Haringey's Design Framework for Integrated Health & Care

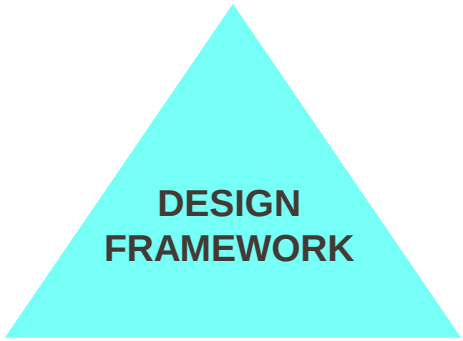
Summary – April 2017

Background

The scale of the demand and financial challenges for health and social care, driven by demographic changes and national spending decisions, has driven a new approach to designing our future local services. Since April 2016 there has been significant engagement between health, public health and social care to define a model for integrated health and care that can improve outcomes for residents as well as move our services towards financial sustainability.

Recognising the complexity of the system we are seeking to change, we have developed a Design Framework to ensure that we have a shared point of reference for defining and agreeing how we use our resources and design our services in the future. This with help us to navigate consistently between where we are starting from, the aspirations for the system and the significant constraints we are working within.

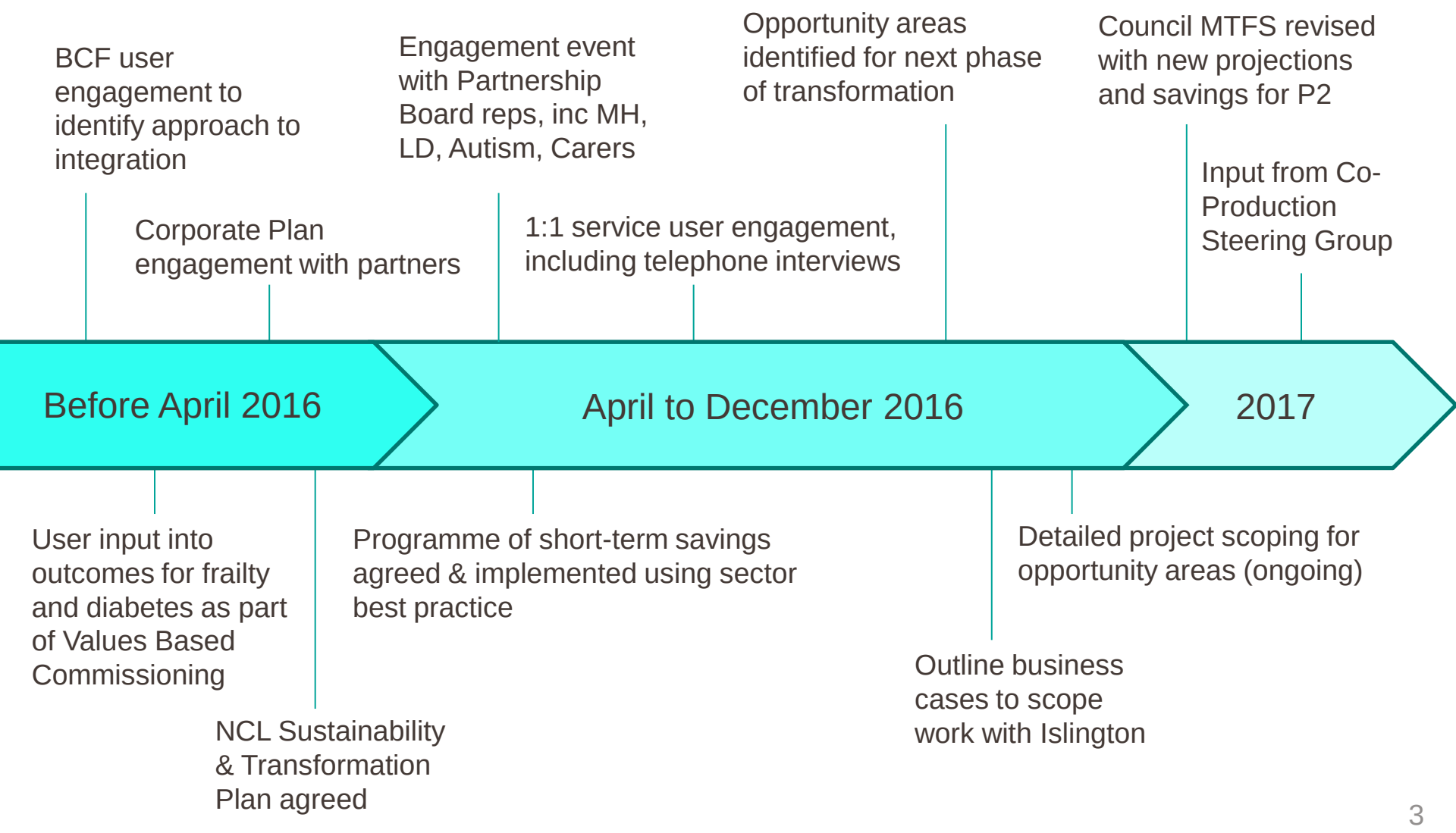
Where we are now
-Progress to date
-Budget position



Where we want to be
-Vision & objectives
-'I statements'
-Outcome measures

What the constraints are
-Financial pressures
-Demographic pressures
-National & regional expectations

Inputs to the design framework



Engaging at different levels

The Design Framework is a living document that will inform but also be shaped by our transformation. It will be used as a starting point as we work across different scales to design future health and care services with Islington and other boroughs in North Central London. It will also be used to engage other Haringey stakeholders in our strategy for health and care, including other council services, community groups and residents themselves.

*Our future health and care model needs to be **broader**, to reflect the benefits of delivering or commissioning for larger populations.*

*Our future health and care model needs to be **deeper**, reflecting the need to address population- and community-level determinants of health outcomes as well as the design & quality of services.*

Haringey's Design Framework for Integrated Health & Care

Three Key Components

Elements of the Framework

The Design Framework contains three elements that we will continue to develop and build on with our partners and stakeholders across Haringey, as well as with Islington and the wider North Central London.

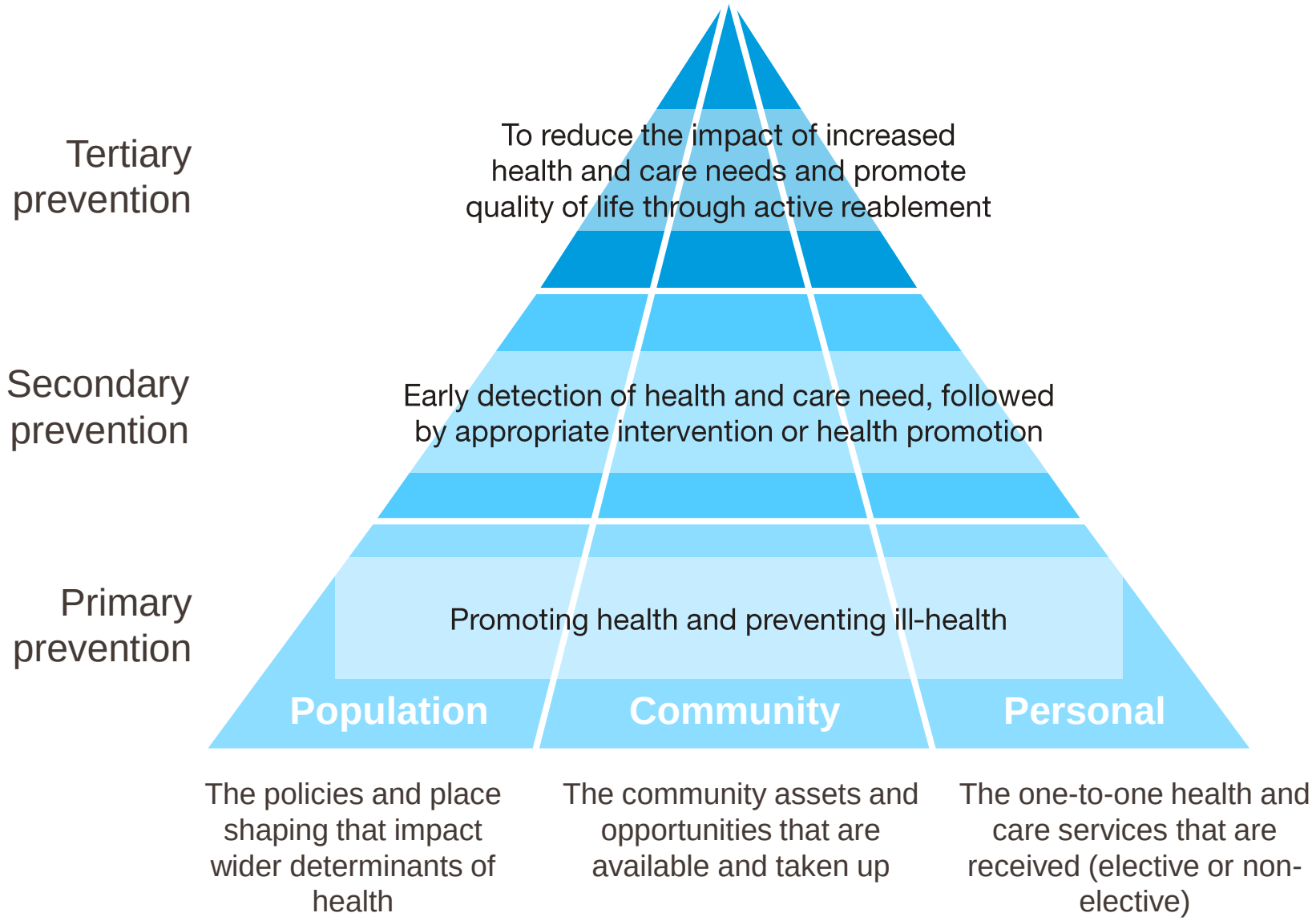
1. Prevention pyramid – sets out our whole population approach to health and wellbeing, reflecting the need to consider how we can support healthy, long and fulfilling lives for everyone by preventing or intervening early; it also sets out the contribution that is made to health and wellbeing by what happens in and is provided by our communities and the overall policy and place-shaping decisions we make.

2. Design principles – these provide the criteria for all of our transformation to ensure strategic fit of each of the parts to the overall direction of travel for health and care; the principles reflect how we know our offer needs to change if we are to balance the constraints and the aspirations we have for health and care.

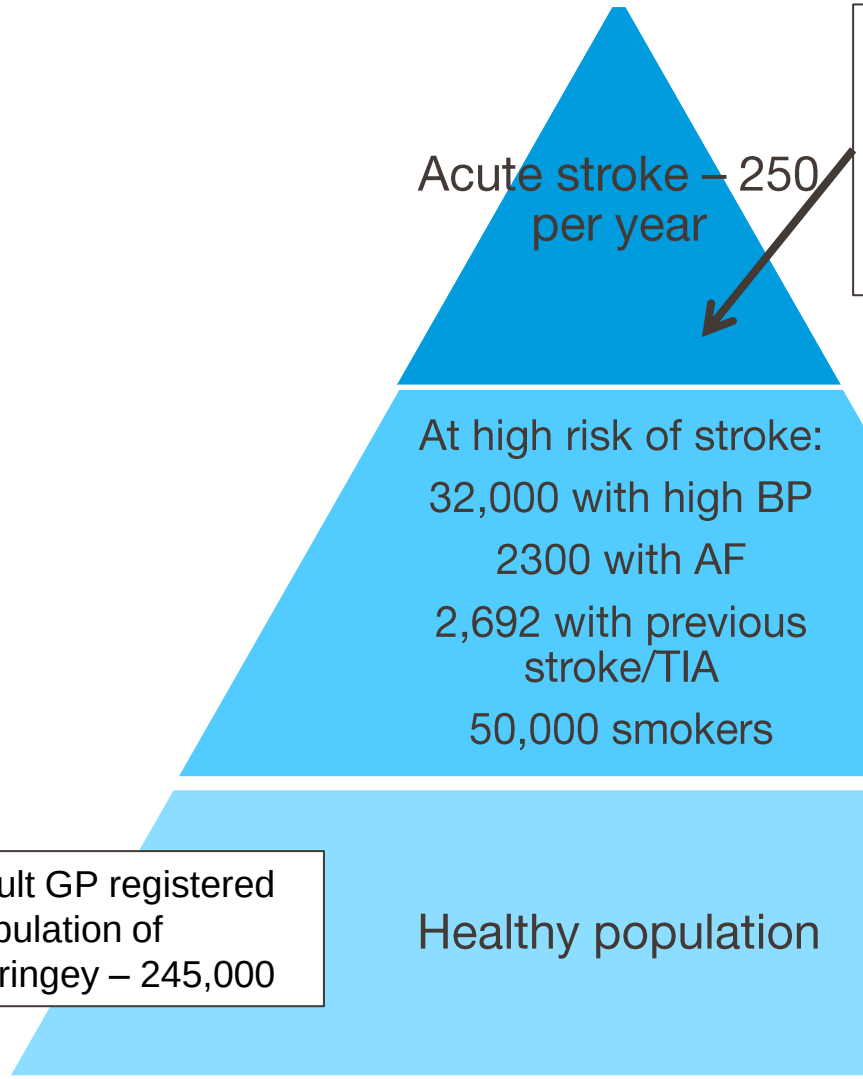
3. Objectives and outcomes – based around the five objectives for Priority 2 in the Corporate Plan, we are developing a set of pithy, person-centred 'I statements' that summarise our shared aspirations for how Haringey residents will experience integrated health and care – in many cases, these do not describe the system as it currently works for people but indicate how we think it needs to work in future. We have also revised the outcome metrics for each objective to ensure we are aligning our transformation work with the outcomes that matter most.

We recognise that the Design Framework in its current form cannot reflect the diversity of experience or needs of our population, particularly those who need specialist services, so we aim to build on the generic framework by exploring with service users and carers how it applies to different cohorts.

The prevention pyramid – our whole population approach to health & wellbeing



Example: taking a whole population approach to stroke – prevalence of need



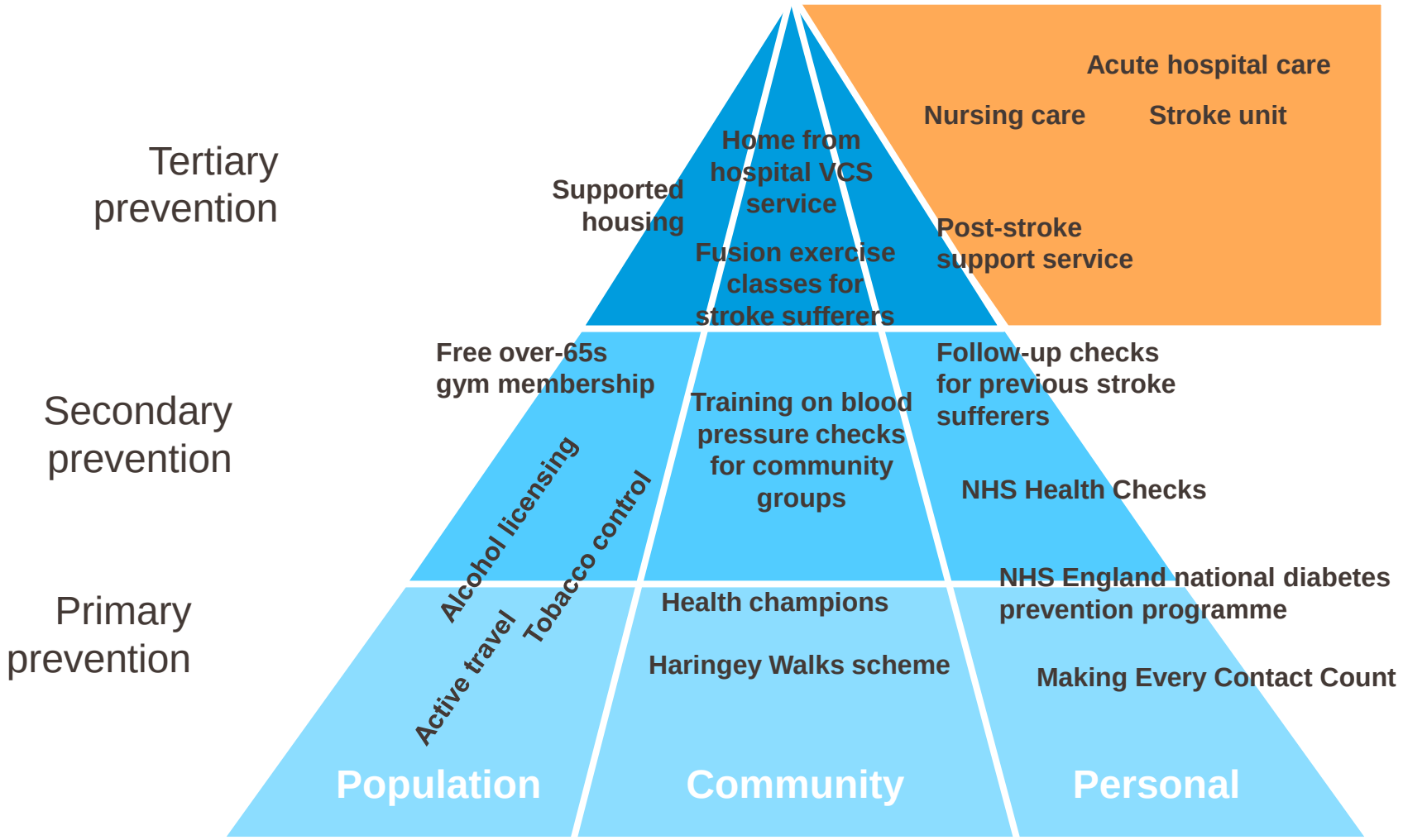
•Estimated annual cost of care following acute stroke in Haringey - £6.2million.
•Focus in London has been on centralising stroke services
•Has resulted in 1% reduction in mortality and cost savings

•Care for this cohort happens in primary care
•Quality of care variable
•Less focus on intervention and improvement at this level, but 80% of strokes preventable,
•Little investment beyond core primary care contracts – cost of care not known

•Public health programmes financed by local government
•less than £1 million on CVD prevention

Adult GP registered population of Haringey – 245,000

Example: taking a whole population approach to stroke – our current offer



Design Principles

There are six guiding principles that underpin our integrated vision for health and care in Haringey:

- **Prevention** – taking every opportunity to support healthy and fulfilling lives by preventing the emergence or escalation of health and care needs and reducing the long-run need for services
- **Stronger in communities** – working with residents, the voluntary sector and providers to ensure more of their needs can be met in a community setting and reflect their personal networks and relationships
- **Maximising independence** – helping residents, patients and service users to find ways to maintain control of their lives and their health and to receive services that are proportionate to changing needs and capabilities
- **Integrating health & care** – designing and commissioning services jointly so that resources are allocated in the most effective way and residents' experience of maintaining or regaining their health and independence is joined-up and supportive
- **A fair & equal borough** – recognising the diversity of our communities and how different groups experience risk and vulnerability so that we can reduce inequalities in their health and wellbeing
- **Co-design** – ensuring that we actively engage all stakeholders in identifying the detailed models of future services and how we will be using our resources, in particular working with users, carers and their representatives in a transparent and evidence-based

We are supporting people to make positive, informed choices about their health and wellbeing

Objective 1
A Borough where the Healthier Choice is the Easier Choice

- I find it easy to make healthy choices about the way I live my life, regardless of where I live in the borough, and often I don't even realise I make these choices.
- I have access to information and support to keep myself healthy and safe or take steps to address any unhealthy behaviours.
- I live in a borough that is inclusive and works to reduce inequalities in the health and wellbeing of its residents.

- Mortality Rate from Cardiovascular Disease (CVD) in people under 75
- Excess weight in Adults
- Smoking prevalence in adults
- Hospital admissions for alcohol-related conditions.
- Number and proportion of residents with undiagnosed and uncontrolled hypertension
- Acute STIs (including all STIs)

Progress to date

- Adopted 'health in all policies' approach within the council, recognising the impact of decisions such as licensing and planning.
- Established the Obesity Alliance and engaged a wide range of local stakeholders in recognising and challenging causes of obesity.
- Roll-out of 'healthy schools' accreditation.
- Initiated a pilot intervention for people on sick leave due to mental health to support improved outcomes returning to work.
- Offered free gym membership for over 65s to promote healthy and active lifestyles
- Established Haringey Walks initiative and campaigning.

Our future model

- Increase the council's powers to create healthy environments locally through clear asks of central government on devolution of powers.
- Work with our regeneration and housing colleagues to incorporate healthy design and planning principles into future developments.
- Improve the quality and amount of information & advice available to residents for healthy living, working with the CCG
- Working with local health providers, including hospitals, to recognise and affect the wider determinants of health.
- Develop the ability of the local workforce to 'make every contact count' for improving health behaviours

We are working with our communities and the voluntary sector so they can support wellbeing

Objective 2
Strong Communities, where Residents are Healthier & Live Independent, Fulfilling Lives

- 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
- I enjoy the support of others with similar interests and challenges to myself, so we can support each other to have full and meaningful lives
- I have a network of people who care for me – carers, family, and friends – in addition to any support staff I might required.
- I feel welcomed in my local community and valued for the contribution I can make
- I know where to get information about what is going on in my community.

- Proportion of residents that reported high or very high levels of life satisfaction
- Proportion of individuals who had participated in voluntary work in the past 12 months
- Proportion of carers whose health had been affected by their caring role
- Number of members for Time Credits schemes

Progress to date

- Haringey Advice Partnership established with Citizen's Advice to provide a first point of contact in the community for information, advice & guidance
- Updated and improved the availability of information about community groups and services on Haricare, reducing the number of unnecessary calls to Integrated Assessment Team
- Appointment of a strategic partner, Bridge Renewal Trust, to help develop community assets and build capacity in the voluntary sector.

Our future model

- Information and signposting to an up-to-date directory of community services online
- Delivering more of our health and social care services in community settings to improve links, including Care Closer To Home Integrated Networks
- Local area coordination, with a particular focus on MH & substance misuse to improve access to community services
- Improvements to the carer support service and a renewed local offer for carers that draws together contributions from across local partners to make caring easier and more sustainable
- Improving the quality of community services and ensuring they are providing the right support to local populations.

We are joining-up health and care to provide services that keep people at home & independent

Objective 3
Support at an Earlier Stage for Residents who have Difficulty in Maintaining their Health and Wellbeing

- If I'm at higher risk of a disease or losing my independence, I am offered the opportunity to know this, and supported to make changes to reduce the negative impact on my life
- I am provided with the information and choices I need to remain as independent as possible, managing my own health and care where possible.
- I have systems in place so that I can easily get help at an early stage to avoid a crisis and remain in my home.
- All long term decisions about my health and social care are made when my health needs have stabilised and I am at home
- If my health or condition deteriorate, I get support that is focused on maximising my independence and helping me to regain skills and confidence

- Total Non-elective admissions to hospital.
- Injuries due to falls in people aged 65+ (BCF measure)
- Permanent residential and nursing care home admissions for the 18-64 population
- Permanent residential and nursing care home admissions for the 65+ population.
- Proportion of older people 65 and over who were still at home 91 days after discharge into reablement / rehabilitation services (BCF measure)

Progress to date

- Locally commissioned service in place for stroke prevention, including identification and treatment of hypertension.
- Increased capacity of the Reablement Team and increased the number of clients receiving six weeks of support to regain independence, particularly from hospital.
- Improved intermediate care (including home-based rapid response and out of hospital beds) to reduce non-elective admissions to hospital due to falls for the over 65s
- Improved discharges from North Middlesex hospital has resulted in a 20% reduction in the number of delayed days in hospital for 2016-17 compared to 2015-16.
- Extended opening for GPs across four 'hubs', including two until 8.30pm Monday-Friday and 8am–8pm Saturday & Sunday

Our future model

- Single point of access for out of hospital services to improve crisis management and prevent unnecessary admissions, including enhanced rapid response and use of 'virtual wards' to enable more clients to be supported to remain at home
- Improving the guidance and support for patients to identify and manage long-term health conditions, including new secondary prevention services for diabetes, kidney disease and mental health to be commissioned over the 2017/18 and 2018/19/
- Working across Haringey and Islington to identify older people with frailty and test interventions to support and prevent a health and care crisis
- Adult social care 'first response' and short-term teams to provide problem solving for clients that helps them to regain independence, including increased use of assistive technology and reablement.

We are focusing services on maximising independence, with flexible choice & control

Objective 4
Those who Need Care and /or Health Support will Receive Responsive & High Quality Services

- I am in control of planning the support I need to manage my health and social care needs
- 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 time.
- I receive quality services that are timely, responsive and safe.
- I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this.
- I am able to develop a package of support can decide the kind of support I need and when, where and how to receive it.

- Overall satisfaction of people who use services with care and support
- Delayed transfers of care (delayed days) from hospital per 100,000 population (18+) (BCF measure)
- Percentage of care homes in Haringey rated as good or outstanding for quality
- Percentage of people in the last six months who have enough support from local services/organisations to help manage long term health conditions (BCF measure)

Progress to date

- Developing new approaches and improving the skills mix in hospital discharge teams to reduce unnecessary referrals to social care from hospitals.
- Implemented a 'day opportunities' offer for Older People and adults with learning disabilities, replacing council day centres with more personalised alternatives that encourage independence
- Improved our processes for reviews for care packages and adjusted packages where they were not well targeted to promote independence for the individual based on changing needs

Our future model

- Extending the availability of assistive technologies as part of a care package in order to maximise independence
- Increased availability of supported living placements as an alternative to residential
- Multi-disciplinary teams for those with long-run social care needs to ensure health conditions are also managed
- Developing our workforce to embed the principles of 'maximising independence' through our assessments, reviews and care planning to ensure all clients are helped to progress towards identified goals
- Use of an integrated digital record across health and care to improve the ability of health and care practitioners to join-up
- Improved quality of support for those who receive direct payments to maximise choice and control

We are making safeguarding everyone's business to reduce the risk for vulnerable people

Objective 5
Safeguard vulnerable adults from abuse

- I know that I am safe from abuse by others
- I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help
- I know that those around me would know if I was at risk and would help me to address my vulnerability
- 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

- Meet the outcomes defined by the person subject to a safeguarding intervention*
- Rate of Section-42 Enquiries
- Proportion of people who use services, who say that those services have made them feel safe and secure.

Progress to date

- Embedding the principles of Making Safeguarding Personal to enhance involvement, choice and control for the individual subject to a safeguarding concern
- Improved the proportion of people subject to a safeguarding intervention who say that outcomes partly or fully met.
- Reduced the number of Section 42 enquiries in Haringey to closer to our comparator boroughs by screening cases only requiring advice, information and signposting
- Improved the proportion of service users who report feeling safe and secure in those services to above the London average.

Our future model

- Focus on improving the quality of our directly delivered and commissioned services to put in place a preventative approach to safeguarding risk
- Increase the coordination and impact of our work with partners through the Haringey Safeguarding Adults Board to ensure it is a shared agenda locally
- Raise awareness of safeguarding among our residents and improve the information and advice available beyond those receiving formal services
- Further develop the awareness and skills of clinical staff across Haringey's health providers to ensure issues are raised and dealt with.