Report for:	Adults Health and Scrutiny Panel on 10th October 2017
Item number:	**9**
Title:	Future Model of Health and Care in Haringey - Discharge pathways and market development
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Ward(s) affected:	All
Report for Key/ Non Key Decision:	**Non Key Decision**

1. Describe the issue under consideration

1.1 The purpose of this report is to provide Adult Health & Scrutiny Panel (AHSP) an update on the Haringey's Design Framework for Integrating Health and Social Care, with a particular focus on the work across health and social care to improve discharge from hospital pathways and market developments to support this.

1.2 This builds on the AHSP meeting in September 2016 and the MLD sessions that took place during 2016/17 on Haringey's Design Framework for Integrated Care/Integrated Target Operating Model.

2. Recommendations

2.1 Adult Health & Scrutiny Panel is asked to:

A) Consider and comment on the progress provided in this report

3. Background information

3.1 Vision

3.1.1 Our vision for all adults in Haringey emphasizes the values which promote and maximize an individual's wellbeing, independence, dignity, choice and control, shifting away from institutional care towards community and home based solutions where appropriate. This approach is embodied by Priority 2

of the Council's current Corporate Plan, which seeks to 'empower all adults to live healthy long and fulfilling lives.'

3.1.2 Haringey Council is seeking a step-change in outcomes for health and care service users, while meeting the challenges of rising demand, shrinking budgets and increasing statutory responsibilities. Yet Haringey, traditionally seen as an Outer London borough, has a comparatively smaller funding base for adult care services than our neighbouring inner-London boroughs, despite the local population facing comparable inner-city levels of deprivation and health inequalities.

3.2 Whole system leadership to better support our residents

3.2.1 Responding to these challenges the Council and its partners have developed an ambitious transformation programme since early 2016. This seeks to put Haringey residents and service users at the centre of our decision-making, ensuring the whole system focuses on those people at risk of losing their independence and declining health.

3.2.2 Strategic leadership from the Council and collaboration between partners and stakeholders, both within the borough and across the North Central London Sustainability and Transformation Plan (STP) area, is at the heart of Haringey's approach to achieving better outcomes for health and social care users.

3.2.3 ***Haringey's Design Framework for Integrated Care*** is a jointly-developed framework for local Council, CCG and Public Health services, defining and agreeing how we use local resources and design services for the future. This has been developed to help us navigate consistently between our starting position, the aspirations for the system and the significant constraints we are working within. It is built around six design principles, informed by local priorities, national best practice, and expertise from the likes of Professor John Bolton, advisor to the LGA on Adult Social Care efficiency:

- Prevention
- Stronger in communities
- Maximising wellbeing & independence
- Integrating health and care
- A fair and equal borough
- Co-design with residents and service users

3.3 Working together to solve a shared problem

3.3.1 To deliver this ambitious whole system transformation we have first needed to focus on creating the strong local foundations required. A critical area where this has demonstrably improved outcomes has been in ensuring those residents who have difficulty maintaining their health and wellbeing can access effective home and community services, particularly when they have been in hospital and are returning home.

A 2015 review highlighted that our intermediate care service (those that help both prevent admission to hospital and those that help them return home in a timely manner), including the Councils reablement service, did not deliver the best outcomes for residents, support joined up working or always deliver value for money.

The review highlighted some of the key issues we needed to resolve as a health and care system:

- High numbers of residents experienced unnecessarily long lengths of stay in hospital. On average it took 10 days for a resident to receive an assessment in hospital to facilitate their safe discharge. This was in part reflected by the high number of reportable Delayed Transfers of Care (DOTC) cases, attributable to social care, in our partner hospitals.
- Haringey's reablement service was not easily able to demonstrate the improvement in the health and independence of those people who had accessed it, it also had significant unit costs and did not offer value for money in services for residents
- LB Haringey's Integrated Access Team's (IAT) workload was not strongly focused on ensuring successful transitions for residents into community-based care, but rather 80% of their time was taken up on the complex administration of Assessment and Discharge Notices, a paperwork processing function.
- Residents were not always receiving the support they needed from health or social care, both when leaving hospital and when experiencing a crisis at home. This was due to the fact that no agreed pathway, to define health and care roles within the system, had been jointly agreed. This caused confusion around who was responsible for care co-ordination and support and critical times.

3.4 Laying foundations for transformation – Developments and Progress

3.4.1 Haringey, with its partners in neighbouring hospitals and the CCG, developed an innovative programme of work to address these issues. Case studies, which will be presented for discussion at AHSP, provide the context of the new or improved approaches and the experiential difference for Haringey residents. The following provides the detail of the steps taken to deliver the improvements:

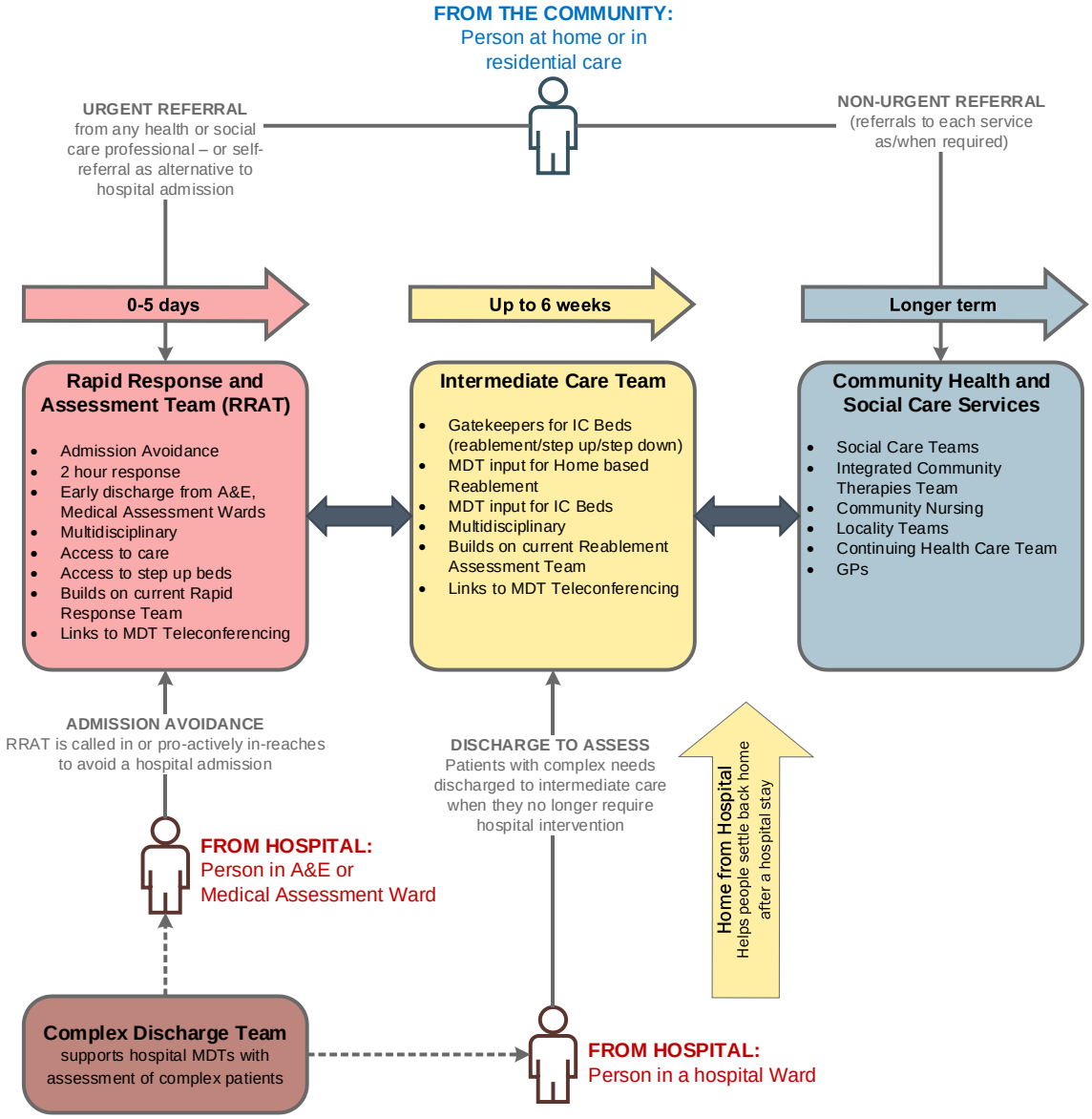
i. System Leadership - Head of Integrated Care Role:

Establishing a new Head of Integrated Care role to provide operational and system leadership and shift the culture toward greater integration between health and social care services was key. This role reports to Council AD and is funded by Council/CCG through the Better Care Fund (BCF) and works closely with the existing Head of Integrated Commissioning post, both of whom play a pivotal role with their teams in driving and steering improvements.

ii. A shared intermediate care pathway for Haringey:

Developing and agreeing with partners a high-level intermediate care pathway for Haringey ensures clarity and transparency on the role of all partners in supporting the prevention of avoidable hospital admissions and reducing the risk of delayed transfers home. This is as illustrated below.

Figure 1: High-level Intermediate Care pathway for Haringey



iii. Service Improvements and Redesign:

Development of the Social Care Intervention Team and a Single Point of Access (SPA) for key partners, residents and their families has streamlined

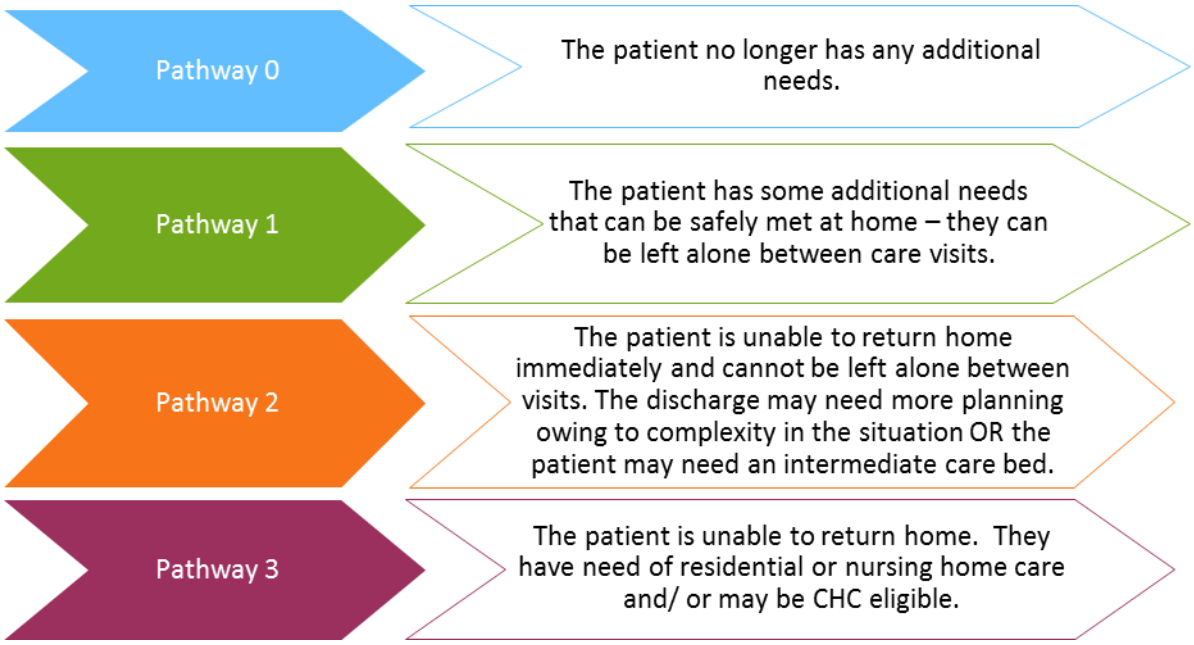
the referral, assessment and discharge process for service users within an acute setting. In conjunction with this we have redesigned Adult Social Care's Integrated Access Team, with a focus on improving performance and managing demand more proactively.

Importantly we have also re-specified and refocused the work of the reablement service to ensure that we were targeting and supporting the right people, at the right time in the right place, whist delivering the best value for money services.

iv. Hospital Discharge: Implementing 'Discharge to Assess'

Ensuring that people do not remain in hospital when they do not need to be there ensures that their health and care outcomes are not compromised and that capacity is maintained within the hospital for those people who need to be there. To address this, system-wide agreement was reached to implement a new process, known as the Medway model of 'Discharge to Assess'. This includes clearly defined pathways based on levels of patient need:

PATIENT PATHWAYS - Four patient discharge pathways based upon level of support required on leaving hospital



v. Professional Expertise

The provision of a Link Worker role to provide input to wards and front-of-house staff, has helped to identify and discharge patients, contributing to

training and support of staff, including patient case discussion on discharge to assess. This role is helping to shape a shared culture across teams within and outside the service to ensure that residents have as seamless a journey as possible.

3.5 Market Development

3.5.1 Haringey's reabelement service is a key component to ensure that people are supported home in a timely manner and receive the care that they need to recover their independence.

3.5.2 However, additional capacity and market development is required to manage our new ways of working and we are therefore working closely with partners and providers to manage this.

3.5.3 For those residents who do need a package of care or who need to move permanently to accommodation based care, including extra care sheltered, residential or nursing care, we have been keen to ensure that we have access to a market which is able to meet their needs.

4.5.4 By changing our commissioning approach for home care – which is now supplied through a Dynamic Purchasing System – we have ensured sufficient local capacity to meet need, have stabilised the home care market in the borough, have decreased local provider reliance on zero hour contracts and are now in a position to redesign the model of home support more fundamentally. To this end, we have been engaging with a range of stakeholders before working through the best procurement option, with a view to commissioning an outcomes based, locality delivered and joined up home support system. We believe a more joined up model of home care could help to reduce levels of hospital and care home admissions, benefiting both individuals and the wider system.

3.5.6 We are also working with our partner authorities across North Central London to safeguard capacity for the local health and care economy particularly in respect of nursing care. As there is considerable demand for this type of provision and limited supply, we are working on ways that we can stimulate and develop the market to be better tuned to meet demand.

3.5.7 Finally, we have been working very closely with providers, through the Providers' Forum, to ensure that they are aware of the pivotal part they play in the whole health and care economy. They are always willing to discuss changes to their model and to the pathways on which they operate and we need to ensure their ongoing involvement in the design and implementation of new services and pathways. Notably too, we have been working with residential and nursing care providers to reduce the level of avoidable A & E attendances and admissions from care homes locally. This involves upskilling staff, good lines of communication and an understanding of the resident's wishes as regards their care.

i. Additional Home based reablement capacity

In the medium term and in order to build the capacity to meet the increasing need for home based reablement, we are looking to develop a preferred provider locality based arrangement (that will mirror the Care Closer to Home Networks – ChiNs) with our existing domiciliary care providers. The thinking is that the Council's reablement service will work with the chosen provider in each locality, providing the necessary training and support to enable them to provide reablement, rather than home care, and increase our capacity to be able to deliver home based reablement. This is due to be in place early in the new year.

The existing Dynamic Purchasing System has already increased the supply of domiciliary care and stabilised price in this area. However, the preferred provider framework model will build on this and in addition to ensuring that providers have the necessary skills will also ensure that we are able to put it in place more quickly.

ii. Home from Hospital

The Council have also commissioned the Home from Hospital service. Our provider, the Bridge Renewal Trust, are commissioned to recruit, train and support Homes from Hospital workers to provide a home accompaniment and visiting service. This service should be provided to an annual minimum of 500 Haringey residents over 18 years old on discharge from A&E and Whittington and North Middlesex Hospital inpatient beds, subject to referral criteria being met. The service focuses predominantly on those people aged 65+. The objectives of the service are:

- Having a visible presence in the acute hospitals working with health and social care particularly at emergency departments and medical assessment wards
- For the Home from Hospital service to be part of multidisciplinary hospital discharge planning
- Building up connections with community resources such as: Neighbourhood Connects; Locality Teams; Information, Advice and Guidance Services; Housing; Community Health services; and voluntary sector services.

iii. Bed based provision

To support those people whose health and care needs are too complex for them to go straight home from hospital we have commissioned additional intermediate care beds that support different levels of need. This includes a 10 bed reablement service in Protheroe House, a One Housing's extra care scheme and a number of nursing beds at Priscilla Wakefield House (this varies over the year but will be 8 this Winter).

The beds are overseen by a dedicated multi-disciplinary team who make support plans and provide specialist therapy input, to enable users to meet their outcomes. This team includes a GP and a dedicated social worker who leads on discharge planning to ensure that people do not block beds and there is good flow through the system.

An audit of our existing bed based provision, including the 12 high needs beds at Bridges Ward, provided by Whittington Health, for both Haringey and Islington is being finalised. It is expected that this will lead to recommendations of how Haringey and Islington can pool their bed based provision. This is part of wider work looking at intermediate care across Haringey and Islington with the view to aligning provision across both boroughs.

3.6 Making a Difference – Improvements and Impact

3.6.1 The strategic approach reflected in Haringey's Design Framework and joined up health and social care planning and implementation of actions outlined in the report have produced significant improvements in the experience of local residents and in their outcomes. Importantly, decisions about residents' short and long term care after a period of illness or in hospital are not being made for them from a hospital bed, but alongside them in an environment which will be more like or be home.

3.6.2 Residents are now less likely to be discharged from hospital only to be readmitted and many achieve a high percentage of their previous mobility and functionality and are therefore able to stay living independently at home with little or no care.

3.6.3 This is reflected in the improved effectiveness of our operations, our stronger approach to developing and delivering integrated care, and importantly the improvements for the experience of residents' in Haringey. These include:

- A transformed Reablement Services: This can now respond within 24 hours of a resident's discharge, providing the opportunity for 849 residents to benefit from a reablement intervention in 2016/17, compared to 459 in 2015/16.
- This refocusing and re-specifying of the service has also helped to reduce unit costs from £45 per person to £23.
- Facilitation, on average, 10 discharges per week through reablement from March 2017 to date, reducing the time residents spend in hospital by saving 2-3 bed days per discharge;
- On average since April 2017, 76% of those people with complex needs supported by reablement, recovered sufficiently from their crisis situation in hospital, not to require a long-term social care service. This potential cost avoidance to Adult Social Care, attributed to transforming reablement, is currently reported at £1.1 million.

- Case studies, which will be presented for discussion at AHSP, will provide the context of the new or improved approaches and the individual experiential difference for Haringey residents.

4. Contribution to strategic outcomes

4.1 The approach and actions support the Priority 2 objective to empower all adults to live healthy long and fulfilling lives and to particularly deliver the following objectives:

1. Support will be provided at an earlier stage to residents who have difficulty in maintaining their health and wellbeing
2. Residents assessed as needing formal care and /or health support will receive responsive high quality services
3. All vulnerable adults will be safeguarded from abuse

5. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

5.1 **Finance** (ref: CAPH60)

The various components of the Transformation programme have been developed with a view to enabling Adults Social Care to meet its financial obligations within the Medium Term Financial Strategy. This will be achieved by controlling demand and reducing cost through a combination of –

- Market management
- Demand management
- Operational management

In addition, the Transformation programme develops the framework within which the council will meet the requirements agreed in the Haringey Better Care Fund plan.

5.2 **Equalities**

The Council has a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share those protected characteristics and people who do not

- Foster good relations between people who share those characteristics and people who do not.

The three parts of the duty applies to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

This report provides Scrutiny members with an update on the Haringey Design Framework for Integrated Care which is intended to improve the outcomes of social care service users, particularly for women, older people, disabled people and BAME communities. An equality impact assessment was undertaken when developing the Framework and any future decision will require further equality impact assessments.

5.3 **Legal**

There are no legal implications arising from the recommendation in the report.

6. USE OF APPENDICES

a. Patient Pathways – Case Studies - To be presented at Scrutiny Panel on 10th October 2017

7. LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985