-Care. Further information on the evidence base is detailed under each of the Scheme Descriptions in Annex 1, with a summary presented here. To meet the reduction in non-elective admissions, the following activity has been modelled, based on this evidence:

- A review of evidence presented in NHS England's BCF technical toolkit reported that a care co-ordination approach could result in a long-term reduction in hospital admissions of 37%. The risk stratification identifies 4500 people as at very high risk of a hospital admission in Haringey. This group accounts for over 5000 acute hospital admissions per year in Haringey. If the care-coordination approach achieves this level of success in Haringey's high risk population, 1665 admissions per year could be prevented in the long-term. Assuming that this effect will be seen in a step-wise progression over 4 years, 460 admissions will be prevented in 2015/16.
- A recent randomised control trial of reablement services which include personal care and support for people with poor physical and mental health to restore independent functioning (Lewin et al, 2014) showed that for every 100 clients, reablement results in 7 less hospital admissions per year compared to usual social care. In Haringey reablement will be expanded to provide to an additional 200 clients in 2015/16 resulting in 14 prevented admissions.
- Clients referred to palliative care services are 30% less likely to require non elective admission in the last 30 days of life (Purdy S, Lasseter G, Griffin T, et al. BMJ Supportive & Palliative Care, Published Online First: doi:10.1136/bmjspcare-2013-000645). In Haringey palliative care services will move from a five day to a seven day service and provided to an extra 200 clients in 2015/16 resulting in 60 prevented admissions.
- Evidence around the effectiveness of falls prevention programmes and self-care (e.g Gillespie et al. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2012) demonstrate a 25% reduction in non-elective admissions. The risk stratification identifies 6,700 people as at high risk of a hospital admission in Haringey. In Haringey the Neighbourhood Connects service will target 2000 people in this cohort by 2019, starting with 1000

people in 2015/16, with self-care including falls prevention and lifestyle and behavioural change. Haringey expect to achieve a reduction of 175 non-elective admissions from this service in 2015/16

The total reductions expected from these key services will be 709 non-elective admissions with improved care through a more integrated approach. Other services will also be developed and strengthened to support the integration agenda and their performance will also be monitored for potential impact on non-elective admissions. These include the development of a Winter Hub, a multi-professional, multi-disciplinary team from health and social care providing intensive, well-coordinated care to expedite reablement and rehabilitation, with earlier discharge to home or the community with the right support over the intensive winter months. The Winter Hub will be overseen by the Systems Resilience Group who will also oversee the Effective Hospital Discharge Scheme and so align learning from implementation of the different services.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Key Milestones

An overview of the overall estimated timeline to be followed by Haringey is provided below.

August 2013 - March 2014 (Achieved)

- BCF programme management approach and governance structure established
- BCF stakeholders including: service users, patients, carers and public; providers; and partners engaged.
- Budget for BCF agreed
- Initial BCF Plan developed and submitted to NHS England/LGA

April 2014 – September 2014 (Achieved)

- Existing Section 256 schemes evaluated and monitored in line with BCF developments
- BCF implementation plan developed, with key work-streams
- Stakeholders engaged in the co-production of integrated services
- GP practices supported to deliver the Unplanned Admissions Enhanced Service
- Revised BCF Plans developed and submitted to NHS England/LGA

October 2014 - March 2015

- Review implementation of support for the Unplanned Admissions Enhanced Service
- Pilot Integrated Locality Teams with selected GP practices
- Develop business cases and service specifications for: Locality Teams; Mental Health Services; Reablement; Home for Hospital; Neighbourhood Connects; Integrated Palliative Care Team; and Interoperable IT.
- Develop and deliver a workforce education and training programme based on local listening events

April 2015 – September 2015

- Commission: Locality Teams; Mental Health Services; Reablement; Home for Hospital; Neighbourhood Connects; Integrated Palliative Care Team; and Interoperable IT.

October 2015 – March 2016

- Monitor implementation of BCF Schemes
- Evaluate services to inform next stage of integration
- Scope services that would further contribute to the reduction in emergency admissions and would be amenable to integration

b) Please articulate the overarching governance arrangements for integrated care locally

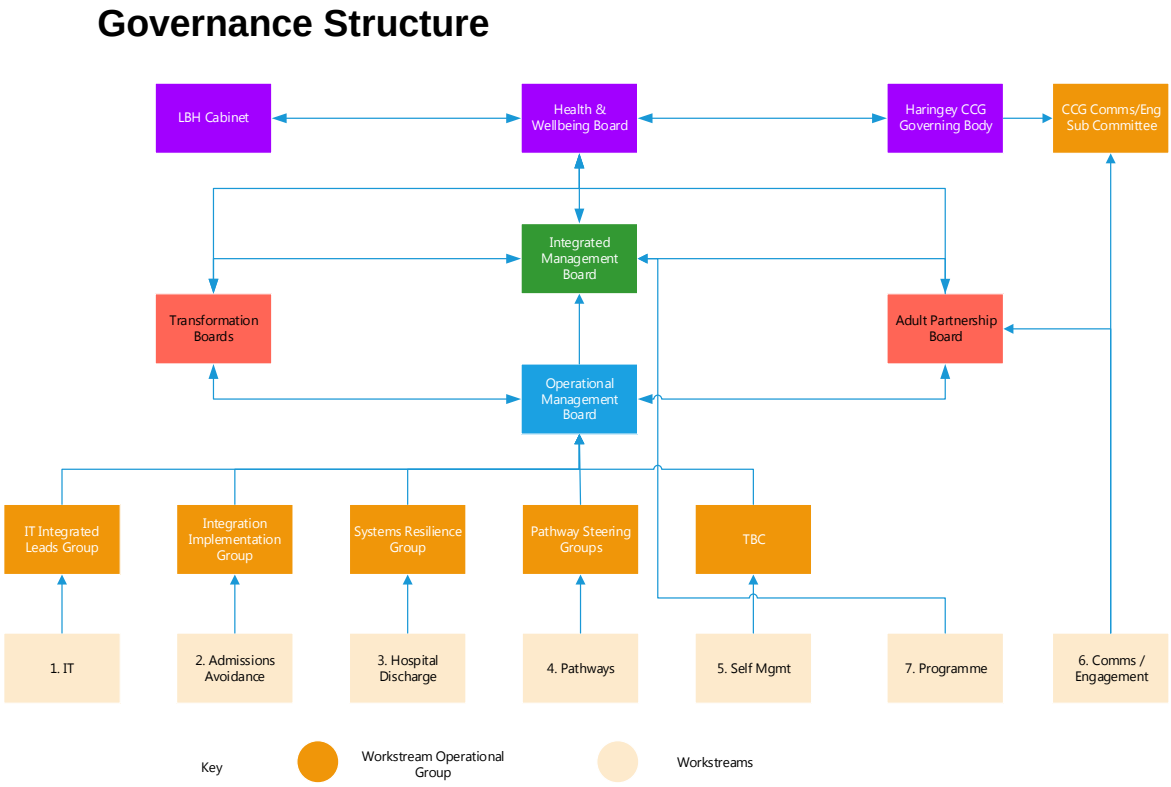


Figure 2: Governance Structure for the Haringey Better Care Fund

Figure 2 describes the governance structure in place to maintain oversight of the BCF and integrated care in Haringey. Haringey has worked hard to integrate governance and develop a shared vision for integration with shared ownership of the target to reduce the number of emergency admissions. The key features of the governance structure are:

Executive oversight and policy direction: This function is the responsibility of the Health and Wellbeing Board, the Governing Body of Haringey Clinical Commissioning Group and the Local Authority Cabinet as the senior executive bodies of the partners responsible for the integration of health and social care. Ultimate responsibility for the delivery of this Integration Plan rests with the Health and Wellbeing Board which has, in line with guidance, been engaged with the BCF. The Chair of the Health and Wellbeing Board will receive briefings with senior managers and the Director of Public Health will assist the Health and Wellbeing Board to discharge its governance responsibilities.

Strategic oversight: The Integrated Management Board is the senior health and social care commissioning group responsible for maintaining strategic oversight of integration. It will plan spend, set priorities, monitor the delivery of key outcomes, make recommendations to the executive level bodies (the Health and Wellbeing Board, the Cabinet and the CCG's Governing Body) and take ownership of the risk log. It is also the forum to which any serious operational problems can be escalated for solution. The Integrated Management Board will meet on a monthly basis, receive regular monitoring reports and be co-chaired by the Chief Officer of Haringey CCG and Haringey Council's Director of Adult Social Care.

Operational oversight and change management: The Operational Management Board will be responsible for implementing the BCF programme and supporting service transformation. It will work with providers to identify and trouble shoot problems, ensure consistency of practice, promote learning and progress service plans.

Opinions, guidance and advice: It is important that the governance of our BCF is informed by, and benefits from, the wisdom and experience of associated groups. The following two groups will be used to engage and consult on plans and issues that result from integration:

a) Adult Partnership Board: The membership of the Adult Partnership Board is made up from service user, patient and public representatives and organisations including Haringey Healthwatch.
b) Transformation Boards: The Transformation Boards are health provider and commissioner leadership groups centred on the Whittington and North Middlesex Hospitals.

Work-streams: Seven work-streams have been established to help implement the BCF. Each of these work-streams will be aligned to existing working groups, where possible. Each working group will be responsible for supporting the implementation of their specific element of the BCF. Each working group will link to the overarching Operational Management Board.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Management and Oversight

The governance structure described above oversees the strategic and operational management of the BCF Plan, with the focus of day to day management lying with the Integration Management Board. A joint commissioning post between Haringey Council and Haringey CCG (titled Commissioning Lead: Better Care Fund) has been appointed to take responsibility for the programme management of the BCF. The Commissioning Lead is matrix managed across the two organisations, embedding integration within commissioning structures. The Commissioning Lead closely links with commissioners in both organisations.

To implement the BCF the Commissioning Lead has key responsibilities for producing reports that highlight progress and that monitor performance. Another joint post (titled Data Analyst: Better Care Fund) has been appointed to oversee the monitoring and evaluation of all BCF schemes. A task and finish group working across Public Health;

and Commissioning and Finance in both Haringey CCG and Haringey Council was established to look in more detail at the evaluation of all integrated services and schemes and to develop a performance dashboard for the BCF outcomes. All service teams will be responsible for collecting their own monitoring data, which the Data Analyst will collate and report to both the Operational Management Board and the Integration Management Board. The data will be used to both inform commissioning decision making and support the proactive management of integration.

d) **List of planned BCF schemes**

List of Schemes

Please list below the individual projects or changes that you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	**Admissions Avoidance:** The Admissions Avoidance Scheme identifies people most at risk of an emergency hospital admission and via a Care Co-ordinator within a Locality Team develops a care plan setting out the integrated support needed, either from self-care or from safe and effective services, to keep them well and independent and prevent an admission.
2	**Effective Hospital Discharge:** The Effective Hospital Discharge Scheme delivers three key services: step down care via a non-acute facility to enable people to convalesce prior to returning home; a volunteer led befriending and home visiting service for people aged over 50 prior to hospital discharge; and a Multi-Disciplinary Team reablement package to patients, for up to 6 weeks, following a hospital discharge. The reablement package includes personal care and support that encourages and equips service users to carry out activities themselves in order to restore independence.
3	**Promoting Independence:** The Promoting Independence Scheme delivers a range of community development interventions to prevent ill-health arising, to support self-management of health conditions and to reduce social isolation. The focus of this scheme is to build community capacity to respond positively to episodes of need. The Scheme also encompasses an integrated service to support palliative care.
4	**Integration Enablers:** The Integration Enablers Scheme includes a number of different and critically important strands that enable the delivery of the other BCF schemes including: Interoperable IT; Single Point of Access; Seven Day Working in Services; Workforce development and implementation of Care Act responsibilities.

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise? [1]	Potential impact [2]	Overall risk factor [3]	Mitigating Actions
1. Unplanned admissions to acute and institutional settings will not be reduced	3	5 £1.2M savings not met Key business objectives not met No funding for investments	**15**	• Develop detailed financial modelling (including saving, investments and contingency plans) and a performance dashboard to track progress on outcomes and funding by September 2014. • Develop an evaluation framework to determine appropriate measures and outcomes for BCF services, based on national and local best practice, by December 2014. • Engage acute trusts in understanding the integration case for change and the need to change behaviour by September 2014.
2. Milestones are missed due to the complexity and scale of	3	4 Not meet statutory requirements and targets	**12**	• Health and Social Care Integration Management Board established September 2013. • Joint LBH/HCCG Commissioning Lead: BCF appointed to provide programme management appointed April

[1] *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*

[2] *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact and if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*

[3] *Likelihood *Potential impact*

There is a risk that:	How likely is the risk to materialise? [1]	Potential impact [2]	Overall risk factor [3]	Mitigating Actions
change				2014. • BCF Implementation Plan developed with full engagement of HWBB, LBH Cabinet and HCCG Governing Body.
3. There is limited service capacity to deliver the scale of change needed	3	4 £1.2M savings not met Key business objectives not met No funding for investments	**12**	• Develop detailed capacity and service planning with local providers linked to BCF outcomes by November 2014 • Develop business case for investment required to deliver savings by December 2014
4. Services will be implemented when incomplete in development	3	4 Providers destabilised Patient/service user safety compromised due to service changes Complaints due to service changes Disinvestment in service before new services up to capacity	**12**	• Develop business cases, with appropriate commissioning and contracting models, for planned services before they are implemented by April 2015. • Develop an evaluation framework to determine appropriate measures and outcomes for BCF services, based on national and local best practice, by December 2014. • Implement an integrated workforce training and education plan across all providers as part of the LETB bid by April 2015.
5. IT systems will not be effectively interoperable	3	4 Information security compromised across agencies	**12**	• Engage Information Governance, IT leads and Service Leads in the development of all IT solutions by September 2014.
6. Funding is reduced by	3	4 Reduced health and	**12**	• Develop detailed financial modelling (including saving, investments and contingency plans) and a performance

There is a risk that:	How likely is the risk to materialise? [1]	Potential impact [2]	Overall risk factor [3]	Mitigating Actions
financial challenges within the CCG and LA		social care investment in integration £1.2M savings not met Key business objectives not met		dashboard to track progress on outcomes and funding by September 2014. • Section 75 agreement to be developed by December 2014.
7. Stakeholders, including public and staff, are not engaged effectively	2	5 Adverse publicity Block of service changes Staff disengage from process	**10**	• Develop a Communication and Engagement Strategy to develop plans, co-design services and to influence behaviour change by September 2014. • Implement an integrated workforce training and education plan across all providers as part of the LETB bid by April 2015.
8. The Care Act is not aligned to the BCF	3	3 Reduced social care resources for integration	**9**	• Ensure Care Act priorities are reflected in the BCF refresh by September 2014. • Section 75 agreement to be developed by December 2014.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The following funding sources have been identified across LBH and Haringey CCG (**Table 3**):

Organisation	Funding Stream	14/15	15/16
LBH	Base Budget	£0	£ 5,601,200
LBH	Section 256	£ 5,041,067	£0
CCG	Section 256	£0	£ 5,261,067
CCG	Transformation	£ 513,000	£ 1,540,504
CCG	Readmissions	£0	£1,000,000
CCG	Over 75s Case Management	£ 1,371,430	£ 1,371,430
CCG	Community Healthcare	£0	£ 7,300,000
	TOTAL	£ 6,925,497	£ 22,074,201

Table 3: Funding Sources for Haringey BCF, 2014-16

The Transformation Fund is a non-recurrent fund created by Haringey CCG following national guidance to reduce hospital activity.

The minimum contribution for the BCF in 2015/16 is £16,473,000. LBH have agreed to voluntarily include £5,601,200 from their base budget as it aligns to BCF principles, bringing the total BCF budget higher than the minimum contribution.

A Section 75 agreement will be developed following the resubmission of the BCF so that the key principles and processes for any budget changes and decisions are clearly outlined. This ensures that both partners are fully involved in and sighted on any decisions that affect integrated services.

The target reduction of non-elective admissions is 3.5%, which translates to a reduction of 705 admissions and will generate savings of £1,247,850. Negotiations are being held with the two main acute providers to reduce activity.

Haringey is working with the principle that social care funding will be protected. There is currently little flex in budgets to meet a rising demand in acute care.

To manage the risk of failing to reduce non-elective admissions it has been agreed that £1,247,850 will be held in reserve from Haringey CCG Transformation Funding and Readmission Funding. The Integration Management Board will agree how this money is used following progress reports on the BCF outcomes.

Table 4 shows the activity expected per service in each scheme. 2015/16 will be the first year of implementation of these schemes, which are closely aligned with the longer-term vision of both the CCG and the council.

SCHEME	SERVICE	Baseline	Activity				
		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
ADMISSIONS AVOIDANCE	Locality Team	0	0	1150	2300	3450	4500
	Rapid Response	352	352	352	352	352	352
	Dementia Day Centre	460	460	460	460	460	460
	MH Recovery College	900	900	900	900	900	900
EFFECTIVE DISCHARGE	Reablement	633	600	600	600	600	600
	Step Down	68	60	60	60	60	60
	Home from Hospital	280	280	280	280	280	280
PROMOTING INDEPENDENCE	Neighbourhood Connects	500 (1 Quarter)	500	1000	1500	2000	2500
	Palliative Care	400	400	400	400	400	400
INTEGRATION ENABLERS	Safeguarding	625	625	625	625	625	625
	Carers	820	800	800	800	800	800

Table 4: Activity Expected per BCF service over first three years of implementation.

As integrated services become more established they will be able to meet the needs of local people more efficiently and effectively. This allows them to better identify and respond to currently unmet need and to increase activity and savings. Specific performance indicators will be developed and closely monitored.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Care and Support Initiatives

There are currently two main care initiatives in Haringey related to care and support that link to the integration of health and social care.

Haringey Council Corporate Customer Services Transformation Programme

Haringey Council's Corporate Customer Services are undergoing transformational change. Customer Services is the main point of contact for all social care queries for Haringey residents and stakeholders.

The Council's vision for customer services is to be a trusted organisation where customers have confidence that their current and future needs will be met in an efficient and effective way. There is a focus on more digital solutions for customer service, encouraging self-service. Bringing together different council services with more activity at the start of the customer service process will enable more customer transactions to be completed more efficiently. Separating less complex from more complex customer facing transactions will deliver the most appropriate and effective response to customers.

There are important interdependencies between the Customer Services Transformation Programme and the Integration of Health and Social Care as well as with the Care Act Implementation Programmes. Specifically these are around the establishment of a Single Point of Access for Health and Social Care as well as the duties in the Care Act for Local Authorities to provide advice and information. A corporate approach is being taken reflecting a commitment to one-Council working and has resulted in improved data analysis. Customer Services daily and monthly reports now include Adult Social Care Activity supporting improved planning for developing the Health and Social Care Single Point of Access. It has also been agreed that Customer Services will link to NHS Choices for information on local health services.

A customer pathway is in a high level draft form which starts to describe the journey that customers travel through from Customer Services into integrated Health and Social Care services. The pathway, when finalised, will inform both interoperable IT system developments and customer service specifications, ensuring systems can link well together.

Restructure of Learning Disability Community Team

Haringey Community Learning Disabilities Team is an integrated team bringing together health and social care staff, under a Section 75 agreement, from: Whittington Health; Haringey Council; and Barnet, Enfield and Haringey Mental Health Trust. The Team is managed by a joint appointed Head of Service and Service Manager.

Over the past 18 months changes to pathways, processes and structures throughout the customer journey have taken place in the team to ensure integration between the disciplines. Some of the initiatives have included:

- Developing Multi-Disciplinary Team (MDT) pathways for entry and eligibility into the service, with robust MDT discussion on all referrals and joint health and social care initial assessments. This has reduced the time that people referred into the service wait for assessment and has also meant that the team have been able to assess those transitioning from childhood to adulthood earlier.
- The establishment of cross discipline service user allocation via weekly MDT waiting list meetings rather than the previous system of separate waiting lists and internal referral for each discipline.
- The early identification of a "lead worker" who acts as a single point of contact for the service user and/or carer and ensures care is co-ordinated.
- Integrated MDT processes for complex care situations such as Child Protection, Winterbourne Reviews and Continuing Health Care assessments.
- Working with IT locally to ensure the social care database used by all staff supports the needs of the health partners in terms of clinical work and performance monitoring. This has resulted in health care staff being far more engaged with the social care IT system with a significant improvement in recording information which supports care planning and service developments.

Learning from the integrated Learning Disability Community Team is being used to inform the integration of wider adult services, particularly around joint assessment, MDT pathways, care co-ordination and interoperable IT.

The dependencies of the customer service transformation programme and the BCF will be tracked via the IT Integrated Leads Group which will oversee the development of interoperable IT and the link to the single point of access. The Learning Disability Community Team will link into the development of the Locality Teams and will be tracked via the Integrated Implementation Group.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Strategic and Operating Plans

For successful delivery the BCF needs to be strategically aligned both to Haringey Council's strategic programme and to Haringey CCG's 5 year strategic plan and operating plan.

London Borough of Haringey's Corporate Plan 2013-15 'One Borough, One Future' sets out the council's strategic direction. One of the key principles of the plan is working in partnership so more can be achieved by working together. This principle clearly links to integration and underpins the council's priorities. The Corporate Plan sets four key outcomes, two of which clearly link to the BCF:

- Safety and Wellbeing for all. A place where everyone feels safe and has a good quality of life. This has a focus of reducing health inequalities and improving well-being, which is also a focus for the BCF.
- A Better Council. Delivering responsive, high quality services and encouraging residents who are able to help themselves to do so. This has a focus of customer services and value for money. The BCF is looking to develop a single point of access which will become integrated with the customer service transformation. The BCF will also seek to deliver services in the most cost effective and sustainable way.

The BCF fits within the 5 year vision for Haringey CCG (Strategic Plan, 2014-19) to 'enable the people of Haringey to live long and healthy lives with access to safe, well-co-ordinated and high quality services'. Specifically, this will be achieved by:

- Strengthening and extending partnership working across the whole Haringey community.
- Implementing a model which works for everyone including those who would prefer to self-care and/or want more independence and choice.
- Developing a joined up model which offers a range of prevention, early intervention and support (not just health) delivered by a variety of providers, including the community and voluntary sector) working together in different ways to support people and families more effectively.
- Engaging communities in new and more innovative ways to build capacity for populations to enhance their own health and wellbeing through enhancing existing strengths and resources.
- Developing the role of GP practices in prevention and community interventions e.g. delivery of prevention services and navigation to other Local Authority services.

Haringey CCG has undertaken extensive local consultation on our 5 year plan. The emphasis on working closely with a broad spectrum of local authority services, not only social care and public health, was acknowledged and welcomed by the local authority. Prevention is a strong theme in Haringey CCG's vision and plans delivered through closer integration of primary, community and mental health services. This approach will in time reduce the reliance of our local population on hospital based services and firmly aligns to the BCF.

Haringey BCF plan is also strongly aligned with those of the 5 North Central London (NCL) CCGs of Barnet, Enfield, Haringey, Camden and Islington which make up the NCL Strategic Planning Group (SPG). The SPG is finalising the NCL SPG 5 year plan which is underpinned by the BCF plans.

Haringey CCG has been successful in securing over £190k Health Education North Central and East London (HENCEL) funding to support the delivery of better integrated patient care including a specific focus on the End of Life Care pathway and supported self-management. Working with: the HENCEL; Tavistock & Portman Trust; Barnet Enfield and Haringey Mental Health Trust; Barnet CCG; and Enfield CCG, Haringey is leading work to improve integration in perinatal mental health services and outcomes.

The Haringey CCG Operating Plan and BCF previously both referenced the metric of reducing avoidable hospital admissions and despite the targets being derived from different population denominators the percentage reduction was similar. Included in the operating plan was the aim to achieve an ambitious 5% reduction in avoidable hospital admissions for 2014/15. This has since been reviewed and the target has remained unchanged. However, the alignment with the BCF target has widened due to a change in criteria used for the BCF. The BCF target now includes reducing admissions by 3.5% across all non-elective general and acute admissions whereas the operating plan continues to include a reduction in avoidable admissions associated with ambulatory care sensitive conditions in adults and children. It is not yet known if the operating plan criteria will change in line with the BCF criteria.

Two other ambitions included in the operating plan are reducing the number of years of

life lost for people with treatable mental and physical conditions by 3.2% and improving the health-related quality of life for people with long term conditions by 1%. Key strategies behind the successful achievement of these outcomes will be through the delivery of better care closer to home and promotion of self-management of long term conditions which are closely aligned to the BCF.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Primary Co-commissioning

Haringey CCG has expressed an interest, along with the four other North Central London CCGs, to NHS England for primary care co-commissioning. Plans are currently at a stage of agreeing the mechanisms rather than the subject matter for co-commissioning.

Primary Care has been engaged in the delivery of the Unplanned Admissions Enhanced Service, which has been used in Haringey as a pre-cursor for the development of integrated Locality Teams.

Recent developments with the transformation of Primary Care in Haringey that align with the BCF include:

- GP practices 'working together at scale' plans for the investment of the Primary Care Strategy Fund of £0.5M to enable GP practices to work together in federations or networks. These planned networks mirror the geography for the Locality Team developments to aid integrated working.
- In order to enable GPs to work at scale, GP IT software is being purchased to enable sharing of patient records, with appropriate consent and Information Governance, between practices and with social care and community healthcare teams.
- A local format has been developed for an integrated care plan housed on the GP IT system that can be viewed and updated by health and social care providers.
- Assigned a small budget (from the over 75s GP Case Management Fund) to each GP collaborative group (the division of all GP practices into four clusters across Haringey) to increase GP engagement in the development of Locality Teams and support care co-ordination.
- Plans for the training and development of all primary care staff in integrated health and social care working.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i. Please outline your agreed local definition of protecting adult social care services (not spending)

Local Definition

Haringey CCG and Council have agreed to use the Department of Health (2012) definition[4] on funding transfers from NHS to social care for the protection of social care services "The funding must be used to support adult social care services in each local authority, which also has a health benefit".

This definition describes the services that have been funded through a Section 256 agreement, including:

- Intensive social care reablement services that promote independence, reduce reliance on health services and the need for long-term social care support.
- Step-up and step-down care home placements.
- Rapid response services to promote hospital discharge and prevent avoidable admissions.
- Community development for initiatives that promote health and well-being, reduce isolation and support self-management of existing health conditions

To guide future decisions on which social care services are eligible for protection, the following principles will be used:

- The service must clearly link to one of the BCF Schemes: Admissions Avoidance; Effective Hospital Discharge; Promoting Independence; or Integration Enablers
- The service must be able to deliver one or more of the BCF Outcome Measures
- Within 2015/16 the service must target older people (65+)
- The service must link to healthcare providers
- The service must deliver safe and effective services in line with quality standards and current evidence of good practice

Using these principles the following services will also be protected in 2015/16:

- Social work capacity linked to integrated Locality Teams.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

BCF Commitment to Protect Social Care

The principles agreed above include a criterion that for social care services to be eligible for protection they must link to one of the BCF Schemes. The Schemes have been chosen based on national and local evidence of best practice for integrated services to reduce the number of unplanned admissions. Social Care are seen as key provider to deliver the services within each of these schemes. These Schemes have been agreed by the Integration Management Board and the Health and Well-being Board as part of the BCF Governance. This demonstrates a commitment from both Haringey CCG and Haringey Council to protect social care as a key provider in the delivery of the BCF.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

Social Care Funding

		Haringey's Allocation
Personalisation	Create greater incentives for employment for disabled adults in residential care.	£14,000
Carers	Put carers on a par with users for assessment.	£79,000
	Introduce a new duty to provide support for carers.	£158,000
Information , advice & support	Link LA information portals to national portal.	£0
	Advice and support to access and plan care, including right to advocacy.	£119,000
Quality	Provider quality profiles	£24,000
Safeguarding	Implement statutory Safeguarding Adults Boards	£39,000
Assessment & Eligibility	Set national minimum eligibility threshold at substantial	£191,000
	Ensure councils provide continuity of care for people moving into their areas until reassessment	£21,000
	Clarify responsibility for assessment and provision of social care in prisons	£31,000
Veterans	Disregard of armed forces GIPs from financial assessments	£12,000
Law reform	Training social care staff in the new legal framework	£22,000
	Savings from staff time and reduced complaints and litigation	-£65,000
Total		***£645,000***
IT	Capital investment fund including IT systems (£50m nationally)	£239,000
Grand Total		***£884,000***

Table 5: Haringey Care Bill Implementation Funding in the BCF (Source. lgfinance@local.gov.uk)

In 2015/16 Haringey Council is expected to take £884,000 from its BCF allocation to cover new duties and associated costs imposed on local authorities by the Care Act (**Table 5**).

The Assessment and Eligibility responsibilities, including support for carers, will link to the

Admissions Avoidance and Effective Hospital Discharge Schemes. Haringey Social Care currently sets its eligibility criteria at the 'significant' level and will move towards the 'substantial' threshold. Service users in this category will also be within the risk group for an unplanned admission and so will be targeted for support by Locality Teams, which will include social care provision.

Personalisation; and Information, advice and support both link to the Promoting Independence Scheme through delivery of services within the community and voluntary sector that support prevention and self-management of existing health conditions.

Responsibilities for: Quality; Safeguarding; Veterans; Law Reform; and capital investments in IT will all be linked to the Integration Enablers Scheme by establishing the systems and processes that will support the delivery of the other BCF schemes.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Care Act 2014 Duties

The core objectives of the Care Act align well with the principles of Haringey Council's Corporate Plan 2013-15 including: delivering high quality services; investing in prevention and early help; promoting equality; empowering communities; and working in partnership. These objectives and principles both align further with the delivery of the BCF.

The work needed to implement the provisions of the Care Act is being led by the Adult Social Services Leadership Team which acts as the Care Act Implementation Board for part of its fortnightly meeting. Membership is extended to include health, children with disabilities and housing to ensure a corporate response and wide engagement in line with the Corporate Plan. Regular briefings are made to the Health and Wellbeing Board. Briefings have also been delivered across Haringey Council and for partners to increase awareness of the implications of the Care Act.

A programme manager has been appointed to oversee and deliver a Care Act Action Plan which has been drawn up to ensure readiness for implementation. Key senior managers have been tasked with leading work-streams in the Action Plan. This transformation work aligns with other change programmes across the Council. This includes the interplay with the BCF, Customer Services and the work to implement the reforms set out in the Children and Families Act.

The work-streams include significant pieces of work in areas such as: maximizing the use of IT; developing service directories to support information and advice; identifying self-funders and the implication of the Dilnot cap (a £75,000 cap on an individual's payment for residential and nursing care) on Local Authority budgets; mapping workforce capacity and development needs with the change in role of Social Care Managers. These work-streams will dovetail with the BCF work-streams to maximise synergies.

v) Please specify the level of resource that will be dedicated to carer-specific support

Care Specific Support

With, approximately 820 carers assessments undertaken in 2013-14 via Haringey Social Care, this gives an indication of the minimum size of the cohort of carers looking after some of the most vulnerable Haringey residents. Reablement data indicates that about 5% - 10% of people receiving Community Based Reablement make no further demand on services because of the support they receive from carers. Carers are key to the successful implementation of the BCF in Haringey and in reducing unplanned admissions to hospital.

Haringey has committed £237,000 in 2015/16 to Care Act responsibilities for the assessment and support of carers. However Haringey has made further commitments to supporting carers within its Carers Strategy.

Haringey commissions four organisations to provide support and services directly to carers. These include the Haringey Alzheimer's Society, Asian Carers Support Group; Black and Minority Ethnic Carers Support Service and the Mental Health Support Association. These organisations provide a variety of services, such as advocacy, benefits advice and counselling

Haringey Council developed and hosts a Carers Hub in Wood Green Library. The Hub is a dedicated space for unpaid carers and gives them a place where they can meet other unpaid carers and access information and advice from weekly drop ins from the carer's organisations commissioned.

Commissioned Carers services in Haringey are currently under review with a procurement exercise expected in Autumn 2014.

Haringey Council Social Care undertakes carers assessments which can result in: a one-off personal budget up to £300 annually to support a life outside caring and access to respite services; free/discounted admission to Haringey Leisure Centres; and back up cover in case of emergencies through the Carers Emergency Alert Card Scheme.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Local Authority Budget Impact

LBH budget has not been materially affected following the resubmission of the BCF plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Haringey's health and social care providers have made a commitment to ensure that services that support hospital discharges are available 7 days a week and over extended hours.

Systems Resilience Planning builds on 7 day working that currently exists in a number of

Haringey services. Reablement and Rapid Response in social care and District Nursing and Community Matrons in community healthcare, are accessible 7 days a week. Patients and service users also have 24 hour access to urgent primary care support via Out of Hours provision, which will have access to the care plans of patients at risk of a non-elective admission. Flexible working arrangements for staff in all agencies are being scoped and reviewed as part of workforce capacity planning for 7 day services with systems resilience funding being used to increase staff capacity.

End of Life Care Services was identified in 2013/14 as a key priority for 7 day working. Investment through the Better Care Fund has been used to expand a 5 day/week nursing led palliative care service into a 7 day/week service, offering both health and social care input. The new palliative care service will offer a single point of access for staff, patients and families.

Different workforce options will be employed to cover 7 day working including moving staff onto new 7 day working contracts and specifically increasing staff capacity for weekend working. The initial focus will be on assurance of seven day working in existing integrated services, prioritising reablement and rapid response. Seven day working will also be incorporated into the development of Locality Teams.

Within the community and voluntary sector a Home from Hospital service was piloted 7 days a week during the winter pressure months and this service is currently being re-commissioned on a permanent basis through the BCF. The Home From Hospital service provided services such as: transport home; assistance with ensuring access to basic food shopping; amenities such as heating and lighting; companionship and confidence building; information and links to community initiatives in order to avoid admission / readmission to hospital.

A single point of access, linked into the Haringey Customer Service Transformation programme, will provide 7 day/24 hour access across health and social care services through a range of technological channels including web-sites and a call centre. This single point of access will include access to urgent services that can respond efficiently and effectively to prevent a hospital admission. Patients at a high risk of an unplanned admission, and any services connected to their care, will also have access to a direct bypass phone number to their GP practice which is expected to provide an efficient response. Plans will be developed to link the various access points for patients and service users.

Seven day working presents two main risks:

- There will be limited capacity in services to deliver the scale of change needed
- Funding is reduced by the financial challenges within the CCG and LBH

The mitigation of these risks will be key to the implementation of seven day working and is captured within the risk log.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

NHS Number

All health and social care systems in Haringey use the NHS Number. To ensure the use of NHS numbers as primary identifiers Haringey Council (Adult Social Care) has issued instructions to all staff members requiring them to routinely record these numbers for all service users and has modified its Framework-I (service user database) interface to make this requirement clear. Use has been made of MACS to insert NHS numbers into the Framework-I record where these are missing. A recent audit showed that 60% of social care records had an NHS number recorded. Further actions are being considered to ensure that the use of NHS numbers in social care is improved including solutions being developed by neighbouring local authorities and potential IT tools.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Open APIs and Standards

In the procurement of new IT systems there is a commitment to looking for systems that have open API's and open standards but they are only one of a number of elements that would be assessed in the search for a value for money solution. Secure e-mail exchange is sued by all providers via the GCSX and N3 network.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Information Governance

There is a commitment to high standard Information Governance controls. Overall responsibility for Information Governance rests with both Haringey Council's Information Governance Board, chaired by the Council's Senior Information Risk Officer and Haringey CCG's Director of Quality and Caldecott Guardian. Haringey has a comprehensive range of policies and procedures in place to ensure compliance with relevant legislation such as the Data Protection Act. Haringey Council's information security policies are certified to this standard to the ISO 27001 International Standard for Information Security Management. Haringey Council has a valid Information Governance Toolkit Assessment as is required to access the NHS N3 secure network.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

High Risk Population

Haringey has identified the top 2% of the population at risk of an unplanned hospital admission which amounts to 4600. Their profile has been broken down in the Section 3:

Case for Change.

Haringey has commissioned four risk stratification tools for use by GP Practices: Health Intelligence; NELIE; EMIS, and VISION. These tools were chosen to support the implementation of the Unplanned Admissions Enhanced Service for GPs. In order to meet key milestones for the implementation of the Enhanced Service, four tools were commissioned as they were each available at different dates and each provided different functionality including: access to different data sources; linkage to existing clinical IT systems; training and development support; and ability to prepopulate a care plan. Following a few months of usage GPs will be surveyed to understand which risk stratification tool provided the best functionality combined with the best predictive ability for identifying patients at most risk of a hospital admission.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Joint Assessment

A draft joint assessment tool is already in place following work between Whittington Health (as provider of Community Healthcare) and Haringey Council and requires further development of supporting processes, procedures and links to interoperable IT systems.

The Unplanned Admissions Enhanced Service for GPs has provided a good baseline in Haringey for developing joint care plans and understanding the information, in terms of intervention, outcomes and format, held by each provider involved in the health and social care of each patient. Local GPs have identified through risk stratification the top 2% of their patients at risk of an admission to hospital. This information is being used by community healthcare and social care services to achieve an integrated approach to care planning and identification of a care co-ordinator and is forming the basis of discussion at weekly MDT teleconferences for each of the GP collaboratives.

A table-top exercise with GPs and representatives from community healthcare and social care tested the care planning process to determine the professionals who would be identified as the accountable lead professional i.e. the care co-ordinator. From this exercise a minimum of 48% of patients would have the GP as the named care co-oridnator; 12% would be someone from community healthcare services; and 9% would be someone from specialist services including social care (mental health or learning disabilities) and respiratory. A further 31% would need further discussion at a Multi-Disciplinary Team meeting to determine the most appropriate lead.

In the Reablement Service, where health and social care colleagues use the same IT system, the recent introduction of MDT meetings have focused on assigning an accountable lead, setting and reviewing predictive discharge dates and ensuring a more collaborative approach to assessment, goal setting and review.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

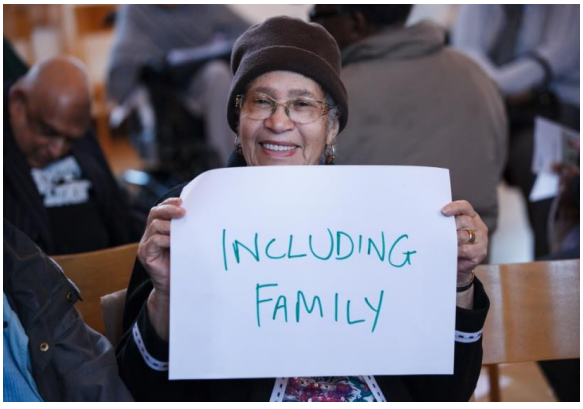
Joint Care Plan

Work is progressing to develop joint care plans for individuals at high risk of an emergency hospital admission. Currently the records of approximately 4600 patients and service users are being examined across primary care (GP practices), community healthcare and social care to look for synergies and to assign a care co-ordinator as part of the implementation of the Unplanned Admissions Enhanced Service. The number of joint care plans will be known following the deadline of 30th September 2014 for completion of this work.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future



The Haringey BCF vision is based on the experiences and priorities of local people. Avoiding a *'one size fits all'* approach, a range of public, patient, service user and carer engagement methods have been used including large and small group meetings, focus groups, semi-structured interviews and workshops. The specific BCF workshop was held in collaboration with the Third Sector (particularly Haringey Age UK and Haringey HealthWatch) and used a theatre group to bring issues to life and facilitate engagement. By working with the third sector extra efforts to engage 'seldom heard' communities were

made including outreach to various cultural and community groups and resulting in a wide cross section of the Haringey population. A key output from this workshop was the development of an *'outcomes hierarchy'* which has been used to prioritise the development of services within the BCF as described in Section 2: Vision for Health and Care.
Through these methods up to 200 people have been directly engaged in the development of the BCF (**Table 6**).

Date	Method	Number of Attendees
07/11/13	One to One Semi-structured interview	1
11/11/13	Older People's Partnership Board	11
12/11/13	One to One Semi-structured interview	2
14/11/13	One to One Semi-structured interview	1
23/01/14	BCF Workshop	117
27/05/14	CCG Network Event on Integration	30
10/09/14	Adult Partnership Board Discussion Forum	17
15/09/14	CCG Network Event	20
	TOTAL	199

Table 6: Public, Patient, Service User and Carer Engagement

An overarching BCF Communication and Engagement Plan has been developed and presented to the Communication and Engagement Sub-Committee with key messages, communication channels and an activity plan. Feedback on the plan reinforced a commitment to: feedback via a 'You Said, We did' framework; use existing networks and groups to communicate; and identify further channels of communication particularly for seldom heard communities reflecting the diversity of Haringey.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Haringey is mainly served by two core acute hospitals: North Middlesex University Trust to the north-east and Whittington Health in the south-west. Whittington Health is an Integrated Care Organisation (ICO) and runs the majority of community services in Haringey.

Acute providers face the challenge of meeting consistently high demand whilst operating at, or near to, full capacity at all times. Day-to-day this creates challenges with managing the flow of patients. For the future there is an acknowledgement that the trend towards increasing hospital admissions must be curtailed if commissioners are to succeed in improving outcomes and to maintain a sustainable health economy.

The impetus to deliver change across the health economy has led to the development of two Transformation Boards in 2012, one focused on North Middlesex (including stakeholders from Haringey and Enfield CCGs/Councils) and one around Whittington Health (including stakeholders from Islington and Haringey CCGs/Councils). Both Boards have facilitated discussions with the mental health trust for Haringey, which is Barnet, Enfield and Haringey Mental Health Trust.

From October 2013 both acute trusts have been regularly engaged in the BCF agenda through a combination of one to one meetings and the monthly Transformation Boards. The Transformation Boards have received regular verbal and written progress reports. Through discussions the impact of the BCF is reflected in the Operating plans for all Trusts.

On an operational level both trusts have been directly engaged in co-producing the services within each of the four BCF schemes including Locality Teams; Hospital Discharge Services; and IT interoperability.

ii) primary care providers

There are 49 GP Practices in Haringey. Each GP Practice is linked to one of four GP Collaboratives: West; Central; North East; South East.

Haringey GPs have had an opportunity to influence the BCF through engagement of the GP Collaboratives and their representation on Haringey CCG via the Clinical Cabinet and Governing Body. GP clinical leads have been assigned to the BCF and some of the work-streams.

At a Haringey CCG stakeholder conference in 2013, GPs were invited to comment on what they hope integration will achieve for their patients. There was considerable unanimity with most believing that integration will allow them to:

a) more easily access a greater range of services for patients;
b) obtain much improved information about service provision that is well managed and up-to-date;
c) offer a holistic response to individuals' health and social care needs.

The stakeholder conference is held annually and integration will be on the agenda for the 2014 event.

Engagement also indicates that GPs have positive experiences of participating in Haringey's Multi-Disciplinary Teams, which allow them to review high risk patients with complex needs alongside a range of health and social care colleagues. This positive experience has been used to support the implementation of the Unplanned Admissions Enhanced Service and will be used to facilitate the development of Integrated Locality Teams, which will mirror the structure of the GP Collaboratives.

GPs have been engaged in plans to develop the Locality Teams through the allocation of the Over 75s GP Case Management (£5/head) funding to each Collaborative. The funding will allow slight local variations to how the Locality Teams develop in each Collaborative, which will provide a comparison of local best practice and foster greater ownership of the BCF agenda amongst GPs.

To support the implementation of the Locality Teams, Haringey GPs have also been at the forefront of developing integrated care plans and proposals for interoperable IT.

iii) social care and providers from the voluntary and community sector

Haringey has a mixed economy of social care provision including council run and externally provided social care services. Council run services have focused on reablement and integration. Externally provided services include domiciliary care and

care home services from the independent sector and preventative services from the Third Sector.

LBH hold a regular social care Providers' Forum to influence local planning. In total 44 social care providers, drawn from 35 agencies participated in Haringey's BCF engagement process from November 2013 via the Haringey Provider's Forum, a one to one interview and a presentation at Age UK Management Committee. Providers are, generally supportive of integration and the Providers' Forum will continue to be used as the main method of engagement on integration.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The majority of Haringey's non-elective admissions (NELs) are shared amongst two acute providers (**Table 7**): North Middlesex and The Whittington. Table 7 shows the full year activity for NELs across the acute trusts. Due to limitations in the data available 'well babies' admissions have not been excluded.

Trusts	NELs 2013/14	% Share of NELs
North Middlesex University Hospital NHS Trust	8,939	44.0
The Whittington Hospital NHS Trust	6,782	33.4
Other (A number of different trusts)	2,190	10.8
Royal Free London NHS Foundation Trust	813	4.0
Barnet and Chase Farm Hospitals NHS Trust	810	4.0
University College London Hospitals NHS Foundation Trust	783	3.9
TOTAL	20,317	100

Table 7: Haringey Non-Elective Admissions by Acute Trust

The target reduction of non-elective admissions is 3.5% which translates to a reduction of 705 admissions and will generate savings of £1,247,850. Based on the percentage share of admissions amongst acute trusts, these savings break down to (**Table 8**):

Trusts	Reduction Target (no.)	Savings (£)
North Middlesex University Hospital NHS Trust	310	549,054
The Whittington Hospital NHS Trust	235	416,782
Other	76	134,768
Royal Free London NHS Foundation Trust	28	49,914
Barnet and Chase Farm Hospitals NHS Trust	28	49,914
University College London Hospitals NHS Foundation Trust	27	48,666
TOTAL	706	1,249,098

Table 8: Forecast Non-Elective Admissions Reduction and Savings by Acute Trust

The BCF will be working alongside a broader range of Quality Innovation Productivity and Prevention (QIPP) Programmes to reduce non-elective admissions. These schemes will not duplicate BCF schemes.

The combination of activities in the BCF will result in the following impacts on acute activity:

a) Reductions in non-elective admissions will provide greater capacity within acute trusts to deliver quality improvements including performance on A&E 4 hour wait targets and Referral to Treatment Time (RTT) targets.
b) Reductions in length of stay will enable acute trusts to repatriate patients to the most appropriate setting for their care and to manage peaks in demand.
c) Improved care planning and care co-ordination will give acute trusts greater access to patient information, support the most effective treatment responses and reduce duplication
d) Self-management of Long Term Conditions will increase outpatient capacity for Long Term Conditions, where it is needed most.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
1
Scheme name
Admissions Avoidance
What is the strategic objective of this scheme?
The Admissions Avoidance Scheme identifies people most at risk of an emergency hospital admission and via a Care Co-ordinator, within a Locality Team, develops a care plan setting out the integrated package of support needed, either from self-care or from safe and effective services, to keep them well and independent and to prevent an admission.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To meet the strategic objective the Admission Avoidance Scheme will: • Use appropriate risk stratification tools to identify people most at risk of an emergency admission to hospital • Assign a named care co-ordinator to each individual identified • Care co-ordinators form part of a multi-disciplinary Locality Team based around GP collaboratives • Use a joint assessment tool to identify health and social care needs and desired goals, including the risk of a fall, in collaboration with the individual • Develop a care and support plan based on the identified health and social care needs, which is reviewed every three months (as a minimum) • Care co-ordinators will oversee the implementation of the care and support plans, including the monitoring of patient/service user goals and facilitate access to services • Provide urgent health and social care interventions through a rapid response service • Provide specific care co-ordination for people with mental health needs with mental health navigators • Provide specific health and social care support for dementia via a Dementia Day Centre • Provide specific health and social care support for mental health via a Mental Health Recovery College • Link people at risk of a fall into prevention programmes that treat, improve or manage risk factors. In line with the case for change the Admissions Avoidance Scheme will mainly target the top 2% of adults at risk of a non-elective hospital admission totalling 4500 people. Key milestones include: • Evaluate which of the four available risk stratification tools is preferred by Haringey GPs, based on usability and accuracy of outputs, by October 2014. • Evaluate existing admission avoidance services to identify local good practice and

align with national evidence base by November 2014 including: Rapid Response; Mental Health navigators; Dementia Day Centres; and Mental Health Recovery College
- Develop Locality Team business case by October 2014
- Co-design Locality Team Pilot with key stakeholders to implement by November 2014
- Review implementation of the Unplanned Admissions Enhanced Service and Locality Team pilot by January 2015
- Co-design and re-develop existing services, that do not meet current performance indicators or national evidence base, with key stakeholders by January 2015
- Develop service specifications for all Admissions Avoidance services by February 2015
- Commission Admission Avoidance services by April 2015
- Monitor implementation of Admission Avoidance services from May 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The BCF governance structure and programme management approach have already been agreed. The Admissions Avoidance Scheme and related services will be overseen by the Integration Implementation Group which is chaired by the Haringey CCG, Assistant Director of Commissioning, with an assigned Clinical (GP) Lead from the CCG Governing Body and an LBH Commissioner and other members (both managerial and clinical/delivery) from acute, community healthcare and social care providers as well as patient/service user representation. The Integration Implementation Group has overseen the implementation of Multi-Disciplinary Team working in primary care and has started the process of overseeing the implementation of the Admissions Avoidance Enhanced Service, evaluation of existing admission avoidance services and co-designing the Locality Teams.

Once the Haringey BCF Plan has been submitted a detailed work-plan will be created for the Integration Implementation Group. An interim project manager will start full time in October 2014 to ensure that the implementation of the work plan is fully supported and monitored, escalating all issues and risks and providing an audit trail. The project manager will have a key responsibility for the development of the Locality Team including the business case and service specification and ensuring that integrated approaches are embedded in the model.

Within the current commissioning arrangement all healthcare elements of the Admissions Avoidance Scheme will be commissioned by Haringey CCG with Community Healthcare currently provided by Whittington Health and additional Primary Care capacity provided by Haringey GP Practices.

LBH Commissioning will continue to commission the social care elements of the scheme including mental health and dementia services. A number of these services are currently provided by LBH itself part from mental health navigators from Barnet Enfield Haringey Mental Health Trust, and mental health recovery co-ordinators from Clarendon Recovery College.

Commissioning arrangements may change over the delivery of the BCF due to the development of a Section 75 agreement.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The key feature of the Admissions Avoidance Scheme is Care Co-ordination. The Better Care Fund Task Force, How to Guide: BCF Technical Toolkit (2014) provided the following evidence for Care Co-ordination.

Care co-ordination is the practice of having someone co-ordinate the care received by an individual that has been designated as needing additional support. Typically, these are older people and those with chronic conditions who often represent 10-20% of the population and 30-70% of costs in the health and care system. The care co-ordinator role can be effectively carried out by a range of professionals including clinicians, social workers and other practitioners. It will be key that the co-ordinator understands the wider health and care economy and the local community and can effectively oversee and connect those people most at risk into effective care and support. There are several essential steps that are required to implement care co-ordination including the identification of individuals who would benefit from care co-ordination, the enrolment of those individuals into a programme, the development of care plans for those individuals and then ongoing follow-up in line with the plan.

The evidence base highlights the following techniques:

- A holistic focus supporting self-care at home
- Single entry point to provide continuity
- Shared electronic health records
- Coordinating care at the neighbourhood level with engagement of local community
- Prioritising engagement with GPs and links with secondary care

8 out of 13 reviews which were analysed assessed care co-ordination and found a positive impact. Other reviews of literature have concluded that hospitalisations may be reduced by approximately 37% (North West London – Whole systems integrated care toolkit, 2014, pooled estimate only reported in 2 relevant reviews). Interventions involving care coordination have shown to reduce HbA1c (in patients with diabetes) by 22% more than interventions without care co-ordination (Shojana et al, JAMA, 2006, 296(4), 427-440).

In Haringey, Locality Teams would be expected to identify people at risk of falls as part of the risk stratification. Once identified, care co-ordinators will be able to undertake a falls risk assessment as part of the integrated assessment in line with NICE clinical guideline (2013) Falls: assessment and prevention of falls in older people. Once people have been identified they can be linked to falls prevention programmes within Scheme 3: Promoting Independence. One study in Torbay showed that falls prevention could reduce acute hospital costs by 25% (Tian et al (2013), 'Exploring the system - wide costs of falls in older people in Torbay').

4500 people have been identified as the top 2% at risk of hospital admission in Haringey. This group accounts for over 5000 acute hospital admissions per year in Haringey. If the care-coordination approach achieves a 37% reduction in hospital admissions, as reported above, 1665 admissions per year could be prevented in the long-term. Assuming that this effect will be seen in a step-wise progression over 4 years, we model that 460 admissions will be prevented in 2015/16

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

NA

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Haringey is participating in the North Central London Value Based Commissioning (VBC) programme. The VBC Programme has defined three levels of outcomes which will cut across the BCF Programme: Clinical Outcome Measures; Patient Reported Outcome Measures; and Patient Defined Outcome Measures. An assessment of these outcomes in August 2014 has generated a list of outcomes that could be measured now:

Topics	Outcomes
1. Mortality Rate / Age of Death	1a. A measure of mortality rate 1b. A measure of average age of death
3. Patient identified outcomes related to Quality of Life	3b. A measure of the feeling of company and contact
4. Evidence-based outcomes related to care process	4a. A measure of the rate of acquired infection rate whilst receiving care e.g. HAP, UTI (with catheter in situ), wound infection 4b. A measure of the rate of pressure sores whilst receiving care 4c. A measure of the rate of falls whilst receiving care 4d. Staying at home after discharge
5. Patient identified outcomes related to care process	5a. A measure of feeling decisions are listened to and acted on 5b. A measure of feeling in control over care
7. Fragility Fractures	7a. A measure of fragility fracture rates 7b. A measure for the recovery period to previous level of mobility post-fragility fracture
9. A 'good death': location/pain /own views considered	9. A measure of a 'good death'
11. Dementia Specific Outcomes	11a. A measure of dementia diagnosis rate 12. A measure of the extent people with dementia/their carer feel supported

LBH Public Health have been engaged in a process of agreeing appropriate outcome and process measures (e.g number of care plans completes, number of people allocated to a care co-ordinator) for the Admissions Avoidance Scheme services by November 2014. This will be based on the work of VBC and national and local evidence of effectiveness.

Monitoring of process and outcome measures using a pre-established monitoring framework will be reported into the Integration Implementation Group and ultimately the Integration Management Board at regular intervals.

What are the key success factors for implementation of this scheme?

The following 4 factors have been identified as key to the success of the Admissions Avoidance Scheme:

Public Behaviour Change: The success of the Admissions Avoidance Scheme will rely on the need for patients and service users to change their behaviours away from an over reliance on hospitals and doctors towards a greater amount of self-management, with and without support. Public behaviour change will be supported through the accessibility,

acceptability and awareness of alternative provision. Having a single point of access for the scheme that will be promoted and communicated in a variety of different ways will support the behaviour change. This scheme will also link with the promoting independence scheme to reduce demand and champion alternative provision.

Organisational Culture Change: Culture change is key to any transformational programme. The Integrated Locality teams within the Admissions Avoidance Scheme will move the culture away from silo working including: organisational (e.g social care, community health care, voluntary sector); professional (e.g. district nursing, community matrons, social workers); health (e.g. mental health will be given the same parity of esteem as physical health); care (e.g. prevention, treatment); and setting (e.g. home, community setting, acute ward). Locality teams will work across these silos working on the health and social care needs of each individual. A model of collaborative leadership, delivered through an extensive training and development programme, will be used to generate a culture of respect and reduce fears and resistance.

Workforce: Staff in all health and social care agencies have been, and will continue to be, engaged in the development of all services within the Admissions Avoidance Scheme. There will be no decisions made about staff without full and proper consultation. Workforce modelling of the number of Community Health Care and Social Care staff needed as Care Co-ordinators for almost 5000 patients/service users per year will be needed by October 2014. Care co-ordinators would be expected to retain their specialisms (e.g. social work or occupational therapy) but would also be expected to undertake a number of generic tasks to reduce the duplication of certain activities (e.g. health and social care assessments). Training and workforce development will be key to engaging staff in the development of the scheme and the skills needed to work in a collaborative way that promotes the independence of patients and service users and will be delivered via implementation of the LETB funding bid. Matrix management structures will also be created that will both support professional supervision and performance management.

Systems: Interoperable IT systems in Scheme 4 will support the implementation of integrated working within the Admissions Avoidance Scheme. Currently each service has their own separate clinical IT system and no service has access to patient and service users' information from the other service. Plans are being developed to collaborate with other HWBB areas to develop solutions on the sharing of data between services and eventually with patients themselves in the form of a person held record. The linkage of these systems will further support the single point of access as a key entry point into the Locality Teams as information will be accessible that can support a quick and efficient service response. An interim solution for interoperable IT and the viewing of care records will be ready by January 2015 with full interoperability by June 2015.

Scheme ref no.
2
Scheme name
Effective Hospital Discharge
What is the strategic objective of this scheme?
The Effective Hospital Discharge Scheme delivers three key services: step down care via a non-acute facility to enable people to convalesce prior to returning home; a volunteer led befriending and home visiting service for people aged over 50 prior to hospital discharge; and a Multi-Disciplinary Team reablement package to patients following a hospital discharge. The reablement package includes personal care and support that enables and equips service users to carry out activities themselves in order to restore independence.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To meet the strategic objective the Effective Hospital Discharge Scheme will: • Plan for a person's discharge as soon as they are admitted to hospital ensuring that all needs are assessed to enable an effective return home • Refer to a person's care and support plan if they are known to the Locality Team to reduce duplication and ensure continuity of care • Deliver a package of care and support that most efficiently restores a service user's independence • Develop a care plan with user defined goals for independence • Hand over to the Locality Team for the monitoring of any service user within the hospital admission high risk group once independence has been regained • Be overseen by a senior clinician with specific reablement skills and knowledge In order to maximise effectiveness of the Scheme, commissioners will: • Re-commission the Home from Hospital service based on the key BCF outcomes • Review the current capacity of community step down care in light of projected needs • Review the capability and capacity of the current reablement service in light of projected needs In 2013/14 there were 20,317 non-elective admissions. Current reablement services have the capacity to target 600 adults to support their discharge. Further planning will be undertaken by November 2014 to explore the potential to expand capacity. Key milestones include: • The Home from Hospital Scheme Pilot has already been evaluated • Evaluate Reablement and Step Down Care to identify local good practice and align with national evidence base by November 2014 • Undertake detailed capacity planning for reablement and step down care by November 2014. • Develop Reablement business case and redesigned pathway by December 2014 • Develop service specifications for all Effective Hospital Discharge Services by February 2015

- Commission Effective Hospital Discharge services by April 2015
- Monitor implementation of Effective Hospital Discharge services from May 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The BCF governance structure and programme management approach have already been agreed. The Effective Hospital Discharge Scheme and related services will be overseen by the Systems Resilience Group which is chaired by the Haringey CCG Governing Body, Secondary Care Clinical (GP) Lead. Other members (both managerial and clinical/delivery) from acute, London Ambulance Service, NHS 111, community healthcare and social care providers. The main aim of the Systems Resilience Group is to develop and deliver a shared strategic vision for the provision of integrated elective and non-elective care services across the Haringey and Enfield health and social care economy. This has a particular focus on winter planning but will be sustained through the year with a clear objective of linking to BCF principles and plans for integration. The Systems Resilience Group will have oversight of the services within the Effective Hospital Discharge Scheme including Reablement, Step Down and Home from Hospital.

The Systems Resilience Group has a detailed work-plan that is overseen by the Commissioning Lead for Urgent Care. A substantive Commissioning Manager will commence work in October 2014 and will be assigned to project manage the implementation of the Effective Hospital Discharge Scheme including the development of business cases and service specifications, escalating all issues and risks and providing an audit trail.

Within the current commissioning arrangement all Community Healthcare elements (currently provided by Whittington Health) of the Effective Hospital Discharge Scheme will be commissioned by Haringey CCG.

LBH Commissioning will continue to commission the social care and community befriending elements of the scheme. The Reablement service is currently provided by LBH itself whilst the Home From Hospital Service was commissioned by the local authority and provided by the Third Sector: Haringey Age UK and Living Under One Sun.

Commissioning arrangements may change over the delivery of the BCF due to the development of a Section 75 agreement.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The main services in the Effective Hospital Discharge Scheme are intermediate care services, including rehabilitation and reablement.

The Better Care Fund Task Force, How to Guide: BCF Technical Toolkit (2014) provided the following evidence for Intermediate care.

Intermediate care has the potential to reduce length of stay in hospital by facilitating a stepped pathway out of hospital (step down) or preventing deterioration that could lead to a hospital stay (step up).

The evidence base highlights the following techniques:

- Commissioning for outcomes instead of periods and tasks
- Workforce led by a senior clinician with specific reablement services and skills
- Adequate provision for rehabilitation and reablement outside acute hospitals, based on demographic characteristics of the local population

A Department of Health funded review showed that home care reablement is almost certainly cost-effective and improves outcomes for users. The study showed that in the first year of setting up a service, set-up costs cancel out savings (http://www.york.ac.uk/inst/spru/pubs/rworks/2011-01Jan.pdf).

Reablement will be provided for 600 clients per year. A recent Randomised Control Trial (Lewin et al, 2014) showed that for every 100 clients, reablement results in 7 less hospital admissions per year compared to usual social care and 6 less people requiring residential or maximal home care per year compared to usual social care. If we assume that 1 in 6 of these step-up packages are residential packages, that equates to a reduction in 1 residential care package for each 100 reablement clients. For Haringey this will equate to 36 fewer hospital admissions and 6 fewer residential care packages in 2015/16.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Haringey is participating in the North Central London Value Based Commissioning (VBC) programme. The VBC Programme has defined three levels of outcomes which will cut across the BCF Programme: Clinical Outcome Measures; Patient Reported Outcome Measures; and Patient Defined Outcome Measures. An assessment of these outcomes in August 2014 has generated a list of outcomes that could be measured now:

Topics	Outcomes
1. Mortality Rate / Age of Death	1a. A measure of mortality rate 1b. A measure of average age of death
3. Patient identified outcomes related to Quality of Life	3b. A measure of the feeling of company and contact
4. Evidence-based outcomes related to care process	4a. A measure of the rate of acquired infection rate whilst receiving care e.g. HAP, UTI (with catheter in situ), wound infection 4b. A measure of the rate of pressure sores whilst receiving care 4c. A measure of the rate of falls whilst receiving care 4d. Staying at home after discharge
5. Patient identified outcomes related to care process	5a. A measure of feeling decisions are listened to and acted on 5b. A measure of feeling in control over care
7. Fragility Fractures	7a. A measure of fragility fracture rates 7b. A measure for the recovery period to previous level of mobility post-fragility fracture
9. A 'good death': location/pain /own views considered	9. A measure of a 'good death'
11. Dementia Specific Outcomes	11a. A measure of dementia diagnosis rate 12. A measure of the extent people with dementia/their carer feel supported

LBH Public Health have been engaged in a process of agreeing appropriate outcome and process measures (e.g number of completed packages of care) for the Effective Hospital Discharge Scheme services by November 2014. This will be based on the work of VBC and national and local evidence of effectiveness.

Monitoring of process and outcome measures using a pre-established monitoring framework will be reported into the Systems Resilience Group and ultimately the Integration Management Board at regular intervals.

What are the key success factors for implementation of this scheme?

The following 4 factors have been identified as key to the success of the Effective Hospital Discharge Scheme:

Public Behaviour Change: The success of the Effective Hospital Discharge Scheme will rely on the need for patients and service users to change their behaviours towards a greater amount of self-management, with and without support. Service users will be supported to define their own goals in order to promote greater ownership of any treatment programmes.

Organisational Culture Change: Culture change is key to any transformational programme. The Effective Hospital Discharge Scheme will move the culture away from silo working including: organisational (e.g social care, community health care, voluntary sector); professional (e.g. district nursing, community matrons, social workers); health (e.g. mental health will be given the same parity of esteem as physical health); care (e.g. prevention, treatment); and setting (e.g. home, community setting, acute ward). The Reablement Team will work across these silos working on the health and social care needs of each individual rather than each individual meeting the needs of separate services for each of their conditions.

Workforce: Staff in all health and social care agencies have been, and will continue to be, engaged in the development of all services within the Effective Hospital Discharge Scheme. There will be no decisions made about staff without full and proper consultation. Workforce modelling of the number of staff needed for 600 patients/service users per year will be needed. Training will be key to engaging staff in the development of the scheme and the skills needed to work in a collaborative way that promotes the independence of patients and service users. Matrix management structures will also be

created that will both support professional supervision and performance management.

Systems: Interoperable IT systems will support the implementation of integrated working within the Effective Hospital Discharge Scheme. Currently each service has their own separate clinical IT system and no service has access to patient and service users' information from the other service. Plans are being developed to collaborate with other HWBB areas to develop solutions on the sharing of data between services and eventually with patients themselves in the form of a person held record. The linkage of these systems will reduce duplication and ensure continuity of care.

Scheme ref no.
3
Scheme name
Promoting Independence
What is the strategic objective of this scheme?
The Promoting Independence Scheme delivers a range of community development interventions based on a model of prevention and early intervention to prevent ill-health arising, to support self-management of health and care conditions and to reduce social isolation. The focus of this scheme is to build community capacity to respond proactively to episodes of need. The Scheme also encompasses an integrated service to support palliative care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To meet the strategic objective the Promoting Independence Scheme will: • Outreach to local community organisations and settings • Identify people who may be pre-frail or socially isolated • Use health coaching and motivational interviewing techniques to identify goals with service users • Develop potential community responses and activities to the identified needs of service users, particularly tailored to specific health conditions • Develop community responses to falls prevention including potential exercise and home hazard interventions • Connect local residents to other services in the community in order to reduce social isolation, support healthy lifestyle and facilitate behavioural change • Enable the management of palliative care within the community via advanced care planning In line with the case for change the Promoting Independence Scheme will broadly target adults in the top 20% of those at risk of a hospital admission. This category is broader than high risk and encompasses some definitions of a pre-frail population as the approach is based on prevention and early intervention. In Haringey this is equivalent to 46,000 people. The risk stratification identifies 6,700 people as at high risk of a hospital admission in Haringey. In Haringey one of the services delivering self-care the 'Neighbourhood Connects' service will target 2000 people in this cohort by 2019, starting with 1000 people in 2015/16, with self-care including falls prevention, reducing social isolation and lifestyle and behavioural change. Key milestones include: • The Neighbourhood Connects service has already been piloted and evaluated • The Palliative Care team already operates at 5 days/week. • Map current community development services by November 2014 • Develop a business case for Promoting Independence services by November 2014 • Co-design Promoting Independence services with key stakeholders by December 2014 • Expand the Palliative Care Team to 7 day working by December 2014 • Develop service specifications for Promoting Independence by January 2015

- Re-commission the Neighbourhood Connects service by January 2015
- Commission additional Promoting Independence services by April 2015
- Monitor implementation of Promoting Independence Service from May 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The BCF governance structure and programme management approach have already been agreed. The Promoting Independence Scheme and related services will be overseen by the Promoting Independence Group which is chaired by the LBH Assistant Director of Commissioning, with representation across Haringey CCG and LBH Including Adult Social Care, Commissioning and Public Health. This group is at an early stage of development and does not yet have a Governing Body clinical lead or representation from providers or the public. The Group has agreed to oversee all projects that link to self-care and self-management including prevention and early intervention, proactive and healthy lifestyle programmes in public health, and community and voluntary sector provision that supports health and wellbeing.

Once the Haringey BCF Plan has been submitted a detailed work-plan will be created for the Promoting Independence Group. An interim project manager for self-management is already in post to ensure that the implementation of the work plan is fully supported and monitored, escalating all issues and risks and providing an audit trail. The project manager will have a key responsibility for the development of the business case and service specifications for services within the Promoting Independence Scheme.

Within the current commissioning arrangement Haringey CCG will continue to commission the Integrated Palliative Care Team from Whittington Health.

LBH Commissioning will continue to commission the Third Sector to deliver the Neighbourhood Connects Service, which was provided by Haringey Age UK and Living Under One Sun.

Commissioning arrangements may change over the delivery of the BCF due to the development of a Section 75 agreement.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The main element of the Promoting Independence Scheme is self-care, with improved connectivity to local community activities and improved social interaction.

The Better Care Fund Task Force, How to Guide: BCF Technical Toolkit (2014) provided the following evidence for self-care.

People with long-term conditions account for 70% of inpatient bed days. Self-management programmes, which aim to support patients to manage their own conditions, have been shown to reduce unplanned hospital admissions for some conditions (COPD and asthma). One study found that supported self-management had the strongest effect on clinical outcomes of all integrated care interventions, and

reduced hospitalisations by 25-30% (Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)).

The evidence base highlights the following techniques:

- Involving patients in co-creating personalised self-care plans
- Telephone health coaching
- Tailoring interventions to the condition (e.g. structured education for diabetes self-care, behavioural interventions for depression)
- Programmes to encourage lifestyle and behavioural change.

The Promoting Independence Scheme will be provided to 2000 residents via the Neighbourhood Connect service by 2019. This will begin with 1000 residents for 2015/16. Based on evidence around the effectiveness falls prevention programmes and self-care (e.g Gillespie et al. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2012) a 25% reduction in admissions, equal to 250 people, has been modelled.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

N/A

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Haringey is participating in the North Central London Value Based Commissioning (VBC) programme. The VBC Programme has defined three levels of outcomes which will cut across the BCF Programme: Clinical Outcome Measures; Patient Reported Outcome Measures; and Patient Defined Outcome Measures. An assessment of these outcomes in August 2014 has generated a list of outcomes that could be measured now:

Topics	Outcomes
1. Mortality Rate / Age of Death	1a. A measure of mortality rate 1b. A measure of average age of death
3. Patient identified outcomes related to Quality of Life	3b. A measure of the feeling of company and contact
4. Evidence-based outcomes related to care process	4a. A measure of the rate of acquired infection rate whilst receiving care e.g. HAP, UTI (with catheter in situ), wound infection 4b. A measure of the rate of pressure sores whilst receiving care 4c. A measure of the rate of falls whilst receiving care 4d. Staying at home after discharge
5. Patient identified outcomes related to care process	5a. A measure of feeling decisions are listened to and acted on 5b. A measure of feeling in control over care
7. Fragility Fractures	7a. A measure of fragility fracture rates 7b. A measure for the recovery period to previous level of mobility post-fragility fracture
9. A 'good death': location/pain /own views considered	9. A measure of a 'good death'
11. Dementia Specific Outcomes	11a. A measure of dementia diagnosis rate 12. A measure of the extent people with dementia/their carer feel supported

LBH Public Health have been engaged in a process of agreeing appropriate outcome and process measures (e.g number of people engaged in services) for the Promoting Independence Scheme services by November 2014. This will be based on the work of

VBC and national and local evidence of effectiveness.

Monitoring of process and outcome measures using a pre-established monitoring framework will be reported into the Promoting Independence Group and ultimately the Integration Management Board at regular intervals.

What are the key success factors for implementation of this scheme?

The following 4 factors have been identified as key to the success of the Promoting Independence Scheme:

Public Behaviour Change: The success of the Promoting Independence Scheme will rely on the need for patients and service users to change their behaviours towards a greater amount of self-management, with and without support. Service users will be supported to define their own goals in order to promote greater ownership of any treatment programmes. Public behaviour change will be supported through the accessibility, acceptability and awareness of alternative provision.

Organisational Culture Change: Culture change is key to any transformational programme. The Promoting Independence Scheme will move the culture away from silo working including: organisational (e.g social care, community health care, voluntary sector); professional (e.g. district nursing, community matrons, social workers); health (e.g. mental health will be given the same parity of esteem as physical health); care (e.g. prevention, treatment); and setting (e.g. home, community setting, acute ward). Both the Palliative Care Team and the Neighbourhood Connects Service will work across a number of these silos working on the health and social care needs of each individual in a much more holistic way.

Workforce: Staff in all health and social care agencies, including the third sector, have been, and will continue to be, engaged in the development of all services within the Promoting Independence Scheme. There will be no decisions made about staff without full and proper consultation. Workforce modelling of the number of staff needed for 2000 patients/service users per year will be needed. Training will be key to engaging staff in the development of the scheme and the skills needed to work in a collaborative way that promotes the independence of patients and service users. Matrix management structures will also be created that will both support professional supervision and performance management.

Systems: Interoperable IT systems will support the implementation of integrated working within the Promoting Independence Scheme. Currently each service has their own separate clinical IT system and no service has access to patient and service users' information from the other service. Plans are being developed to collaborate with other HWBB areas to develop solutions on the sharing of data between services and eventually with patients themselves in the form of a person held record. The linkage of these systems will reduce duplication and ensure continuity of care.

Scheme ref no.
4
Scheme name
Integration Enablers
What is the strategic objective of this scheme?
The Integration Enablers Scheme includes a number of different and critically important strands that enable the delivery of the other BCF schemes including: Interoperable IT; Single Point of Access; Seven Day Working in Services; Workforce development and implementation of Care Act responsibilities.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To meet the strategic objective, the Integration Enablers Scheme will: • Deliver interoperability and information exchange to share data between GP's, providers and patient/service user • Deliver a digital person held health and social care record (PHR) for Haringey residents • Provide a Single Point of Access for all patients/service users via a web portal, backed up by a telephone and face to face service • Support LBH responsibilities for Winterbourne, Safeguarding, Carers, Community Capacity and Disabled Facilities. The Integration Enablers Scheme supports the delivery of each of the other schemes and so covers the widest cohort of older people and adults at risk of a non-elective admission, taken as the Promoting Independence top 20% of the population, 46,000 people. However due to the nature of the enablers they will also support the health and well-being of the whole of the Haringey population. Key milestones include: • Develop and agree plans for an interim interoperable IT system by October 2014 • Implement plans for an interim interoperable IT system by January 2015 • Develop a business case for a fully interoperable IT system by January 2015 • Develop a service specification for a fully interoperable IT system by February 2015 • Agree information governance for appropriate sharing across the health and care economy by April 2015 • Commission a fully interoperable IT system by June 2015 • Commission a Person Held Record by April 2016 • Develop plans for a Single Point of Access for Health and Social Care by November 2014 • Implement plans for a Single Point of Access for Health and Social Care by February 2015 • Monitor Single Point of Access from March 2015 • Develop linkage of the Health and Social Care Single Point of Access and the Transformation of LBH Customer Care by June 2015. • Commission Fully integrated Customer Care and Single Point of Access by September 2015

- Monitor delivery of LBH and CCG Care Act responsibilities from April 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The overarching BCF governance structure and programme management approach have already been agreed. The Integration Enablers Scheme and related services will be overseen by the Operational Management Board. This group is not fully established but the aim will be for it to be running by November 2014. The Chair is not yet confirmed but membership will be across all partners, providers and public including Haringey CCG, LBH, and managerial and clinical/delivery from acute, community healthcare and social care providers as well as patient/service user representation. The group will mainly oversee the development of interoperable IT and workforce strategies.

Once the Haringey BCF Plan has been submitted a detailed work-plan will be created for the Integration Enablers Scheme. The Commissioning Lead for the Better Care Fund (who is already in post) as overall programme manager will ensure that the implementation of the work plan is fully supported and monitored, escalating all issues and risks and providing an audit trail.

Interoperable IT will be overseen by the IT Integrated Leads Group jointly with Islington CCG. Haringey CCG has decided to partner Islington due to the shared Community Healthcare provider (The Whittington). The group will oversee the development of the IT interoperability business case and service specification.

Haringey CCG is in the process of establishing an overarching workforce training and development committee which will ultimately oversee all workforce programmes. Haringey has been successful in securing a Health Education Central East and North London (HENCEL) bid which includes listening events to co-create a training and development programme for all staff across health and social care (including primary care and third sector agencies) and the implementation of the resulting programme. A small steering group of workforce leads across Haringey CCG, LBH and provider organisations will be established by October 2014 to oversee implementation of the bid. This group will eventually form part of the wider training and development committee.

Within the current commissioning arrangement Haringey CCG will commission the interoperable IT solution. There is not a current provider for this solution but it is expected that this will be form the private sector.

LBH Commissioning will commission the Single Point of Access from the private sector.

Both the CCG and LBH will deliver their Care Act responsibilities.

Commissioning arrangements may change over the delivery of the BCF due to the development of a Section 75 agreement.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In order to deliver the ambitious scale and depth of integration proposed by Haringey CCG and LBH, it is recognised that the systems infrastructure needs to be redesigned to facilitate joint working, measure patient defined outcomes, share information and improve the user experience. This Scheme therefore represents a significant body of work to ensure underlying processes and systems actively support an approach based on integration, self-care, prevention and early intervention and reablement. As the Integration Enablers Scheme specifically supports the other schemes impacts have not been modelled and an evidence base is not presented.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
N/A
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Process measures for the impact of Integration Enablers (e.g number of people accessing the Single Point of Access, number of people accessing social care grants) will be developed. Monitoring of process and outcome measures using a pre-established monitoring framework will be reported into the Operational Management Board and the Integration Management Board at regular intervals.
What are the key success factors for implementation of this scheme?
As the Integration Enablers support the achievement of the other BCF Schemes they are the key success factors for the other schemes.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Haringey
Name of Provider organisation	**North Middlesex University Hospital NHS Trust (RAP)**
Name of Provider CEO	Julie Lowe
Signature (electronic or typed)	Julie Lowe

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	10,427
	2014/15 Plan	10,534
	2015/16 Plan	10,850
	14/15 Change compared to 13/14 outturn	1.0%
	15/16 Change compared to planned 14/15 outturn	3.0%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	188
	How many non-elective admissions is the BCF planned to prevent in 15-16?	251

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust acknowledges the methodology that has been applied within the CCG plan to derive the numbers quoted in the document that assess the potential impact. The Trust would reference that in its opinion 14/15 outturn will material exceed 14/15 plan levels, although that does not affect the estimated impact per se.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*N/A*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust acknowledges the potential impact that the BCF schemes included within the plan may have if successfully implemented. The Trust advises that further consideration be given within BCF plans to understanding the scope and nature of transitional arrangements that may be needed to support providers in withdrawing fixed and semi-fixed capacity.

Name of Health & Wellbeing Board	Haringey
Name of Provider organisation	**Whittington Hospital NHS Trust**
Name of Provider CEO	Simon Pleydell
Signature (electronic or typed)	 Siobhan Harrington, Deputy CEO

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	7,619
	2014/15 Plan	7662
	2015/16 Plan	7892
	14/15 Change compared to 13/14 outturn	0.6%
	15/16 Change compared to planned 14/15 outturn	3.0%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	141
	How many non-elective admissions is the BCF planned to prevent in 15-16?	188

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We agree that the data in terms of a reduction in non-elective admissions is in line with commissioners assumptions.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*N/A*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We continue to work through and consider the implications on services provided by our organisation. As an integrated care organisation we are identifying the benefits on community service provision of the local BCF plans.