Haringey
LONDON

Transformation Programme

Developing a Medium-Term Integrated Target Operating Model

(Objectives & How Statements)

DATE: 12 August 2016

VERSION 14.0

Haringey LONDON

CONTENTS

[1] **P2 Objective 5**: All Vulnerable Adults Will be Safeguarded from Abuse is treated as one of a set of Overarching (or 'cross-cutting') Statements which apply equally to each P2 Objective, and will be used more generally to help steer the development of our Integrated Target Operating Model. For further details, please refer to the Introduction.

Introduction

The development of a set of pithy, meaningful and readily understood statements (referred to as 'How Statements') that explain **how we will deliver** on a range of goals (and hence our P2 Objectives) is a key stage in the development of our Integrated Target Operating Model - as these will be used to guide the development of this.

The How Statements have been developed for each P2 Objective by the Transformation Team working alongside the SRO Owners for each of these. As part of the development process they have also been reviewed by range of senior managers from across Health, Public Health and Adult Social Services at two Validation Workshops (on 14 July and 05 August) to make sure that they:

- Are unambiguous, comprehensive and robust
- Are integrated - across the P2 Objectives
- Do not contradict one another
- Form a consolidated set of statements that can be used as the basis for designing our future service operating model
- Reflect our level of ambition for the future

A set of Overarching (or 'cross-cutting) How Statements (which apply equally to each P2 Objective, and will be used more generally to help steer the development of our Integrated Target Operating Model) have also been developed to sit alongside those for each P2 Objective:

- Maximising service users and carer's independence
- Achieving financial sustainability
- Prevention
- Working with communities
- Creating a fair and equal Borough, by investing a proportionate amount of effort into those who need it most
- Safeguarding vulnerable adults from abuse

Both the Overarching How Statements and those developed for each P2 Objective were 'signed off' at P2 Steering Group on 10 August. The remainder of this document contains details of the How Statements that have been developed for each P2 Objective.

Haringey LONDON

Integrated Target Operating Model: Objectives & How Statements

P2 Objective	Objective	How we will do this	Measures (examples to be further developed)
Objective 1 A Borough where the healthier choice is the easier choice	**Primary Prevention Population Health Objective** I live in a borough, that no matter where I live, it is easy to make healthy choices about the way I live my life, and often I don't even realise I make these choices **Equality Objective** I want to live in a borough that is inclusive and works to reduce inequalities **Primary Prevention Personal health Objective** I have access to	By understanding the health needs in the borough, so that we are able to target efforts and adapt our approach, in order to reduce health inequalities By working to ensure health outcomes are embedded across the policies and actions of the council and partner organisations, for example workforce policies, regeneration, housing, licensing and planning By advocating for increased powers for the council to shape a healthier borough By influencing our partners including local businesses to be health promoting and inclusive organisations By working with our partners and communities to advocate and campaign for a healthy Haringey By training frontline staff in the council and partner organisations to feel more confident in recognising poor mental health or unhealthy behaviours and to support behaviour change or access to support services By ensuring that residents are able to access health information, advice and a range of health promotion services in accessible settings, for example community pharmacists.	• The life expectancy gap across the Borough will reduce • Age-standardised rate of mortality considered preventable from stroke in those aged <75 per 100,000 population • Artrial Fibrillation measure being developed - e.g. Observed/estimated prevalence of atrial fibrillation • The proportion of overweight or obese children at year 6 (ages 10-11) *(Adults not currently measured to be developed)* • The proportion of adults participating in less than 30 minutes of physical activity per week

P2 Objective	Objective	How we will do this	Measures (examples to be further developed)
	information and support to what I need, to keep myself healthy and safe or take steps to address any unhealthy Behaviours	By providing information and support in an accessible and equitable way, so that all residents can lead healthy lives	• The proportion of people who travel by bicycle in London where trip origin is in Haringey • The proportion of people who travel by walking in London where trip origin is in Haringey
Objective 2 Strong communities, where residents are healthier & live independent, fulfilling lives	**Primary Prevention Community Health Objective** I come together with other people to find ways we can support each other or make our neighbourhoods a healthy more fulfilling place to live	By working with the voluntary and community sector to develop volunteering and peer support roles and enabling people in our community to come together around an issue or problem and develop shared solutions By facilitating the creation of support networks such as community hubs, peer support group and area-based initiatives through effective use of social media and community organising approaches By co-designing, co-producing and co-delivering solutions with our community.	**Outcome measures:** • Reduction in Alcohol-related admissions • Increase in early diagnosis of HIV • Reduction in STIs • Average Warwick-Edinburgh wellbeing score for adults

P2 Objective	Objective	How we will do this	Measures (examples to be further developed)
	Safeguarding Objective I know that I am safe from abuse by others	By making sure that safeguarding is everybody's business, with communities playing a part in preventing, identifying and reporting neglect and abuse	**Process measures:** • Hypertension measure being developed e.g. proportion of people who have high blood pressure whose blood pressure is controlled (BP<150/90) **Financial measures:** To be developed
Objective 3 Support at an earlier stage for residents who have difficulty in maintaining their health and wellbeing	I have the information and support I need to remain as independent as possible I am able to view a menu of services that helps me understand the support that I am able to access at all times I have access to easy-to-understand	By ensuring people, and their carers, needs are met at first contact with community and statutory services without being passed between services By identifying early those people who could benefit from technology and Assistive Technology By ensuring good quality information and advice when people first contact all services that will help them to navigate the systems By working with agencies to ensure that they have processes and systems in place that are clear and simple and early identify and prevent escalation of risk By developing points in the community to be better able to target	**Outcome measures:** • Reduction in the number of people requiring ongoing formal care • Increase in the number of people accessing community resources • Increase in the number of people who are satisfied with the information that they receive

P2 Objective	Objective	How we will do this	Measures (examples to be further developed)
	information about my care, support and community which is consistent, accurate, accessible and up to date I want my health needs identified early to help me make informed choices and self manage risks to my health I have access to 7 day a week services that help me to avoid hospital admission and support my continuing recovery If I'm at higher risk of a disease or losing my independence the early stages of a disease, I am offered the opportunity to know this, and supported to make changes to reduce	those people at risk of deterioration By supporting and influencing the development of diverse and representative voluntary and community sector services By ensuring that services procured achieve value for money and better outcomes for people By ensuring that people are able to have all of the relevant information on their care, community and health available to help them manage their condition By identifying early those people who are socially isolated and frequently attend primary and secondary care By developing a cohesive pathway between a range of agencies and services to improve the quality of information given to people to ensure that their holistic needs are better met By helping those with complex needs to self manage these needs and help those in recovery to help themselves By developing out of hospital pathways to prevent hospital or nursing home admission and help facilitate safe and rapid discharges from hospital and avoiding re-admission and supporting older peoples recovery By ensuring that contact entry points are easily accessible and widely known about so that people don't fall through the net	• Increase in the number of people who have Assistive Technology • Increase in the number of carers who are in receipt of the right level of support • A reduction in the number of complex patients being admitted to hospital • Increase in the number of people who complete their recovery programme • Increase in the number of people who remain drug and alcohol free following completion of their recovery programme • A reduction in the number of people re-admitted to hospital and to a recovery programme • A reduction in non-elective admissions to hospital and

P2 Objective	Objective	How we will do this	Measures (examples to be further developed)
	the negative impact on my life If my disease or condition gets worse, I get the support I need to get me back on my feet as soon as possible, or to manage it so that it doesn't get worse and I can continue to lead a fulfilling and independent life I enjoy the support of others with similar difficulties to myself, so we can support each other to have full and meaningful lives I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help	By giving individuals the right information about how to recognise abuse and what they can do to keep themselves safe and giving them clear and simple information about how to report abuse	permanent admission to residential and nursing care **Process measures:** • Decrease in the number of repeated calls to adult social services • Increase in the number of multi – disciplinary assessments leading to holistic outcomes **Financial measures:** • Reduction in the cost of long term care • A reduction in the cost of non elective admissions to hospital and permanent care

P2 Objective	Objective	How we will do this	Measures (examples to be further developed)
Objective 4 Those whose need care and / or health support will receive responsive and high quality services	I am in control of planning the support I need to manage my health and social care needs I have access to a menu of services and help me access the support I need through self directed support I have access to opportunities that enable me to play a full part in society and support me to reach my potential I feel safe, I can live the life I want and I am supported to manage any risks I receive quality services that are timely, responsive and safe	By providing interventions that maximise independence and helps people to regain skills and confidence which minimises the amount of time spent in contact with services By providing person centred planning and interventions that help to support people to fully utilise their local networks and communities By working collaboratively with colleagues across health, housing and other agencies to avoid duplication and ensure that their assessment addresses peoples holistic needs By designing a whole system that supports safe and speedy discharges for Haringey residents within all hospitals By ensuring education, support and advice is shared across organisational boundaries to help inform decision making By providing efficient reablement / enablement services that offer value for money for Haringey residents, council and NHS By ensuring that all people, including their carers, in receipt of care have their health and care needs reviewed at timely intervals By developing pathways that take account of the persons wishes, feelings and choices at the end of their life By ensuring that people can readily get in touch with someone to raise concerns and there are mechanisms in place to ensure feedback	**Outcome measures:** • A reduction in the number of people moving permanently into institutionalised care • Increase in the number of people who believe that their personal outcomes have been met • Increase in the number of people managing their own support as much as they wish • Reduction in the number of people receiving on-going social care support • Number of people with a goal focussed reablement plan in place • Reduction in the number of people readmitted back to hospital after 91 days

P2 Objective	Objective	How we will do this	Measures (examples to be further developed)
	I am confident that no long term decisions will be made about my health and social care needs when I am in crisis but I will be supported through this I am a carer who has a life outside of my caring role and have my needs reviewed regularly I have a network of people who support me, carers, family, friends, community and if needed paid support staff I am confident that professionals working with me are working together, consult with me and help me make the right decision about my needs at the right	By ensuring that the workforce across all service areas has the capabilities and capacity to deliver a high quality services that are quality assured By designing an integrated service that assesses, plans and agrees discharge planning By developing an IT system to be used across an integrated health and social care system By working together across professional boundaries to ensure that communication is clear and consistent By ensuring that care is delivered and meets the needs of the person 7 days a week through the development of integrated services By ensuring that paid support staff are available By commissioning services as a system, maintaining staff and market development to ensure there is a constant service delivery By ensuring the roles of all agencies are clear, together with the lines of accountability and that staff understand what is expected of them and others By ensuring agencies recognise their responsibilities to each other, act upon them and accept collective responsibility for safeguarding arrangements	**Process measures:** • Consistent application of equality and eligibility criteria • All reviews completed in year • Increase in the number of referrals to the Haringey Reablement Service • Number of initial reablement assessments started within 2 working days from acceptance of new referral • 95% of patients having an Estimated Discharge Date within 24 hours **Finance measures:** • Reduction in the number of Delayed Transfers of Care • Reduction in the cost of care packages at the start of the reablement period compared to the completion of reablement

P2 Objective	Objective	How we will do this	Measures (examples to be further developed)
	time I will get help to support to report abuse I get help to take part in the safeguarding process to the extent of which I want to and to which I am able to - **Cross-cutting Secondary and Tertiary Community Health Objective**		• 3 day reduction on the average length of stay for complex discharge • Reduction of 10 patients from the medically optimised list per month