Report for:	**Health and Wellbeing Board – 24th March 2015**

Title:	**Health and Care Integration Programme Update**

Report Authorised by:	**Zina Etheridge – Deputy Chief Executive, Haringey Council and Sarah Price – Chief Officer, Haringey CCG**

Lead Officer:	**Asad Butt, Interim Joint Integration Programme Manager**

1 Describe the issue under consideration

1.1 This paper provides an update on progress on the Health and Care Integration Programme report brought to the Health and Wellbeing Board on the 13th January 2015. This paper provides an overall update with greater detail around the Better Care Fund (BCF)

2 Cabinet Member introduction

2.1 Supporting everyone to be healthy and have a high quality of life for as long as possible is a core aim for the Council and its partners. Integrating health and social care so that care is person centred, joined up and meets their needs is core to that vision. The establishment of the health and social care programme is an important step towards delivering that integration. The high level vision and approach is now agreed, with planning and implementation of the initial focus areas under way.

3 Recommendations

3.1 The Health and Wellbeing Board is asked to note progress.

4 Alternative options considered

4.1 None

5 Background information

Overview

5.1 The Health and Social Care Integration Programme has been established to build on the strong relationship between the CCG and the Council to support Haringey in meeting its vision for Integrated Care, i.e.:

- 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. This means:
    - The individual's perspective should be at the heart of any discussions about integrated care
    - When planning and providing integrated care services the individual's perspective should be the organising principle of service delivery

5.2 The programme has good fit with the Corporate plan with its intent to implement a whole borough vision embedding the principles of prevention, early intervention and building community resilience and delivering services that matter to residents in a timely, effective, efficient and satisfactory way. There is particularly strong alignment to outcomes 1 & 2.

Governance

5.3 The governance model and programme structure can be found in Appendix A

5.4 The breadth and depth of the Integration Programme is such that it requires different levels of specialist and detailed oversight and steer. To ensure the appropriate people are involved, the governance structure consists of three layers,

- Strategic
    - Set the vision and ambition for integration in Haringey
    - Provide guidance and strategic direction
    - Make strategic decisions (impacting vision and direction of travel) within the agreed scope and principles
- Steering
    - Have the ultimate oversight of the Integration Programme
    - Steer the Integration Programme and associated projects
    - Ensure progress on track to achieve the agreed vision and goals set out for integration in Haringey
    - Make management decisions (enabling the programmes and projects to continue) within the agreed scope and principles

- Operational
    - Manage and direct projects (at an operational level)
    - Agree proposals for operationalisation of the integration plan which are developed through the projects
    - Ensure the projects are on track and progressing as expected
    - Make operational project decisions, within the agreed scope and plan, enabling the project to continue to deliver

5.5 This layered governance structure aligns with the existing governance that is already in place within the Council and the CCG.

Scope

5.6 The programme has agreed three key themes, integrated care for adults, children, and mental health and wellbeing. These themes align with the outcomes set out in Haringey's Health and Wellbeing Strategy, the Council's Corporate Plan and the 5 year strategy for CCGs in North Central London.

5.7 Within each theme, a number of projects / programmes have been identified to deliver the agreed integrated care vision, for that theme. Additionally, the Integration Programme includes cross cutting themes in the areas of technology and finance that will enable and support integrated commissioning and service delivery

5.8 The vision for the HACI Adults theme is to join up and co-ordinate health and care services in a way that:

- enables residents to be as healthy as possible for as long as possible
- enable residents to feel more supported by the community to be healthier and to live independently for longer
- ensures support will be provided at an earlier stage to residents who have difficulty in maintaining their health and wellbeing
- there are convenient and easily accessible services available near where people live
- ensures people are treated as quickly and safely as possible so they can return home and return to independence
- ensures residents assessed as needing formal care and / or health support will receive responsive, safe and high quality services
- jointly commissioned services are based on outcomes rather than activity
- all vulnerable adults will be safeguarded from abuse

5.9 The benefits of the Adults theme are expected to be:

- Increased joint working

- More people will have healthy lifestyles
- More residents will be engaged in employment, physical activity, sports and in volunteering
- The number of people feeling isolated
- Individuals enabled to do things for themselves
- Good and timely information
- Increased community capacity
- Reduction in non-elective admissions
- Reduction in permanent admissions to residential/nursing homes
- Increase in the proportion of older people still at home 91 days after discharge
- Reduced delayed transfers
- Improved GP patient survey results
- Decrease in falls injuries

5.10 Projects/programmes underway in the Adults theme are:

- Better Care Fund: encompassing actions to tackle health, for the first year, focusing on integrated service for frail older people (65+) to enable them live independently. Projects under the BCF include:
    - Design, develop and implement locality teams
    - Review Rapid Response service
    - Review Dementia Day Centre
    - Review and redesign Reablement Service
    - Review of Step Down Service
    - Review of home from hospital funding
    - Procure and monitor Neighbourhood connects
    - Monitor Palliative Care contract
    - Design, develop and implement approach to IT Interoperability
    - Design, develop and deliver a Workforce Development programme for 7 day working
- Value Based Commissioning: establishing models and approaches to commission services based on values / outcomes rather than activity; working in partnership with Enfield CCG.

5.11 Working Age Adults With Disabilities: revising the approach taken to providing support to Working age adults who have difficulty in maintaining their health and wellbeing.

5.12 The vision for .the Childrens theme is: By implementing an integrated approach for commissioning and service delivery we will enable every child and young person to have the best start in life, with high quality education. To deliver this:

- We will work with children, young people and families in a joined up way to co-produce solutions
- We will develop prevention, early intervention and targeted early help from conception to 25 years, so that children and families can thrive in their communities, with improved outcomes
- We will work together to reduce the need for more specialist support and seek to deliver provision in family and community settings wherever possible

5.13 The benefits of the Childrens theme are expected to be:

- Improved family and community resilience, with greater choice and control
- Thriving children, young people and families
- Strong partnerships making effective use of all resources, with an increased emphasis on early interventions & coordinated working

5.14 Projects/programmes underway in the Childrens theme are:

- SEND reforms Programme: implementing the changes set out in the Children and Families Act regarding special educational needs and disabilities (SEND) which came into effect from September 2014. Projects within SEND include:
    - Local offer
    - ECH Plan and assessment
    - Personal Budgets
    - Preparing for adulthood
    - Mediation
    - Joint Commissioning
    - Workforce development
    - ICT and IG
    - Communications and engagement
- Early Help Project (input): Providing input into the Childrens project considering the range of provision often described as prevention, early intervention and targeted early help, which may be delivered by universal services or by commissioned services. The governance for this project will be via the Haringey 54k Programme Board.

5.15 Transformation of Children and Young People Mental Health services: will review the tier1 to 4 services

5.16 An additional project is being considered in the area of “Facing the Future Together” looking at primary and acute children services.

5.17 The vision for .the Mental Health and Wellbeing theme is “All residents in Haringey are able to fulfil their mental health and wellbeing potential. Initial activities are focused on establishing a more joined up approach; where services are managed around the individual and where the person is able to live independently at home or locally in the community.” Our priorities are:

- Promoting mental health and wellbeing and preventing mental ill health across all ages;
- Improving the mental health outcomes of children and young people by commissioning and delivering effective, integrated interventions and treatments and by focusing on transition into adulthood;
- Improving mental health outcomes of adults and older people by focusing on the three main areas: meeting the needs of those most at risk; improving care for people in mental health crisis; improving the physical health of those with mental-ill health and vice versa;
- Commissioning and delivering an integrated enablement model which uses individuals, families and communities’ assets as an approach to support those living with mental illness to lead fulfilling lives.

5.18 The benefits of the Mental Health and Wellbeing theme are expected to be:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm and die by suicide
- Fewer people will experience stigma and discrimination

5.19 Projects/programmes underway in the Mental Health theme are:

- Mental Health Strategic Framework: setting the strategic direction and implementation approach for integrated mental health services in Haringey. This project will specify a delivery plan from which a series of projects will be defined.
- Mental Health Enablement Model currently contains two projects looking at the accommodation and employment needs of people with mental ill health.

Plan and Budget

5.20 The theme leads are working to define the outcomes, deliverables and plans at the next level of detail and this progress will be included in the next update to the board.

5.21 For the programmes and projects underway the plans are developed at a high level and the programme is now fleshing out the detail so we better understand the risks and budget.

5.22 Based on the current information it is expected that Integration projects already underway have the necessary agreement and approval of their requirements for resources and funding.

5.23 The table below indicates which projects have confirmed resourcing and budget . Where projects do not have confirmed resourcing and budget or need additional support, requests will be made to Integration Programme Steering for approval after the scoping has been completed

Theme	Projects	Resources confirmed	Budget agreed	Comments
Adults	Better Care Fund Projects	✓	✓	Confirmed for 2014/15 and 2015/16
	Value Based Commissioning Project	✓	✓	Confirmed for the development of the Business Case only. The Business Case will set out the requirements for delivery.
	Working Age Adults	×	×	Project currently being defined.
	Healthy Lifestyles	×	×	Project currently being defined.
Children	SEND Reforms Programme	✓	✓	A Programme Manager has been recruited 2 days a week. A new Joint Commissioner to represent the health aspects is in place.
	Facing the future together	×	×	Project currently being defined.
	Trasnsforming CAHMS services	×	×	Project currently being defined.
Mental Health and Wellbeing	Housing and support for people with MH	✓	✓	Covering the development of pathways only.
	Employment and support for people with MH	✓	✓	Agreed for this project to be managed together with the Housing project.
	MH Framework	✓	✓	Commissioning Leads driving the

				development. Additional resources will be required for implementation
Enablers	Interoperability IT	✗	✗	Project currently being defined.
	Integrated Financial Management	✗	✗	Project currently being defined.
	Self Management – Telehealth solutions	✗	✗	Project to be defined.

Better Care Fund

5.24 Overview

The Haringey Better Care Fund (BCF) Plan was submitted on the 19th September 2014. Following a national assurance process the Haringey BCF plan was formally approved by NHS England on 7th January 2015. The BCF is expected to deliver 705 fewer emergency hospital admissions over 2015/16. This is a £1.26m performance related target and this budget has been held back as a contingency fund in the event that the emergency hospital admissions target is not met.

In order to deliver a reduction in the performance related target, the initial focus of the Haringey BCF is on services for older people (65+), as the group most at risk of an emergency hospital admissions. Haringey CCG and LBH have approved plans for the use of the £22m BCF budget (2015/16) to review and deliver 19 services organised into four schemes:

Scheme	Service	2015/16
Scheme 1: Admission Avoidance	Locality Team	£ 11,649,297
	MDT	£ 266,000
	Lymphedema	£ 48,000
	Rapid Response	£ 482,067
	Overnight District Nursing Service	£ 204,000
	Dementia Day Centre	£ 475,000
	Recovery College	£ 620,000
	Falls Prevention	£ 80,000
Scheme 2: Effective Hospital Discharge	Reablement	£ 3,142,905
	Step Down	£ 625,000
	Home From Hospital	£ 150,000
Scheme 3: Promoting	Neighbourhood Connects	£ 270,000
	Palliative Care	£ 300,000

Independence	Supported Self-Management (Generic)	£	52,000
	Supported Self-Management (Diabetes)	£	64,600
Scheme 4: Integration Enablers	Interoperable IT	£	22,333
	Workforce Development	£	535,000
	Disabled Facilities	£	949,000
	Care Act Responsibilities	£	879,000
	Contingency	£	1,260,000
	TOTAL	**£**	**22,074,202**

Each scheme has a specific perspective on the integration of health and social care services to prevent emergency hospital admissions in older people:

- Scheme 1 will deliver services that will prevent health conditions from escalating to a crisis where emergency services are needed.
- Scheme 2 will deliver services that will facilitate discharge from hospital as quickly, safely and effectively as possible
- Scheme 3 will deliver services that build community capacity to reduce isolation and improve health and wellbeing
- Scheme 4 will deliver services that support the implementation of the first three schemes.

The BCF services are going through a business case/service review process in 2014/15 to ensure that BCF investment is being used on evidence based services that will deliver improvements to public and service user outcomes in the most effective and cost effective way.

5.25 Benefits expected

The Haringey BCF will be assessed against six outcome measures in 2015/16 and has set trajectories as part of the national assurance process:

Target	Increase/Decrease	Number	Saving
Emergency Admission Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	3.5% Decrease	705	£1,248,000
Care Homes Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	1.8% Decrease	2	£101,000
Reablement Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	1.7% Increase	6	£600
Delayed Transfers Delayed transfers of care (delayed days)	1.7% Decrease	0	

from hospital per 100,000 population (aged 18+)			
Patient Survey In the last 6 months, has the Service User received enough support from local services (not just health) to manage their long term health condition(s)? (Measure biannually)	1.2% Increase	N/A	
Falls Injuries due to falls in people aged 65 and over, per 100,000 people	4% Decrease	10	To be confirmed

As well as these outcome measures Haringey has surveyed over 200 local people and service users and has summarised their priorities into seven public and service user outcomes. Integrated services will (be):

1. **Easy to access**, through a single point of access
2. **Well managed** and provided by competent professionals and staff
3. **Person Centred** and personalised to the experiences and views of people who use them
4. **Provide good and timely information**, from a variety of sources including the voluntary and community sector
5. **Enable individuals to do things for themselves** through prevention , self-management and reablement
6. **Work together as one team**, including the patient/service user, with clear and constant communication
7. **Promote wellbeing and reduce loneliness** through community capacity building.

Services will be expected to demonstrate progress against these public defined outcomes and will be supported by public health to use the most effective method for measurement.

A case study of 'Harry Gray' has been developed to demonstrate how the proposed service changes will impact on service users. The case study was based on a live case known to services and which identified a number of issues and gaps in the system. The case was anonymised and used to test whether service user outcomes would be improved by the Haringey BCF (see appendix B).

5.26 Progress to date

The BCF has necessitated the development and implementation of a significant amount of programme planning and management including plan submissions, assurance processes, progress reports, stakeholder engagement, finance and performance frameworks and governance structures. Some of these processes and structures are now being finalised in readiness for the first year of delivery, from 1st April 2015.

Out of the 19 BCF services, three are new and the remaining 16 are either existing services or are further developed from existing services. The three new services are the locality team and the two supported self-management projects.

As part of the development of the locality team model we have rolled out several pieces of work that are being used to inform the development of the model in Haringey including:

- Multi-Disciplinary Team (MDT) teleconferences – a team of professionals discuss older patients who have attended A&E more than once in the last 6 months or have been recently discharged from hospital. The aim is to reduce further emergency attendances through improved communication between professionals and co-ordination of patient care across hospital and community settings.
- Unplanned admissions enhanced service – a scheme run by NHS England that pays GP practices to risk stratify their practice population, identify the top 2% at risk of an unplanned hospital admissions, identify a lead GP in the practice who then develops a basic care plan with the patient and records it on their IT system.
- GP collaborative care co-ordination projects – Between £50-60k of funding was provided to the four GP collaboratives by Haringey CCG as a quality premium to facilitate their further involvement in care planning targeting patients over 75 years old.
- Locality team test and learn pilot – the pilot was developed with the north east GP collaborative linking a nascent multi-disciplinary care co-ordination team with two to three GP practices to develop learning about the identification of the cohort, the role of the care co-ordinator and the processes of care co-ordination.

These projects are being managed by the Integration Implementation Group as part of the BCF governance process.

The evaluation of the locality team test and learn pilot will include the following components:

1. Patient surveys will compare patient reported experience of care and quality of life before and after the pilot projects. This is linked to the BCF public and service user defined outcomes.
2. Medical and social care use will be tracked using the patient's number.
3. Patient demographic information will be used to assess equity of access to the services,
4. An internet based staff survey will capture the experiences of staff involved in the pilots

The evidence from the test and learn pilot and the other local projects combined with national evidence of effectiveness, determined by public health, will be used to develop the Haringey locality team model and business case.

The two self-management projects include the following elements: a chronic disease self-management service, similar to an expert patient programme, which is generic for one project and diabetes specific for the other; a diabetes web based self-management tool; a diabetes DVD and workbook support package; and programme capacity building to sustain the programme going forward. Service specifications are being developed and these services will be commissioned, to start delivery in 2015/16. These services will be overseen by the Promoting Independence Group as part of the BCF governance.

The remaining 16 services are going through a similar cycle of review, communication and engagement with relevant stakeholders for the service, development of a business

case/commissioning plan and service specification, developing a performance framework, regular monitoring, and identifying opportunities for the service to be further integrated within the health and social care system.

The majority of the service reviews should be completed by the end of March 2015.

6 Comments of the Chief Finance Officer and financial implications

6.1 The prescribed Better Care Fund for 15/16 for Haringey is £16.5m revenue funding and a further £1.6m capital funding. In addition the London Borough of Haringey has chosen to create a joint budget for the integrated locality teams by adding a further £4m funding for social work, care management and occupational therapy making an overall Better Care Fund of £22m. It should be noted that none of this is new funding and it is mainly funding existing and ongoing services of high importance to local health and social care provisions. The introduction of the Better Care Fund requires the local authority and the NHS to work more closely together and jointly manage the BCF budget to achieve the desired outcomes.

6.2 This report also outlines a number of new further initiatives that are expected to deliver improved outcomes for local residents. Small amounts of funding are in place to cover the early work for these projects. The children's work is funded in 2014/15 from SEND reforms and the Mental Health work at this stage is being carried out within existing staff time and resources. The overall programme management costs are being included in 2014/15 in an Adults bid to the central transformation reserve.

6.3 Once further work is identified above these start up costs funding will have to be identified by one or other of the partners. Since both the Council and the NHS are currently experiencing a high level of budgetary pressure the amount of funding available will be extremely limited so a degree of prioritisation will probably be required.

7 Comments of the Assistant Director of Corporate Governance and legal implications

7.1 The Council's Assistant Director of Corporate Governance has been consulted about this report.

7.2 The Health and Care Integration programme is conducive to the Board's statutory duty to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population (Section 195 of the Health and Social Care Act 2012). The Integration Programme is also conducive to the Council's and the CCG's statutory powers to promote integrated commissioning and provision of services in health and social care. These powers are set out in Sections 75 of the National Health Services (NHS) Act 2006 (as amended) (arrangements between NHS bodies and local authorities for the delegation of functions), Sections 13N and 14Z1 of the NHS Act 2006 (14Z1 Duty as to promoting integration), Sections 25 and 26 of the Children and families Act 2014 (Education, health and care provision: integration and joint commissioning)

and Section 3 of the Care Act 2014 (Promoting integration of care and support with health services etc)

8 Equalities and Community Cohesion Comments

8.1 The proposed Health and Care Integration Programme is designed to provide health and social care services that produce better outcomes and a better experience for all local people. As a result it serves the interests of all protected groups, whose health and wellbeing it promotes, and is aligned with the Council's commitment to equalities.

8.2 Equality impact assessments will be carried out as part of the project planning and delivery process.

9 Head of Procurement Comments

9.1 N/A There are no direct procurement implications arising out of this report however as and when the projects identify procurement requirements the appropriate processes will be followed.

10 Policy Implication

10.1 Integration of health and social care is a national policy arising from the Better Care Fund and Care Act Implementation and this programme of work will complement and add value to work under this remit.

11 Reasons for Decision

Not applicable.

12 Use of Appendices

Appendix A: Governance Model and Programme Structure
Appendix B: Better Care Fund case study