NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Wednesday, 15th November, 2023, 2.00 pm - George Meehan House, 294 High Road, N22 8JZ (watch the live meeting here, watch the recording here)

Members: Please see list attached on item 2

Quorum: 3

1. FILMING AT MEETINGS

Please note this meeting may be filmed or recorded by the Council for live or subsequent broadcast via the Council's internet site or by anyone attending the meeting using any communication method. Members of the public participating in the meeting (e.g. making deputations, asking questions, making oral protests) should be aware that they are likely to be filmed, recorded or reported on. By entering the 'meeting room', you are consenting to being filmed and to the possible use of those images and sound recordings.

The Chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual, or may lead to the breach of a legal obligation by the Council.

2. WELCOME AND INTRODUCTIONS (PAGES 1 - 2)

3. APOLOGIES

To receive any apologies for absence.

4. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at agenda item 11).

5. DECLARATIONS OF INTEREST

A member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and

(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Register of Members' Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interests are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

6. QUESTIONS, DEPUTATIONS, AND PETITIONS

To consider any requests received in accordance with Part 4, Section B, Paragraph 29 of the Council's Constitution.

7. MINUTES

To confirm and sign the minutes of the Health and Wellbeing Board meeting held on 20 September 2023 as a correct record.

8. WORKFORCE UPDATE - NOVEMBER 2023 (PAGES 3 - 10)

To receive a presentation on the Workforce update - November 2023.

9. APPROVAL OF HARINGEY BETTER CARE FUND (BCF) 2023-25 - SUBMISSION TO NHS ENGLAND (PAGES 11 - 132)

To receive an update on the Better Care Fund Plan.

The Better Care Fund (BCF) Plan is a national programme to fund integration of health and cares services at a local level. In Haringey, it is underpinned through a £38m annual Section 75 agreement to pool funds between North Central London (NCL) ICB and London Borough of Haringey (LBH). The Department of Health & Social Care (DHSC) who run the BCF Programme requested each local area to submit a full Plan in June 2023 for the period 2023/24 and 2024/25.

10. HARINGEY BOROUGH PARTNERSHIP UPDATE AND INTEGRATED CARE PARTNERSHIP UPDATES (PAGES 133 - 228)

To receive a presentation on Haringey Borough Partnership update and an update on the Integrated Care Partnership.

11. NEW ITEMS OF URGENT BUSINESS

To consider any new items of urgent business admitted at item 4 above.

12. FUTURE AGENDA ITEMS AND MEETING DATES

Members of the Board are invited to suggest future agenda items.

To note the dates of future meetings:

17 January 2024
13 March 2024

Bhavya Nair, Principal Committee Co-ordinator
Tel – 020 8489 332126
Email: bhavya1.nair@haringey.gov.uk

Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Tuesday, 07 November 2023

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Agenda Item 2

Membership of the Health and Wellbeing Board

* Denotes voting Member of the Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	* Cabinet Member for Health, Social Care, and Wellbeing – Chair	Cllr Lucia Das Neves
			* Cabinet Member for Children, Schools and Families	Cllr Zena Brabazon
			* Cabinet Member for Climate Action Environment, Transport, and Deputy Leader of the Council	Cllr Mike Hakata
	Officer Representatives	4	Director of Adults, Health and Communities	Beverley Tarka
			Director of Children's Services	Ann Graham
			Director of Public Health	Dr Will Maimaris
			Chief Executive	Andy Donald
NHS	North Central London Integrated Care Board	3	Clinical and Care Director for Haringey (NCL ICB)	Nadine Jeal
			Director of Integration for Haringey	Rachel Lissauer
			Executive Director of Place	Sarah McDonnell-Davies
	North Middlesex University Hospital NHS Trust	1	Chief Executive	Dr Nnenna Osuji
	Whittington Health NHS Trust	1	Chief Executive	Helen Brown

	Barnet, Enfield and Haringey Mental Health Trust	1	Managing Director, Haringey	Gary Passaway
	Haringey GP Federation	2	Chief Executive	Cassie Williams
			Medical Director	Dr Sheena Patel
Patient and Service User Representative	Healthwatch Haringey	1	* Chair	Sharon Grant
Voluntary Sector Representative	Bridge Renewal Trust	1	Chief Executive	Geoffrey Ocen
Haringey Local Safeguarding Board		1	Interim Independent Chair	David Archibald

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HARINGEY BOROUGH PARTNERSHIP

North Central London Integrated Care System

Haringey Borough Partnership

Workforce Update

Nov 2023

Workforce in the Borough Partnership

- Through conversations across the Borough Partnership over 2022 and a recruitment discovery report, we identified workforce was a recurring theme
- Our sense was there were opportunities to collaborate and do some activities once
- We now have an established ICS People Board and there are further opportunities to think about what is happening at an ICS level, how we influence that and how we ensure we can amplify the work
- We now have a 0.6 WTE 8b Workforce Integration Lead to drive this work in partnership with workforce leads across our partners, hosted by the Training Hub and reporting into Neighbourhoods Delivery Board

NCL Context:

Workforce: Strategic Aims

North Central London Integrated Care System

Vision

'One Workforce' delivering joined-up, preventative and person-centred care for North Central London

ICS Strategic Pillars and Aims

2023-2028

SUPPLY

Optimising the volume of staff with the right skills and values to achieve our population health improvement outcomes across NCL, sustainably.

DEVELOPMENT

Continuously improving staff, systems and processes to maximise the talent and assets we have across North Central London

TRANSFORMATION

Utilising technology to drive productivity and efficiency improvements, and further connect our workforce with advanced data and analytics

ENABLERS

- Health & Wellbeing
- Equality, Diversity & Inclusion
- Leadership & Talent

Delivery of People Functions

- Growing the workforce for the future and enabling adequate workforce supply
- Driving and supporting broader social and economic development
- Leading coordinated workforce planning using analysis and intelligence
- Supporting the health and wellbeing of all staff
- Valuing and supporting leadership at all levels, and lifelong learning
- Supporting inclusion and belonging for all, and creating a great experience for staff
- Educating, training and developing people, and managing talent
- Leading workforce transformation and new ways of working
- Transforming people services and supporting the people profession
- Supporting system design and development

NCL Context:

Building out the ambition: 5-year targets under development

North Central London Integrated Care System

WORKFORCE SUPPLY

	DATA	SUPPLY ROUTES
YEAR 1	Scope enhanced data analytics with system partners to determine the data sharing, quality and access requirements needed to support 'one workforce'	Identification of routes into health and social care careers. Focus on increasing opportunities for school and care leavers.
YEAR 1	Develop in-depth understanding of local labour markets; demographics and profiles to better target training and employment	Scope out opportunities to develop high-impact approach to apprenticeships across North Central London.
YEAR 2/3	Build data modelling capability (inc. system-wide metrics/benchmarks) to drive service efficiency and workforce productivity	Review workforce gaps and opportunities for rotational placements across sector boundaries to support future skills and training model
YEAR 4/5	Invest in automated data gathering and analysis; utilisation of big datasets to drive workforce planning and decision making	Systematic delivery of workforce interventions, consistently aligned and refreshed in line with Population Health goals

WORKFORCE DEVELOPMENT

	FLEXIBILITY	ENHANCED CAPABILITY
YEAR 1	System-wide mapping of requirements for the development of an 'NCL passport' to support enhanced staff portability	Identification of high impact roles that could unlock care delivery i.e. poly-potential, generalist or advanced clinical practice
YEAR 1	Development of an approach to flexible employment to support portfolio or blended careers to further attract and retain staff	Partner with higher-education institutions to develop staff upskilling and training programmes aligned to system priorities
YEAR 2/3	Expansion of collaborative staffing mechanisms and existing centralised corporate services to support sharing of staff (demand, vacancy, internal recruitment)	Redesign People processes to reflect policies supporting workforce flexibility / portability
YEAR 4/5	Realise collaborative, inclusive culture framework with systems developed to action feedback from staff (inc. system-wide staff survey and EDS2, WRES/DES)	Develop an enhanced partnering strategy with university and educational institutions to train staff

WORKFORCE TRANSFORMATION

	INNOVATION	WAYS OF WORKING
YEAR 1	Identify opportunities to accelerate, enhance and scale innovation across the system	Development of the workforce model to support the implementation of the Long-Term Conditions management in Primary Care
YEAR 1	Identify, develop and support the delivery of the change management requirements for the NCL digital strategy	Integrated Neighbourhood Workforce model defined to realise the ambitions of the Fuller Review of Primary Care
YEAR 2/3	Development of a funded innovation pipeline; test and learn process and established partnerships w/ Education & Industry	Roll-out digital upskilling to workforce across the system
YEAR 4/5	Piloting of digital solutions aligned to priority staffing groups / pathways	Identify priority solutions (and training) to deliver at scale; engage partners and resource projects

Governance Structure

North Central London Integrated Care System

People Board

NHS North Central London Integrated Care Board (ICB)

North Central London Health & Care Partnership (ICP)

Committee of the Board of Members

ICS People Board

Workforce PMO

People Programme Steering Group

Senior Leadership Forums

Quarterly Advisory Group (Strategic Enablers)

Delivery Boards

- Workforce Supply
- Workforce Development
- Workforce Transformation

Haringey Workforce Integration Priorities

- Maximising entry-level recruitment
- Neighbourhood training offer
- Dissemination of workforce information

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Health & Wellbeing Board

Haringey Borough Partnership Exec

Neighborhoods and Health Inequalities

- Start Well
- Live Well
- Age Well

Workstream: Maximising Entry-Level Recruitment across HBP

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North Central London Integrated Care System

Workstream Objectives	Key Milestones	Programme Deliverables		
Ensuring that recruitment opportunities are maximised across Haringey for health & social care partners, with an awareness of workforce recruitment initiatives at system level. Supporting the pathway development of local people into health and social care careers via entry point recruitment.	• Creation of Haringey Health & Social Care Academy to support joined up recruitment to entry level positions • Joined up offer of careers fairs across partners • Joined up comms • Identification of key areas of demand challenges at borough and link to system level work, such as apprenticeship and MH Practitioners	**Key Deliverables (maximum of 3)**	**Status for current reporting period**	**Previous Month Status**
		Established Haringey Academy offer, targeting the 270 vacant admin & care giving roles in Haringey		
		First joined up H&SC careers fair for Haringey, March '24 and 3 per year thereafter		

Key activities delivered in current reporting period	Key activities scheduled for delivery in next reporting period	Risks / Issues	Potential Impact	Risk Level
• Engaged with NCL Health & Social Care Academy • Agreed on a Haringey-only Academy offer, with potential for joint offer across Enfield in future • Agreed distribution list for stakeholders across health/LA/VCS partners. • Comms to partners to engage for a working group to be sent	• Discussions re the Accelerating Reform Fund and International Recruitment at the LA commissioners meeting • Communication to workforce leads to go out in the next week to set workshop via AA and ZB • Ambitions and timeline to be set at workshop • NCL H&SC Academy first Information, Careers and Recruitment event on Friday 10th November at Edmonton Green Library	Low uptake from residents	Demand would outstrip supply of recruits.	
		Low engagement from partner organisations	Low number/proportion of appropriate vacancies given visibility at a borough level	
		Crossover with NCL offer	Duplication of work	

Workstream:
Neighbourhood Workforce Development

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North Central London Integrated Care System

Workstream Objectives	Key Milestones	Programme Deliverables		
Staff working across organisations in each neighbourhood have access to training resources to better meet the needs of local people and priorities. Improve awareness within services of other services within the neighbourhood, enabling the "no wrong front door" approach, and facilitating integration between services.	• Ongoing regular training delivered across each neighbourhood that provides a platform for integration of workforces across health and social care. • Develop the current Padlet offer to include health offerings, providing workforce training and development including in-person, online, e-learning and cheat sheets.	**Key Deliverables (maximum of 3)**	**Status for current reporting period**	**Previous Month Status**
		East training with established structure and inclusive of health partners		
		Central and west training programmes rolled out		
		Inclusion of health subjects and of service spotlights/deep dives on neighbourhood progs		

Key activities delivered in current reporting period	Key activities scheduled for delivery in next reporting period	Risks / Issues	Potential Impact	Risk Level
• Engaging with SW/LW/AW leads • Visits to NRC • Scoping of current NRC offers • Neighbourhood training (east locality) began with Rough Sleeping Briefing	• Form invite list to SPRINT Workshop to agree on ambitions for a T&F group in relation to neighbourhood training • Engage organisation leads to facilitate protecting of staff time	Staff not being released for training	Minimises impact of training. Some services alienated from Integrated Front Door approach.	
		Estates – unable to identify space for face-to-face trainings	Only able to host training online, inhibiting colocation as an enabler for integration	
		Health and Social Care partners have different training priorities	Inability to agree a list of And risk of future disengagement	

Workstream: Enabling Dissemination of Workforce Information Across HPB

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North Central London Integrated Care System

Workstream Objectives	Key Milestones	Programme Deliverables		
Creating process whereby partners can feed in workforce challenges & initiatives. Themes of challenges can be identified and channelled up to ICS level, and information can be disseminated at a borough level, highlighting/scaling successes.	• Agreement upon preferred method(s) of communication for target leads/services • Agreement with a communications team	**Key Deliverables (maximum of 3)**	**Status for current reporting period**	**Previous Month Status**
		Receive feedback on the idea from stakeholders across HBP		
		Regular monthly/6-weekly/bimonthly newsletter or alternative		

Key activities delivered in current reporting period	Key activities scheduled for delivery in next reporting period	Risks / Issues	Potential Impact	Risk Level
Work in progress	• Programme initiated, feedback welcome	Low engagement amongst partners	Workforce challenges remain in silo	
		Cross over with partner offers	Duplication of work	

Report for: **Health and Wellbeing Board**

Title: **Approval of Haringey Better Care Fund (BCF) 2023-25 Submission to NHS England**

Report authorised by: Vicky Murphy, Service Director & Deputy Director of Adults, Health and Communities, London Borough of Haringey
Rachel Lissauer, Director of Integration (Haringey), North Central London Integrated Care Board

Lead Officer: Paul Allen, Head of Integrated Commissioning (Older People & Frailty), North Central London Integrated Care Board (NCL ICB)
0203 6881173

Ward(s) affected: **All**
Report for Key/ Non Key Decision: **N/A**

1. Describe the issue under consideration

1.1 The Better Care Fund (BCF) Plan is a national programme to fund integration of health and cares services at a local level. In Haringey, it is underpinned through a £38m annual Section 75 agreement to pool funds between North Central London (NCL) ICB and London Borough of Haringey (LBH). The Department of Health & Social Care (DHSC) who run the BCF Programme requested each local area to submit a full Plan in June 2023 for the period 2023/24 and 2024/25.

1.2 NCL ICB, LBH and partners worked to construct and agree the BCF funding schedule to support integration, in particular through Haringey's Ageing Well Strategy, as part of the Haringey Partnership Board's responsibilities. The Plan was discussed with partners at Haringey's multi-agency Ageing Well Board, a sub-group of the Haringey Borough Partnership Board. Out-of-hospital targets were also signed-off through North Middlesex University Hospital (NMUH) A&E Board.

1.3 As per DHSC mandated requirements, as national release and completion of the BCF Plan framework and template was outside the cycle of the Health & Well-Being (HWB) Board meetings, the Chair was requested to sign off Haringey's Plan pending full submission of the Plan to the Board during the first half of 2023/24. This report requests the Board to approve the BCF Plan Narrative, its investment schedule (confirming the breakdown of the funding fulfils National Funding conditions for 2023-25) and the trajectories for the metrics included in its scope over the next year. DHSC also requested each area produce a demand and capacity summary associated with intermediate care, i.e. services relating to recovery from crises.

1.4 The BCF Plan is subject to a quarterly update nationally and the first update for Haringey since the BCF Plan was submitted to the national BCF Team is included in Appendix 4.

2. Cabinet Member Introduction

2.1 Not applicable.

3. Recommendations

3.1 The Health and Wellbeing Board is asked to note the year end summary for the Haringey Better Care Fund (BCF) Plan Narrative for 2021/22 (Appendix 1).

3.2 The Board is asked to confirm the Plan meets national BCF Plan Conditions discussed for 2023/24 and 2024/25, and to note, however, that details in the latter year's Plan will need to be resubmitted to the Board as part of a national and local update in the latter half of 2023/24.

3.3 The Board is asked to endorse the BCF Plan submission for 2023-25:

- The updated Haringey BCF Plan Narrative (Appendix 2);
- The BCF National Funding Template for Haringey with an investment schedule and trajectories for BCF metrics, plus a demand & capacity analysis associated with Haringey's intermediate care services in 2023/24 (Appendix 3). The funding schedule in Appendix 3 includes additional Discharge Fund investments that assure the availability of the stated service capacity in 2023/24.
- The BCF Plan Q2 update for Haringey is included in Appendix 4.

4. Reasons for decision

4.1 The BCF Plan is a national programme to support integration of health and social care, to enable people to stay well, safe and independent and to provide the right care in the right place at the right time to support positive outcomes for local people. It aligns with the ICB and Council Plans (including the Haringey Deal) and is key to delivering Haringey's multi-agency Ageing Well Strategy.

4.2 One requirement of DHSC's BCF national programme is for the Health and Well-Being Board to report on progress on last year's investments from the Plan, and the current report incorporates highlights key successes and areas for improvement from the 2022/23 Plan the Board signed off in September 2022.

4.3 The DHSC's national policy requirements, template and supporting documents for the BCF Plan 2023-25 to local areas were released in May 2023, with local Health & Well-Being Boards needing to submit the Plan to DHSC by the end of June 2023. The entire BCF Plan for this two-year period is included in Appendices 2 & 3.

4.4 The information presented in the Plan should give the Health and Wellbeing Board the assurance Haringey is maintaining its commitment to health and social care integration to deliver its vision in light of local and national strategies and plans, such as NHS Long-Term Plan, Haringey Deal and Haringey's Ageing Well Strategy.

4.5 The Narrative submitted for Haringey's 2023-25 BCF Plan built on progress in previous years. It focusses on our response to three national challenges:

- The need to continue to respond to the legacy of the pandemic and system shocks such as higher cost of living, in particular the consequences for patients and residents and the health and care system of managing a greater number of people whose underlying health status and conditions have worsened during the pandemic which has consequences for the health and care system.
- Assuring out-of-hospital systems are well prepared for heightened activity, and particularly average acuity of resulting care needs per patient, in local secondary care Trusts to facilitate safe and timely hospital discharge. This includes through additional NCL ICB and Council investment in intermediate care services to support discharge and short-term support for patients.
- Addressing underlying issues associated with equity of access, outcomes and experience – and the resources to 'level to need' - across NCL and within the Borough. We know people living in more deprived (and often most diverse) neighbourhoods had around 17 years shorter healthy life expectancies than their most affluent peers pre-pandemic and there is good evidence nationally social gradients in inequality have worsened as a result of the pandemic.

4.6 The Narrative Plan sets out how partners will address these multi-agency medium- and longer-term challenges in as integrated a way as possible building a framework of support – called Haringey's integrated 'care cone' - that tailors the needs of individuals to the best response in the system. The framework's aim is to:

- Emphasise the importance of a strength-based approach, prevention, self-management and personalisation, so people can stay as healthy, well and independent as possible;
- Where people do need help, to ensure the 'right joined-up solutions for the right person are delivered at the right time' as close to home as possible, to improve or maintain their physical and mental health, well-being and independence now and in the future - and best support their carers;
- Help people avoid future health or social crises as far as possible and/or people can recover as fully as possible after crises, ideally at home. We know we can

mitigate the risk of some of these avoidable crises for residents via earlier detection, diagnosis and improved management of physical and mental health conditions, particularly in more deprived (and diverse) communities;

4.7 Achieving these people-centred aims also promotes system outcomes, including mitigating demand for intensive and costly interventions within the population. The framework of support achieves this is in 'the here and now' through reducing people's risk of crises and acute or non-acute hospitalisation. It also mitigates future demand by investing in early help and prevention to reduce the risk of individuals acquiring, or exacerbating existing, long-term conditions or adversely affecting their mental health and well-being. A key priority for 2023-25 is to continue to address inequity in access and outcomes (and the resources available to do so) in under-served communities, as well as a priority to support carers, in Haringey.

4.8 The BCF Narrative provides details of our approach. Our plans and investments categorises solutions within the care cone's levels of intervention as a way of matching our solutions to the underlying need:

- *Feeling Healthy, Safe & Well*: This element of the 'care cone' is closely linked to local and national public health messages/services to encourage people to adopt, or get help with adopting, healthier lifestyles, e.g. smoking cessation, being active etc., and 'making every contact count'. Investment in this area is *outside* of the BCF Plan, e.g. Council Public Health spend;
- *Early Help & Prevention*: a targeted approach working with individuals to address issues or needs within communities, and/or those at 'rising risk' of needing more intensive or crisis-driven solutions soon. This includes encouraging people to come forward for earlier diagnosis, adopt healthy lifestyles, and better self-manage their conditions, or get help to meet health, housing or social needs. In response, we launched a 'Healthy Neighbourhoods' collaboration between the statutory and voluntary sector to work together to engage and support communities, starting in under-served communities in the more deprived (and diverse) east of the Borough. The collaboration consists of a locally-based network of Council, VCSE and NHS partners, including primary care, who will work to engage with communities and their representatives on local health priorities, and develop community asset-based solutions to address them. The initiative is part-funded through the £5m NCL-wide ICB Inequalities Fund aimed at addressing inequity of access, outcomes and experience amongst under-served communities, and partly through the BCF Plan in 2023-25.
- *Proactive and Anticipatory Care & Support:* people whose health, housing and social needs are more complex and/or intense, who need a tailored and often an integrated and multi-disciplinary response to these needs including care and support services. Two major initatives discussed in the BCF Plan are the Multi-

Agency Care & Coordination and Enhanced Care in Care Homes Team to plan with, and support, people proactively with frailty/multi-morbidity.

- *Specialist/Emergency Solutions*: people who need highly specialised health and social interventions and/or who are approaching or are at a social or health crises or need help recovering from crisis, ideally at home. This includes a focus on out-of-hospital solutions to meet demand, and we have continued to expand capacity of our existing schemes, partly through the 'main' BCF Plan and partly via additional BCF Discharge Funding available in 2023-25.

4.9 BCF-funded services particularly fit the latter three 'care cone' categories. The Plan and its investments set out in Appendix 1 reflect the need to balance additional investment to support out-of-hospital services in the short-term, with funding for longer-term preventative solutions to help people adopt healthier lifestyles and self-manage in the community earlier, particularly in more deprived communities.

4.10 The BCF Plan is just one investment 'pot' which promotes integration and out-of-hospital solutions – several other local and national funding streams are available, e.g. NCL ICB Inequalities Fund. These investments and the joint work across partners should be seen as a developing an integrated response across Haringey and NCL. The Plan sets out some of the areas of particular development:

- How we intend to improve equity of access, outcomes and experience in terms of health, well-being and independence amongst our under-served communities;
- How we intend to improve our integrated health and care system in the Borough as part of our response to the NHS Long-Term Plan, including development of multi-disciplinary primary care and integrated care networks, to deliver health and care closer to home at a Borough and neighbourhood footprint;
- How we continue to work with our wider set of partners, such as housing and the voluntary sector, to ensure our plans are aligned with wider planning to strengthen communities;
- How we will continue to support unpaid family/friend carers of all ages, including through our multi-agency Carers' Strategy. The 2023-25 Plan includes enhanced investment in cross-Haringey locality-based carers' support as part of our early help and prevention offer.
- How we will ensure there is a 'golden thread' connecting care solutions across differing geographical footprints so there is a coherent picture of support across NCL, Borough and neighbourhood footprints.
- How partners intend to utilise the additional ICB and Council investment in Discharge Funding in the BCF Plan to build care and support capacity to deliver timely and safe hospital discharge for patients.

4.11 We know delivery of the previous year's Plans already had a positive impact on supporting people in Haringey to have healthy, long and fulfilling lives in 2022/23, and the 2023-25 BCF Plan will further enhance these outcomes. Highlights include:

a. Rising to the challenge of recovery from the pandemic and how this has changed delivery of care and support. There is national and local evidence the number of older people with moderate or severe frailty increased by 20% post-COVID Wave 1 due to individuals' deconditioning (e.g not being as active as they were, feeling isolated etc.), and nationally Office for Health Improvement and Disparities estimate up to half of older people did not come forward when their conditions worsened during lockdown. In response, our care system increased the level of support available to people including:

- We developed and updated an Ageing Well Guide and Ageing Well Resource Directory on the Council's web-site with hints, tips and contacts to support people to stay as fit, well and independent as possible. We are currently finalising a training and awareness-raising programme targeted at the VCSE and public-sector colleagues about the issues people face as they age as part of our development of 'Age-Friendly Haringey' initiative. We intend to roll this out as a partnership in the latter half of 2023/24.
- The ICB and Council made a substantial part-BCF investment in a range of VCSE projects within the Healthy Neighbourhood (HN) model described above. A Community Chest was developed to support development of 7 voluntary sector led initiatives from Q4 2022/23 associated with HN themes such as Improving Long-Term Conditions or Best Start in Life. Further VCSE investment collaborative opportunities, including development of a Community Participatory Budget, are planned in the latter half of 2023/24.
- Nearly 30% increase in the number of GP consultations for older people pre-pandemic and post-Wave 2 in 2021/22 with this level of consultations sustained in 2022/23. This increase in the number of consultations was largely equitable across Haringey, e.g. a nearly 30% increase in consultations for residents living in more deprived areas. We continue to work on improving access to primary care.
- Expanded access to our Multi-Agency Care and Coordination Team (MACCT) in the community and in our Enhanced Health in Care Homes (EHCH) Teams in 2022/23 to better manage and work with a group of individuals, including to manage the holistic (and often complex) needs of older residents/those with multi-morbidity in the community and in care homes. The EHCH Team, in conjunction with primary care, provides a comprehensive health support service to Haringey's 300 residents living in care homes, which include some of the most vulnerable individuals in the Borough. The Team is expanding to cover care homes for people with learning disabilities in 2023/24.

- MACCT, which is a joint GP-led integrated team consisting of nurses, therapists, pharmacists, social and mental health workers and care navigators, worked with nearly 2,000 individuals over the last 12 months. Patients with whom the service works are largely representative of Haringey's population (e.g. nearly 40% of cases are of people living in 20% most deprived areas). A recent evaluation of the MACC Team showed outcomes were positive:
  - Satisfaction was overwhelmingly positive amongst patients, with 94% who thought their care was well coordinated and 85% knowing who their care coordinator was. Two-thirds of participants reported they had improved their health, independence and social opportunities;
  - There was an encouraging 40% reduction in hospitalisation rates pre- and post-MACC Team intervention amongst patients.

  Our next steps are to expand scope of the service, and number of people supported, to a wider group of patients, e.g. those living with specific long-term conditions such as COPD, CKD etc., as part of improved LTC management in primary care, and alignment with the neighbourhood-based initiatives emerging in Haringey.
- BCF investment in a dedicated Council-led Coordinator supported partners to refresh our Dementia Friendly Haringey initiative post-pandemic. This is a partnership network across the statutory, voluntary and private sector to support organisations to make simple adjustments to their services to better support people with lived experience of dementia. We are currently looking to expand the network of organisations committed to making these changes, and build our partnership, including planned development of a North Central London-wide recognition scheme of these organisations' efforts.

b. During the pandemic, the proportion of people discharged from hospital who needed short-term care and support to recover increased nationally and locally. This was in part due to the direct impact of individuals hospitalised due to COVID, but it was also in part due to the issue that the typical acuity of older patients who did need to be admitted was greater than pre-pandemic – a trend emerging nationally.

c. In response, the NHS, Council and voluntary sector worked together at WHT, NMUH and other NCL hospitals to discharge more patients, predominantly back home, more quickly than at any time pre-COVID, with staff working extended hours and 7 day working. For example:
   - 93% of acute Haringey patients were discharged home from hospital over the 12 months ending June 2023, as part of our 'Home First' approach which is where people tell us they would prefer to return. This figure is one of the highest proportions in NCL, and our target is to achieve 95% for March 2024.

- Conversely, only 1.2% of acute patients were admitted directly to long-term care home placements. Partners remained committed to helping as many people to recover post-discharge as possible, and to avoid making decisions about their long-term accommodation in a hospital bed;
- The number of people aged 65+ per 100,000 population admitted to Council-funded long-term residential and nursing care placements decreased by 3% between 2021/22 and 2022/23, despite the increased complexity of cases, largely due to this commitment to help remain at home for as long as possible. Current performance analysis suggests the Council and its partners are on course target to meet its target of no more than 116 admissions in 2023/24.

d. The number of people aged 65+ per 100,000 who were admitted to hospital due to falls is a new BCF measure introduced in the 2023-25 Plan. Haringey's rate of 1,809/100,000 65+ population (509 admissions) for 2022/23 is in the best performing quartile in England (and better than the London average), with the number of hip fractures (155 or 433/100,000) also much lower than the national position. The ICB is committed to improving this promising position further, and Whittington NHS Trust and its partners are developing a more holistic falls network in 2023/24 funded outside of the BCF Plan.

e. Nearly 1,350 reablement episodes were completed in 2022/23. LBH's Reablement Service and its partners provide short-term (<6 weeks) intensive therapy to help people recover their ability to undertake daily living, such as washing or getting around their home, after a crisis and/or hospital episode, e.g. due to a fall.

f. The majority of these individuals were aged 65+, and, of these, 76% were at home for 91 days after hospital discharge, i.e. as opposed to returning to hospital or being admitted to a care home. This is a considerable improvement on the figure the previous year (53%) partly due to better tracking of patients in the community during and post-recovery, e.g. onward connections to services to support people to live at home. However, the increased level of underlying need in the population due to the legacy of the pandemic and cost of living crises means the proportion of reablement clients who need Council-funded long-term care and support has nearly doubled pre-pandemic to 2022/23.

g. During the pandemic, there was a 64% increase in the typical month number of patients (to over 180) accessing the multi-disciplinary Rapid Response service (usually responding within 2-4 hours) to treat people who are nearing, or at, a health crisis at home for up to 5 days following referral via a care professional. The service ensures people don't need to go to A&E unnecessarily.

h. As a result of the above initiatives, we have reduced the number of emergency admissions of Haringey patients aged 65+ per head of older population by one-third between 2019/20 and 2022/23. However, the average length of stay for older people increased significantly due to acuity of need, as the number of conditions associated with each patient increased by nearly 40%. Our hospitals therefore continue to have very high utilisation due to increased acuity and greater likelihood of multi-morbidity than corresponding patients pre-pandemic.

4.12 One element of improvement partners have agreed to address is to strengthen our joint commitment to support for carers as part of the Carers' Strategy and roll out of locality working within the BCF Plan 2023-25. This reflects partners' aim is to build a local neighbourhood-based support network with carers to better help them continue their caring role and to have a life of their own. Overall funding for Carers' Services has therefore increased by one-third to £1.4m in the BCF Plan – the highest BCF contribution amongst the 5 Boroughs.

4.13 One funding stream newly-incorporated into the BCF Plan is the ICB and Council Discharge Fund. Nationally, the BCF Discharge Fund stream consists of two separate investments elements, one directly paid to Councils (the 'Local Authority element'), the other paid to ICBs (the 'ICB element') and then distributed onwards to each Health & Well-Being Board within each ICB's respective Integrated Care System. For NCL, the ICB element of the Discharge Fund investment is split between the 5 Borough Boards. Details of funding are included in the next section.

4.14 Discharge Fund investments need to focus on enhancing investment to assure capacity against predicted demand for safe and timely discharge of secondary care patients and onward support to help people recover in the short-term. Both the total amount of funding split between the ICB and Council for the 'ICB element' in each Borough and how both elements of the Discharge Fund should be utilised need to be agreed between both parties. For 2023/24, partners agreed how the final agreed total of £2.4m (Table 1) should be utilised in Haringey. The schemes in which partners agreed Discharge Fund investment are included in Appendix 1.

4.15 Nationally, there will be a substantial increase in both elements of the Discharge Fund between 2023/24 and 2024/25. For example, the 'Local Authority element' of the Discharge Fund will increase by nearly two-thirds in Haringey to £2.4m in 2023/24. However, the ICB and all 5 Councils in North Central London were unable to conclude their discussions about the distribution of the 'ICB element' of funding between the 5 Health & Well-Being Boards for 2024/25 and the schemes that could be invested in prior to national submission deadlines at the end of June 2023.

4.16 Further work is ongoing between NCL-wide partners to conclude this discussion and a placeholder was included in each Borough's BCF Plan to acknowledge this

position at the time of the submission at the behest of the BCF Regional Team (included in Appendix 1). However, the BCF template in Appendix 2 will show Haringey's BCF Template submissions has 'failed' the automated checklist for completion against its Expenditure tab; however, the BCF Regional Team have acknowledged this interim position, as they have for the other NCL Boroughs, and accepted all 5 Borough's BCF submissions.

4.17 For the first time post-pandemic, the BCF Plan covers 2, rather than a single, year. National expectations are that the contents of local BCF Plans will be refreshed in the latter half of 2023/24 for 2024/25. This will provide an opportunity locally to consider the effectiveness of all of the current schemes and the potential to re-allocate funding to match local and national priorities in 2024/25, including finalising utilisation of the Discharge Fund for 2024/25. A further refinement of Haringey's BCF Plan will therefore be submitted to the HWB later in 2023/24 when national requirements and timescales are available. The current BCF investment schedule for 2024/25 in Appendix 1 is therefore provisional and subject to change in discussions between partners.

5. Alternative options considered

5.1 Not applicable.

6. Background information

6.1 The national policy requirements state the Health & Well-Being Board must sign-off the schedule of investment for the Better Care Fund (BCF) Plan as part of a pooled Section 75 for 2022/23.

6.2 NCL ICB is expected to make a Minimum Contribution to the Haringey BCF Plan (outside of the Discharge Fund). Two of the national conditions are that:

- The agreed contribution to social care from the ICB meets or exceeds the minimum expectation allocated;
- The spend on ICB commissioned out-of-hospital services meets or exceeds the minimum ringfence.

6.3 There are additional grants that represent LBH's contribution, in the BCF Plan:

- Improved Better Care Fund (iBCF) to meet the growing demand for care packages and reduce LBH's financial risk;
- Disabled Facilities Grant to fund major adaptations to LBH clients' properties (regardless of tenure type) to support them to live at home.

6.4 Table 1 shows the changes in BCF Plan funding between 2022/23, 2023/24 and 2024/25 and the proposed schemes are listed in Appendix 1. The majority of these schemes are existing services which we are continuing to fund in 2023/24. There is a step-change in investment overall in the BCF Plan between 2022/23 and 2023/24, largely due to the introduction of the £2.4m Discharge Fund into the BCF Plan in 2023/24 – a national discharge funding scheme was available in NCL in 2022/23 but this was outside of the original national BCF Plan last year.

6.5 There is an £1.26m uplift in the Minimum ICB Contribution between the two years. To conform to the national conditions above, £412k of this uplift must be spent on social care, including preventative solutions. Appendix 1 highlights schemes that are either newly BCF funded or in which the investment in an existing service from 2022/23 has been increased; collectively the additional investment in these rows make up the £1.26m uplift, including the £412k spend on adult social care.

Haringey BCF Plan Investment	2022/23	2023/24	Change 23-24 v 22-23		2024/25	Change 24-25 v 23-24	
	Inv Needed	Inv Needed	Increase	% increase	Inv Needed	Increase	% increase
Disabled Facilities Grant*	£2,678,851	£2,678,851	£0	0%	£2,678,851	£0	0%
iBCF, including WP Grant*	£9,806,399	£9,806,399	£0	0%	£9,806,399	£0	0%
ICB Contribution, *of which minimum spend on:*	**£22,210,641**	**£23,467,763**	**£1,257,122**	**5.7%**	**£24,796,038**	**£1,328,275**	**5.7%**
- NHS commissioned Out-of-Hospital Spend	£6,311,634	£6,668,873	£357,238	5.7%	£7,046,331	£377,458	5.7%
- Adult Social Care Spend (LA Recharge Value)	£7,295,342	£7,708,259	£412,916	5.7%	£8,144,546	£436,287	5.7%
NEW: Discharge Fund - Total. Of which:	Not included in BCF Plan in 2022/23	**£2,413,842**	-	-	**£4,276,986**	£1,863,144	77%
- LA Element Discharge Fund*		£1,374,842	-	-	£2,295,986	£921,144	67%
- ICB Element Discharge Fund (Haringey Allocation)		£1,039,000	-	-	£1,981,000	£942,000	91%
TOTALS	**£34,695,891**	**£38,366,854**	**£3,670,964**	**10.6%**	**£41,558,274**	**£3,191,419**	**8.3%**

NB: ICB element of Discharge Fund is initial proposal for 2024/25 & needs to be confirmed between partners. 2023/24 corresponding position confirmed.

Table 1 – Requirements for Spend Haringey BCF Plan Funding 2022 - 2025

6.6 Table 2 confirms the schedule in Appendix 1 fulfils the 2023/24 National Conditions in Haringey. The position for 2024/25 is more complex given that although the table does confirm the schedule meets the National Conditions, this is because a placeholder in the schedule of investments is included in relation to the ICB element of the Discharge Fund in 2024/25. This table will need to be updated and re-presented to the Board once agreed as part of the 2024/25 Plan refresh.

	2023-24			2024-25		
Running Balances	Income	Expenditure	Balance	Income	Expenditure	Balance
DFG	£2,678,851	£2,678,851	£0	£2,678,851	£2,678,851	£0
Minimum NHS Contribution	£23,467,763	£23,467,763	£0	£24,796,038	£24,796,038	£0
iBCF	£9,806,399	£9,806,399	£0	£9,806,399	£9,806,399	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,374,842	£1,374,842	£0	£2,295,986	£2,295,986	£0
ICB Discharge Funding	£1,161,600	£1,161,599		£2,394,206	£2,394,206	£0
Total	**£38,489,454**	**£38,489,454**	**£0**	**£41,971,480**	**£41,971,480**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24			2024-25		
	Minimum Required Spend	Planned Spend	Under Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£6,668,873	£15,643,480	£0	£7,046,331	£16,535,468	£0
Adult Social Care services spend from the minimum ICB allocations	£7,708,259	£7,708,259	£0	£8,144,546	£8,144,546	£0

Table 2 – Schedule of Funding v. National Requirements for BCF Plan 2023-25 (taken from BCF Spreadsheet, Expenditure Tab)

7.1 Contribution to strategic outcomes

7.2 The BCF Plan will contribute to objectives within the Adults, Health & Welfare Theme in the Haringey Deal:

- High Level Outcome 1: *All adults are able to live healthy and fulfilling lives, with dignity, staying active, safe, independent and connected in their communities*
- High Level Outcome 2: *Advice and Support - Low-income residents will receive accessible, non-stigmatising and holistic advice and support to reduce debt and address the underlying causes of financial hardship.*

7.3 Policy Implication:

7.3.1 Haringey's BCF Plan is one of the key plans for the London Borough of Haringey (LBH) and North Central London ICB. In particular it supports and helps deliver:

- North Central London Sustainability and Transformation Plan.
- North Central London Response to the NHS Long-Term Plan.
- LBH Joint Health and Well-being Strategy and is line with Haringey's Joint Strategic Needs Assessment.
- Haringey Borough Partnership Delivery Plan.
- Haringey Deal and LBH Corporate Plan.

Statutory Officers comments (Chief Finance Officer (including procurement), Head of Legal and Governance and Monitoring Officer, Assistant Director of Corporate Governance, Equalities)

8.1 Finance

8.2 The Better Care Fund (BCF) is a pooled budget of £38m in 2023/24 and £41m in 2024/25 between the London Borough of Haringey (LBH) and North Central London Integrated Care Board (NCL ICB), as shown in Table 1. It is part of the overall Section 75 Agreement between both these parties.

8.3 The purpose of the fund is to enable integrated working across NCL ICB, LB Haringey and its partners to ensure the best value for money is achieved, across the agreed projects, as listed in the BCF Planning template.

8.4 Funding was allocated jointly by LBH and NCL ICB in accordance with the aims and objectives of the plan. As noted above, the BCF Plan investment schedule for 2024/25 in Appndix 1 will be refreshed and is provisional for that financial year.

9.1 Legal

9.2 The Government's mandate to the NHS, republished in March 2021, set a deliverable for the NHS to 'help ensure delivery of its wider priorities, which include manifesto commitments to further improve the experience of NHS patients, working with local government to support integration and the sustainability of social care through the Better Care Fund (BCF) and to contributing to the planning for life outside of the EU once the current transition period ends'.

9.3 The BCF requires integrated care boards and local government to agree a joint plan, owned by the Health and Wellbeing Board. These are joint plans using pooled budgets to support integration governed by an agreement under s75 NHS Act 2006.

9.4 The Better Care Fund Policy framework updated in April 2023 states that BCF plans must include a clear approach for delivery against 2 Policy objectives in 2023-25: firstly that they must enable people to stay well, safe and independent at home for longer and secondly, they must provide the right care in the right place at the right time. Two further sub-objectives were added for this BCF Plan which align with the above long-standing objectives, and which reflect the inclusion of the additional Discharge Fund objectives:

- Improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services
- Tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow

9.5 The Policy Framwork also confirms the conditions and funding for the BCF in 2023 to 2025. The national conditions are the need for:

- a jointly agreed plan between local health and social care commissioners, signed off by the HWB
- the plan contains how partners plan to implement BCF policy objective 1: enabling people to stay well, safe and independent at home for longer
- the plan contains how partners plan to implement BCF policy objective 2: providing the right care, at the right place, at the right time
- the plan should maintain the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services

9.6 Planning and assurance of BCF plans for 2023 to 2025 requries plans to be developled locally between the local authority and health commissioners. Plans must be agreed by the ICB and the local authority chief executive, prior to being signed off by the HWB. Plans should align with other stragegic documents such as

plans for integrated care systems, wider community services programmes and the implementation of adult social care reform. Local authorities must comply with the s31 Local Government Act 2003 grant conditions.

9.7 The improved Better Care Fund (iBCF) is grant monies paid to local authorities with condition attached. The grant may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported. The conditions require local authorities to a) pool the grant funding into the local Better Care Fund, unless an area has written Ministerial exemption; b) work with the ICB and providers to meet national condition that relates to hospital discharge within the policy framework.

10. Equality

10.1 The Council and its NHS partners have a Public Sector Equality Duty (PSED) 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 protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not.

10.2 The three parts of the duty apply 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. Although it is not enforced in legislation as a protected characteristic, Haringey Council treats socioeconomic status as a local protected characteristic.

10.3 An Equalities Impact Assessment (EIA) was undertaken as part of the wider Ageing Well Strategy in 2020 for which the BCF Plan is largely a funding vehicle .

10.4 The 2020 EIA indicates the Ageing Well (and by extension BCF Plan) programme has a number of perceived benefits to people with protected characteristics. The assessment highlighted a particularly positive impact on promoting outcomes for older people (over 65), disabled people (including mental health), women and people from non-white British ethnic groups. The same positive impact will occur in 2023-25, but we recognise that the EIA needs to be refreshed to better consider the impact of COVID-19 in particular on specific communities or groups in Haringey. The BCF Plan Narrative has a dedicated section that considers equity of access, outcomes, and experience. No negative impacts were highlighted.

10.5 The positive impacts in the Ageing Well EIA were mainly due to: the cohort of patients and services users that will be the main beneficiaries; the delivery of services in people's homes; working in a service user centred way to define health and social care goals; and the intention to improve health and well-being.

10.6 Since 2020, there have been developments to specific aspects, specifically the 'Healthy Neighbourhoods' scheme (which focuses on the east of the Borough), and aims to help tackle equity of access and outcomes within Haringey's more deprived (and diverse) neighbourhoods. The Healthy Neighbourhoods model will also support particularly vulnerable groups, including people at risk of homelessness, those with specific conditions, and carers .

10.7 Intersectionality is a consideration here, recognising the inequalities experienced by Black and minority ethnic populations who live in the east of the Borough, young people from black ethnic groups experiences mental health issues, and older adults with disabilities .

10.8 The Bridge Renewal Trust report on the impact of the pandemic on specific ethnic groups recommended a number of actions, including better collection of ethnicity data, improved engagement, communication and shaping of solutions to improve equity of access and outcomes, and the need to address practical barriers, such as digital exclusion. These recommendations were absorbed into the Ageing Well Strategy, and many other projects, such as working with communities to promote vaccine take-up and embedding statistical monitoring on equity of access.

10.9 The BCF Plan EIA is currently being updated to reflect the impact of the pandemic on the population for 2024/25. For example, we know the pandemic was disproportionately more likely to result in adverse health outcomes for some groups, including people from Black African and Caribbean, SE Asian and eastern European backgrounds, as well people living in more deprived neighbourhoods.

10.10 We will reflect these responses, as well as initiatives part of BCF-funded Healthy Neighbourhoods scheme (specifically designed to address social gradients associated with deprivation and ethnicity in the east of the Borough), in our updated EIA for the BCF Plan.

11. Use of Appendices

- Appendix 1: Haringey's BCF Plan 2023-25 – List of Scheme Investments

- Appendix 2: Haringey's BCF Plan Narrative 2023-25
- Appendix 3: Haringey's BCF Plan Funding Template 2023-25 including Haringey's Demand & Capacity Forecast Oct-22 – Mar-23
- Appendix 4: Haringey BCF Plan Update Q2 2023/24

12. Local Government (Access to Information) Act 1985

Previous years' BCF Plan documents, including the original Equality Impact Assessment, can be found at:
http://www.haringeyccg.nhs.uk/about-us/better-care-fund.htm

Appendix 1 – BCF Plan 2023/24 Schemes (including new proposals / increased investment in schemes funded via CCG Minimum Allocation/iBCF in green cells; Discharge Fund investments in red font. ** 2024/25 stated investments may be subject to change for 2024/25 BCF Plan Refresh*

Service Area	Description	23/24 Budget	24/25 Budget*
EARLY HELP & PREVENTION			
Health-orientated information, advice and guidance for citizens in Healthy Neighbourhoods	Voluntary sector provision of advice, information, signposting and guidance for people needing help	£55,000	£55,000
Local Area Coordination element of locality working and Healthy Neighbourhoods initiative	Voluntary sector coordinators to provide advice, information & signposting for people who need assistance and help develop community assets	£120,136	£120,136
Integrated Early Intervention In Hospital - 'Healthy Neighbourhoods in Acute'	Advice and early help solutions for people to manage finances, housing, health, well-being & independence via integrating community solutions such as Connected Communities in health facilities	£159,000	£159,000
Integrated Early Intervention Solutions to support Health Neighbourhoods	Solutions to provide early help to people to help manage finances, housing, health, well-being & independence via integrating community-facing VCS solutions in HN collaboration	£204,000	£204,000
Self-Management Support	Structured programme of courses for patients on condition self-management/expert patient	£91,600	£91,600
First Response Social Care Team	LBH posts to increase capacity in community first response, initial triaging & management of cases to support timely response (NB: Was 2 lines of investment in 2022/23 merged together in 2023-25, total unchanged)	£282,000	£282,000
Strength and Balance Opportunities	Strengthening & balancing classes & exercises for people with a falls risk	£58,000	£58,000
Support for Dementia Friendly Haringey	LBH-funded Dementia Coordinator to take forward development of DFH (full-year funding from 2023/24)	£65,000	£65,000
Support for Community Navigation / Social Prescribing	Council commissioned support for community navigation/social prescribing network & community of practice (full-year funding from 2023/24)	£45,000	£45,000
PROACTIVE CARE AND SUPPORT			
COPD Exercise Programme	Community-based exercise groups for suitable COPD patients referred via health professionals	£13,000	£13,000
Dementia Day Opportunities	LBH commissioned services to support people with dementia with home/community-based day support	£475,000	£475,000
Nursing Services & WHT Contract Uplift*	District nursing for non-ambulant patients at home (* Increase is associated with NHS Trust upifts)	£7,115,211	£7,115,211
Multi-Agency Care & Coordination (MACC) Team	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & deliver solutions to people with frailty	£1,186,993	£1,186,993
ICB Contribution to Haringey Joint Community Equipment Budget	ICB funding of Joint Community Equipment Service for individuals who need small items of equipment / minor adaptatios prescribed by health professionals	£1,150,000	£1,150,000

Service Area	Description	23/24 Budget	24/25 Budget*
New to BCF: Community Wheelchair Services	NHS commissioned long-term patient wheelchair assessment, delivery and repair services	£693,206	£693,206
Enhanced Health in Care Homes/Trusted Assessor	Implementation of EHCH & Trusted Assessor Model to support care homes, their staff & residents	£216,000	£216,000
New to BCF: Community Health Specialised LTC Services	Investment in planned/crisis management CH investments in LTC pathways (e.g. diabetes, respiratory, falls)	-	£651,988
Palliative Care & Advanced Care Planning	NMUH-led multi-agency services to support range of community-, hospital- and bed-based palliative care	£766,000	£766,000
New To BCF: Bereavement Support	Interventions to support VCSE development, community empowerment, health and wellbeing improvements, including support for carers	£15,000	£15,000
Carer's Support	LBH commissioned range of solutions for carers: identifying carers, undertaking assessment of needs and support through to carers' respite.	£1,434,916	£1,434,916
Disabled Facilities Grant	LBH commissioned provider undertaking major adaptations of individuals' home to facilitate improvements in daily living functioning	£2,678,851	£2,678,851
IBCF*	Most of spend on providing long-term packages of care as part of social care clients' Personal Budgets (**includes £1.4m on intermediate care beds/step-down flats, reablement & care packages)*	£9,806,399	£9,806,399
New to BCF: Complex Case Management	Funding to support complex cases, to deal with the increase in demand and acuity within Adult Social Care in the community (transition, hospital avoidance- but not exclusive to) in younger adults.	-	£436,287
SUPPORTING DISCHARGE - RECOVERING AFTER CRISIS / ILLNESS (*includes Discharge Fund investment*)			
Integrated Discharge Team/Single Point of Access to support hospital discharge	Investment in teams involved in discharge (social work & nursing resources), including onward management & assessment of individual. Includes costs to cover extended hours and 7 day working	£266,093	£266,093
Home from Hospital	Voluntary sector scheme to support hospital patients (who do not need public-sector intervention) return home and settled if they need it	£150,000	£150,000
Whittington Integrated Care Therapy Team	Multi-disciplinary therapy service in community and acute that supports older people (& other groups)	£3,494,293	£3,734,293
Rapid Response & Enhanced Virtual Ward	Multi-disciplinary nursing & therapies team to respond when people are at crisis and/or need short-term rehabilitation at home or in A&E (NB: Was 2 lines of investment in 22/23 merged in 2023-25, total unchanged)	£452,000	£452,000
Alcohol Liaison Services	Alcohol Liaison Nurses & Support Worker to support hospital patients with alcohol-related issues & coordinate support in community	£61,585	£61,585
Reablement Solutions and Packages of Care (*see also iBCF line uplift)*	Community Reablement solutions to support people regain ability to undertake daily living skills, including patients with more complex needs (NB: Was 3 lines of investment in 22/23 merged in 2023-25, total unchanged)	£3,389,534	£3,389,534

Service Area	Description	23/24 Budget	24/25 Budget*
Enhanced bed-based intermediate care capacity	Intermediate care beds in care home to help people recover, assess individuals' needs and eligibility for post-recovery as part of ASC commissioning (beds at PWH & other care homes)	£280,136	£280,136
Nursing Intermediate Care	Nursing beds in care home with MDT input & nursing outreach to patients' homes for those needing period of convalescence post-discharge	£466,523	£466,523
MDT capacity to support patient patient move-on post-recovery	Additional therapy & social worker resources to support for home- and bed-based intermediate care patients in intermediate care nursing care beds	£319,816	£319,816
Supporting people with challenging housing needs to return home post-hospital discharge	Investment in out-of-hospital housing liaision function to facilitate acute and non-acute hospital discharge of people with challenging housing environments to return home (full year from 2023/24)	£96,000	£96,000
LA Element DF: Workforce investment	Funding allocated to LBH workforce Initiatives, to support hospital discharge processes and reviews	£1,184,080	£1,147,993
LA Element DF: Care Purchasing packages of care for Home First	LBH commissioned domiciliary care to support short-term Council interventions to support hospital discharge, return home and recovery	£190,762	£1,147,993
ICB Element DF: Care Purchasing packages of care for HomeFirst (LBH)	LBH commissioned domiciliary care to support short-term Council interventions to support hospital discharge, return home and recovery	£140,098	-^
ICB Element DF: Care Purchasing of interim residential/nurs' ing care placements (LBH)	LBH commissioned interim residential/nursing care placements to support hospital discharge and recovery prior to assessment outside acute hospital	£502,501	-^
ICB Element DF: D2A Pre-CHC Assmt P1 Home First Pathway (NHS)	Domiciliary care to support hospital discharge and return home for patients likely to need assessment for long-term NHS care	£192,000	-^
ICB Element DF: D2A Pre-CHC Assmt Interim Res/Nursing Care Step-down beds (NHS)	Short-term interim residential/nursing care for patients likely to need assessment for long-term NHS care home placement	£327,000	-^
ICB Element of DF: TO BE DETERMINED 2024-25 (Placeholder)	NCL ICB and Councils will conclude the final use of the Discharge Fund for 2024/25 in latter half of 2023/24 and re-submit to the HWB. Could include funding for elements marked as '^' in 2024/25	-	£2,394,206$
ENABLERS			
Commissioning Support	To provide multi-disciplinary and multi-agency commissioning support for BCF Plan Programme	£286,721	£286,721
Principal Social Worker	To provide quality assurance and plan workforce development for social care	£60,000	£60,000
Total		**£38,489,454**	**£41,971,480**
Investments to BCF Plan Schemes from ICB Min. Allocation		**£22,210,640**	**£1,189,781**
Investments from Discharge (both elements) in BCF Plan		**£2,536,441**	**£4,690,192$**

'$': Placeholder amount for the ICB element of the Discharge Fund in 2024/25 and its utilisation within Haringey are to be determined. Current figure indicates potential level of investment from ICB element in Haringey in 2024/25

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Title:	**Haringey Health & Well-Being Better Care Fund (BCF) Narrative**
Report Authorised By:	**Beverley Tarka, Director of Adults and Health, London Borough of Haringey**
	Rachel Lissauer, Director of Integration (Haringey), North Central London Integrated Care Board (NCL ICB)
	Sarah Mansuralli, Chief Development & Population Health Officer, North Central London Integrated Care Board

Bodies Involved in Developing Plan:	**North Central London Integrated Care Board**
	London Borough of Haringey (including its housing function)
	North Middlesex University Hospital NHS Trust
	Whittington Health NHS Trust
	Barnet, Enfield and Haringey Mental Health NHS Trust
	Haringey GP Federation
	Bridge Renewal Trust (as strategic partner for voluntary sector in Haringey)
	Haringey Healthwatch
	This BCF Plan was developed in partnership chiefly between NCL ICB and Council and its executives and clinicians. It is an extension of the 2022/23 Plan and reflects our progress. The Narrative builds on Haringey's multi-agency Ageing Well Strategy developed in conjunction with partners, and direction of the NHS Long-Term Plan. The Age Well Board, a multi-agency sub-group of the Haringey Integrated Care Partnership (Haringey's Borough Partnership), endorsed the Plan prior to submission to the Health & Well-Being Board. The above organisations, represented at the Board, supported the Narrative's integrated care approach and many are delivery partners for solutions discussed below, e.g. the Healthy Neighbourhoods collaboration in east Haringey between the statutory and voluntary (VCSE) sectors. This oversight included our partners involved in out-of-hospital services, including our acute Trusts (North Middlesex University Hospital (NMUH) NHS and Whittington Health (WHT) NHS Trusts), with whom we reviewed our High Impact Change Model self-assessment and out-of-hospital metric targets in this Plan.

Executive Summary
Our ambition is to work with residents of all ages so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, to age within a connected and supportive community and to have a dignified death. North Central London Integrated Care Board's (NCL ICB's) Population Health Strategy & Health Inequalities 2023-25

Our vision is for Haringey to be a place where everyone can live healthy and fulfilling lives and feel connected and safe in communities where people support each other. Haringey Council Corporate Delivery Plan 2023/24, Adults, Health & Welfare.

Our approach to the 2023-25 BCF Plan reflects these aims, extends the direction of previous Plans and incorporates more recent changes to local and national policies and strategies. Our Plan aligns with the Integrated Care System and Council responsibilities in the NHS Operating Plan (including those relating to inequalities), Health & Care Bill, the NHS Long-Term Plan and Putting People at the Heart of Care, as well as NCL ICB's recently published Population Health Strategy and Haringey Council's Delivery Plan. This Narrative explains how the BCF supports NCL ICS and Haringey to take forward these requirements, including emerging developments such as our response to the Fuller Report or NCL Community Services Review; it should be noted the BCF is just one lever to promote integration. We continue to build on our foundations in shaping a person-centred approach to integration on a multi-geographical footprint.

Our three main priorities relate to challenges in our system:

- *Managing Demand-Led Pressures:* Managing a greater number of people whose underlying health status and social conditions worsened as a legacy of the pandemic, with consequences for the system. Although emergency admissions of older people decreased in 2022/23 compared to pre-pandemic, the typical acuity of individuals' cases, particularly those aged 50+, is more complex.
- *Ensuring our hospital/out-of-hospital systems are well-prepared and sufficiently resilient* to manage patient flow, including how we address financial and workforce constraints (such as recruitment and retention), to facilitate safe and timely hospital discharge and recovery post-hospitalisation.
- *Addressing underlying issues associated with equity* of access, outcomes and experience and the systemic consequences of inequality in Haringey; people living in deprived (and often more diverse) neighbourhoods have 17 years shorter healthy life expectancies than their most affluent peers.

Our Approach: Haringey's Integrated 'Care Cone' (see Integration Section)

Our 'care cone' model (aligned to the NHS Comprehensive Personalised Care Framework) is the framework we use to organise our response to the individuals' presenting needs. Our model informs the structure of several strategies, such as Haringey's Ageing Well Strategy and NCL ICS's Population Health & Inequalities Strategy. It aims to:

- Emphasise the importance of a strength-based approach, prevention, self-management of health conditions and personalisation, so people can stay as healthy, well and independent as possible.
- Ensure where people do need help, the 'right joined-up solutions for the right person are delivered at the right time' as close to home as possible, to improve or maintain their physical and mental health, well-being and independence now and in the future and best support carers.
- Help people avoid future health or social crises as far as possible and/or people can recover as fully as possible after crises, ideally at home. We can mitigate the risk of some crises for residents via earlier detection, diagnosis and improved management of physical and mental health conditions, particularly in more deprived (and diverse) communities.

The 'care cone' is a population-wide model though BCF investments chiefly focus on supporting people who are likely to, or who have, acquired long-term physical or mental health conditions, have multi-morbidity and/or frailty; or who need help to recover post-crises. Most individuals (>90%) likely to benefit from BCF schemes are aged 50+, but there is no 'age restriction' on services. Some BCF schemes *do* support an 'all age' approach, e.g. Haringey's Healthy Neighbourhoods model or carers' support.

Achieving these aims promotes positive system outcomes, including mitigating demand for intensive and costly interventions within the population. The model achieves this is in short- to medium-term by reducing people's risk of crises and acute or non-acute hospitalisation or supports their recovery. There is evidence we were successful in doing so: a 20+% reduction in 1+ day non-elective (NEL) admissions for Haringey 65+ residents in 2023/24 v. 2019/20 (pre-pandemic), due to better managing complex patients in primary and proactive care in the community, including in under-served communities.

Delivery of our 'care cone' model mitigates future demand by investing in early help to reduce the risk of people acquiring, or exacerbating existing, long-term physical or mental health conditions, including a greater level of engagement and investment to tailor our response to better support under-served communities. The BCF includes preventative schemes particularly targeted to:

- Address Borough-wide physical and mental well-being/health-related issues, the latter including social isolation, bereavement and support for those with lived experience of dementia, and carers.
- Tackle inequalities in Haringey's deprived east locality and responding to the Fuller report, including via our Healthy Neighbourhoods model, focussing on our most deprived areas in east Haringey.

Improving Planned Care & Out-of-Hospital Support to Help People Recover After Crisis/Hospitalisation
The pandemic's legacy and 'system shocks', such as rising cost-of-living, led to significant deconditioning in many people's physical and mental health and well-being and increased demand on the care system, particularly amongst older people with existing long-term conditions (LTCs)[1]. This group are typically now more likely to be frailer, less physically active and isolated, and more likely for existing conditions to exacerbate than pre-pandemic. We estimate a 20% increase in the number of Haringey residents with moderate/severe frailty aged 50+ post-Wave 1 due to deconditioning[2]. We also know that there is a significant increase in the number of younger adults with complex health and care needs in the Borough also.

Our community system responded well to these issues: for example, the number of Haringey GP consultations increased by a third between 2019/20 and 2022/23. This helped mitigate the number of older people with crises resulting in ED attendances over this period, with NEL admissions decreasing; but it meant there was an increase in the typical acuity of older people now admitted to hospital needing community and acute care, e.g. average length of stay for those aged 75+ at NMUH hospital increased from 10 to 13 days between Mar-21 and Mar-23, with consequences for short- and long-term

[1] Public Health England: Wider impact of COVID-19 on physical activity, deconditioning & falls in adults, Aug-21
[2] Based on an 18% increase in the number of people on GP lists with 3+ LTCs pre- & post-pandemic and a 20% increase in the proportion of older people presenting to EDs with moderate/severe frailty over this period.

care system utilisation and resources. Similarly, we see more people in our system in poor housing environments or at risk of homelessness.

Partners in Haringey and across NCL worked together to shape our resulting solutions and plans, including those contained with the 2023-25 BCF Plan (including the pooled Discharge Fund), to meet rising demand and acuity, particularly in relate to several new or expanded out-of-hospital schemes to ensure people can mitigate crisis, avoid hospitalisation or support people to recover post-hospitalisation, ideally at home. Investments, linked to integrated discharge/intermediate care and NCL Community and Mental Health Service Reviews, to which the BCF contributes include:

- Expanding our planned and proactive care network to better manage people with LTCs, including falls, dementia, multi-morbidity, frailty and end of life, improve our neighbourhood care 'offer' to respond to the Fuller report across Haringey and enhance our statutory-sector community response to patients and residents, e.g. in terms of timely delivery of assessments, community equipment or adaptations/improvements/repairs to property.
- Sustaining our investment in joint Discharge Teams to support patient discharge from acute or non-acute hospitals locally and across NCL; and enhance our investment in support for P2 bedded and particularly joint P0/P1 Home First pathways in Haringey and across NCL. This includes additional support for discharge for people with challenging home environments and those at risk of homelessness/rough sleeping; and investing in admission avoidance services.
- Investing to address financial and workforce pressures associated with complexity and rising costs of short- and particularly long-term care in Councils, NHS and private providers in a range of settings.
- The above support includes enhanced investments for patients/residents known to be vulnerable, including those with severe and enduring mental health issues, those part of inclusion health or those more generally from under-served communities or groups.

Improving Equity of Access and Outcomes (see Equality Section)

A long-term commitment of the Integrated Care System is to provide a more equitable NCL allocation of resources to tackle inequalities in access, outcomes and resources that impact on health, care and life chances. For example, NCL ICB plan to increase investment in health and care services in Haringey in response to the Community and Mental Health Services Reviews to reduce unwarranted NCL variation in service provision. Haringey will be a 'net beneficiary' of this 'levelling to need' over the next 5 years, as it is a less well-resourced Borough for its relative needs. Initial investment priorities in Haringey for 2023-25 include planned and proactive care (improved falls prevention pathways and pain management services) and intermediate care (expanded Rapid Response/P1 Home First pathways).

The pandemic's legacy and other 'system shocks' will continue to reinforce existing population social gradients of outcomes without a more targeted approach to investment within under-served groups across Haringey and NCL. This forms part of NCL ICB's Population Health Strategy, incorporating our response to the Core20Plus5 requirements.

The ICB continued to commit an annual £5m Inequalities Fund Programme across NCL in 2023/24 (with c. £1.8m in non-BCF IF projects in Haringey alone). Haringey's BCF part-funds Healthy Neighbourhoods, our IF prevention model into under-served communities, and this model will be expanded in 2023-25 as part of our response to the Fuller report and need to build resilience and infrastructure in the voluntary and community (VCSE) sector as one of our key stakeholders.

Our 'Healthy Neighbourhoods' model is a locality-based collaboration between the Council, NHS/primary care, VCSE sectors and residents/patients focussed in deprived and diverse east Haringey wards to improve social and health-related equity of access and outcomes. The collaboration brought together a network of statutory and voluntary sector partners to engage with communities to tackle and find solutions to specific population physical and mental health and social needs around a set of key themes. We will expand the scope of our work in east Haringey, increase IF Programme investment to deprived communities around our NMUH system. We will support residents living in these communities to decide on, and build, the solutions and community assets right for these communities, as part of building an approach to community empowerment. We also intend to expand our approach to engagement, codesign and community-asset building to our central and west localities in 2023-225 with different demographic profiles as part of our response to the Fuller report and Core20Plus5 requirements within our Population Health Strategy and PCN DES requirements.

Our Healthy Neighbourhoods model supports particularly vulnerable groups, including people at risk of homelessness, those with specific conditions and carers. This goes beyond the expectations of the Protected Characteristics to acknowledge even in deprived communities there are especially vulnerable individuals who needed support. The BCF Plan includes schemes to support such individuals.

Governance

BCF Plan governance is a two-stage process involving oversight of Narrative and contract development, respectively, with oversight across NCL's multi-geographical Integrated Care System structure. The governance structure is shown below, with those Boards heavily involved in creating and agreeing the BCF Plan 2023-25 in orange boxes.

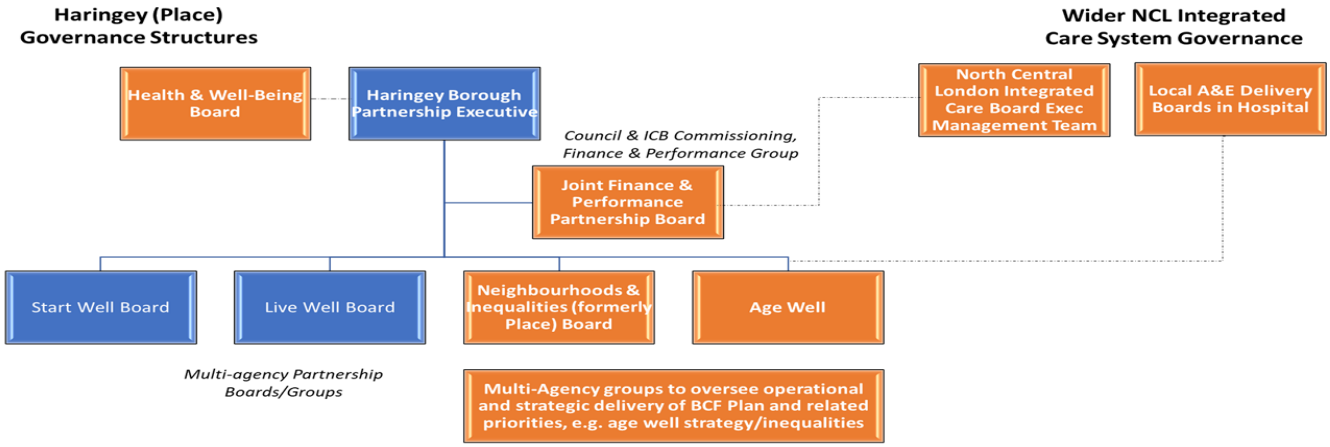


Figure 1 – Summary of Governance Structure for BCF Plan 2023-25

The Plan's content will be signed off by Haringey's Health & Well-Being Board in Q2 2023/24, but the Chair has signed-off submission in June in consultation with partners. The Director of Integration in the ICB's Haringey Directorate and LBH Director of Adults and Heath oversaw local Plan development, including its investment schedule. We agreed the Plan locally via Haringey's Joint Finance & Performance Partnership Board which these Council/ICB executives oversee. The latter Board is a local Haringey executive commissioning, performance and finance group which has responsibility for shaping and agreeing joint s75 agreements (including BCF investments), liaising with individual organisational directorates in Council and ICB, and joint monitoring and reviewing progress, performance and impact of the BCF (see below).

Partners listed in the first section endorsed the Plan at the Age Well Board and agreed its direction and approach, and over time helped shape investments in the BCF Plan, e.g. additional investment in supporting people with dementia and prevention. This involvement includes our secondary care partners: we included the High Impact Change Model (HICM) self-assessment review, capacity & demand and metric targets to our A&E Delivery Board to provide assurance the plans were in line with the NCL Operating Plan and national ambitions.

The BCF is a pooled Section 75 agreement between Council and NHS held by the ICB and includes investments in out-of-hospital services including via both ICB and Local Authority Discharge Fund components. The budget and its allocation – including assuring compliance with minimum Council and out-of-hospital spend – was provisionally agreed between commissioners and finance leads at the Joint Finance & Performance Partnership Board locally.

The ICB's Strategy and Development Committee then reviewed and gave the ICB's commitment to the Plan contents, metrics and s75 investments, alongside the other 4 Borough BCF submissions. NCL ICB's Governing Body will formally sign-off CCG commitment to the 5 Plans and investment into each Borough-based s75 pooled budget, based on the recommendations of the Committee.

Reviewing Progress

Partners remain committed to jointly managing the BCF Plan, the initiatives within it and its impact. The main vehicles for this are Haringey's Age Well Board and Joint Finance & Performance Partnership Board. A small proportion of the BCF Plan funds infrastructure continues to support commissioning programme oversight, including joint Council/CCG commissioning and workforce development.

The Age Well Board's role is to bring partners together to progress its Strategy which this Plan largely underpins. The Board acts as the Strategy's Programme Board and BCF Plan implementation and has oversight of integrated care solutions partners are developing and delivering together. The Board also receives report on the impact of these solutions, and this includes the BCF Plan metrics on a routine basis. Our NMUH and WHT A&E Boards receive reports on progress against out-of-hospital metrics, including those included in the BCF Plan. We will incorporate routine updates associated with the new

demand and capacity requirements into these integrated reports with each organisation responsible for reporting on their individual out-of-hospital services (e.g. LBH for reablement).

The Joint Finance & Performance Partnership Board is responsible for compiling year-end BCF Plan evaluation of individual schemes against a range of pre-agreed criteria based on national and local expectations of ongoing strategic fit, quality, integration, impact and value for money. Based on the evidence in this evaluation, it also recommends whether to continue with these investments (or not) the following year. This Board has local oversight of the s75 agreement and is responsible for reporting on allocated BCF budgetary spend and has oversight of the impact of the BCF investments on metrics. It will have oversight of the quarterly returns to the national and regional BCF Teams in 2023-25, and oversight of the process to produce the fortnightly ASC Discharge returns.

Reviewing the BCF Plan commitments in 2023/24

As noted in the Provide Right Support at Right Place at Right Time section later in this report, partners have agreed to review key aspects of the BCF/Discharge Fund investments in 2023/24, with a view to making agreed changes to the proposed BCF schedule included in this Plan. Partners anticipate our current schedule of investments in the BCF Plan particularly for 2024/25 will be subject to change, and we will commit to update this schedule post-review.

Our Approach to Integration and Collaborative Commissioning

Our 'care cone' tailors solutions to individual's needs and circumstances and categorises solutions into:

- *Feeling Healthy, Safe & Well* aligned to local and national public health messages/services to encourage people to adopt, or get help with adopting, healthier lifestyles, e.g. smoking cessation, being active, and 'making every contact count'. This is a 'universal' offer across the population, with greater investment/promotion to groups or communities most under-served, e.g. addressing higher levels of smoking prevalence amongst specific groups. Investment in these solutions is non-BCF.
- *Early Help & Prevention*, a targeted approach working to address issues or needs amongst people at 'rising risk' of needing more intensive solutions, e.g. those at risk of acquiring or living with existing LTCs and/or those in under-served communities or groups. Our objectives are to encourage people to come forward for earlier diagnosis, adopt healthy lifestyles, better self-manage their conditions, get help to meet their health, housing or social needs and avoid or mitigate crises.
- *Planned and proactive care* for people whose health, housing and social needs are more complex and/or intense, who need a tailored and often an integrated and multi-disciplinary response to these needs including care and support services.
- *Specialist/emergency care including discharge/intermediate services* to support people who need highly specialised health and social interventions and/or who are approaching or are at crises or need help recovering from crisis, ideally at home.

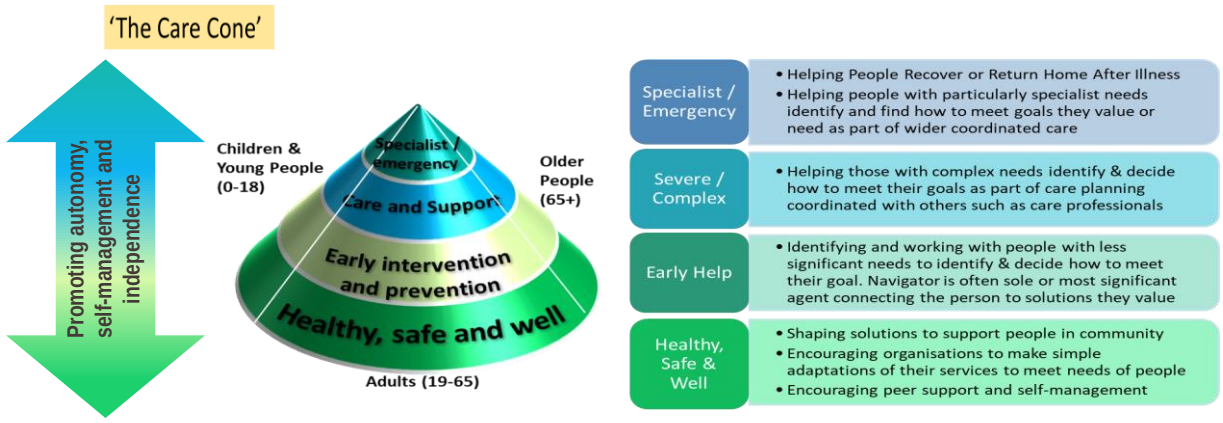


Figure 2 – Haringey Care Cone Framework

Our priorities for enhanced 2023-25 BCF Plan delivered in partnership across health, social care, housing and VCSE includes the following investment in this framework (details in each relevant section).

Early help & prevention

- Consolidate and expand our IF and BCF investment in building locality-based, coproduced community assets through our Healthy Neighbourhoods collaboration and tackle inequalities in east Haringey around our NMUH acute hospital which serves the most deprived populations in Haringey and Enfield, including responding to the Fuller report. Our locality approach, and response to the Fuller report, will then be rolled out across central and west Haringey in 2023-25, partly utilising existing BCF Plan resources (see Right Care at Right Time section).
- Respond to the support our Borough Partnership Executive's Haringey-wide priority focus on mental health, social isolation and bereavement, including for carers of people with terminal conditions.
- Increase our BCF investment in delivering early help for carers and people aged 50+ as part of our locality working, including supporting community navigation and asset-building and developing our approach to dementia-friendly Haringey and improving support for people living with dementia.

Planned and Proactive Care

- Consolidate and expand our planned and proactive care network to facilitate better management of people with LTCs, including in relation to Core20Plus5 LTCs, dementia, multi-morbidity, frailty and falls, and build our neighbourhood care 'offer' to respond to the Fuller report, and ICB and PCN Direct Enhanced Services requirements.
- Enhance our re-procured joint community equipment service between Council and NHS, partly funded via the BCF Plan, and establish a handyperson scheme funded via BCF DFG investment and bring Wheelchair Services into the scope of BCF planning.
- Respond to financial and workforce pressures associated with acuity of care and rising costs of short- and long-term care within Councils, NHS and private providers in a range of settings.

Specialist/emergency care including discharge/intermediate services (including investment from DF)

- Build our investment in joint Discharge Teams across Haringey, our local acute and non-acute hospitals and NCL, including through our NCL-wide Transfer of Care Hub which organises cross-boundary discharges. This will ensure we have sufficient capacity and capabilities to promote safe and timely discharges within the HICM framework, tailored to the patients' underlying needs.
- Significant additional investment in our P0/P1 Home First 'offers' for admission avoidance (particularly to expand our 2-hour response) and post-discharge across social care and community health and virtual wards to meet rising demand.
- Build investment in our NCL-wide P2 intermediate care beds and the need they fulfil (e.g. rehabilitation/reablement/step-down) for community, non-acute and acute patients, as well as the MDT support to prevent deconditioning and plan timely move-on.
- Enhance our approach to support people with challenging housing environment and those at risk of homelessness in secondary care: a dedicated post to coordinate discharge and temporary move-on arrangements for patients with our housing colleagues; step-down flats to help people recover physically and from homelessness, and support move-on to longer-term housing solutions.

Investments in the above lines include key groups of individuals known to be vulnerable, such as those with severe and enduring mental health issues living in the community or who are in acute or non-acute settings, those who are part of inclusion health or those from under-served communities, e.g. within the Healthy Neighbourhoods model or the above investment in discharge arrangements.

Collaborative Commissioning Between Partners across a Multi-Geographical Footprint

Our approach to integration assures a 'golden thread' to align system solutions between partners at a multi-geographical footprint – a seamless 'offer' of support for our population at an Integrated Care System, Borough and neighbourhood/primary care network footprint. This approach to integration is supported through our collaborative approach to joint commissioning, which in turn in under-pinned through the multi-agency governance structures described above.

The BCF Plan promotes joint ICB/Council commissioning across all population groups to better understand population health needs holistically across partners and engage a range of statutory- and voluntary-sector partners to jointly develop and fund solutions built around the structure of the 'care cone' across the health, housing and social care system. This led to joint commissioning of individual multi-agency services, such as our proactive care model with, for example, a single agreed specification for services even if there are multiple contracts with individual providers.

Our collaborative approach helps us synthesise the needs of multi-geographical developments across neighbourhoods, Boroughs and the ICS. For example, one objective is to ensure we deliver solutions, tailored to individuals' needs, as close to home as possible. This places a bias on codesigning local solutions in the places people live and can access services tailored to the way they want them delivered, particularly for those communities at risk of being under-served. At the same time, our aspiration across the ICS is to provide a more equitable 'core' set of community health solutions to reduce unwarranted variations in outcomes and resources between Boroughs.

These two drivers can be reconciled, and the development of our multi-agency proactive care model is a good example of how our approach to strategic commissioning and integration brings together NCL standardisation and local shaping. A consensus emerged across NCL Boroughs on a 'proactive care blueprint': the key features of, and outcomes for, a proactive care model based on that emerging from the PCN DES and NHSE requirements. This led to an 'equity-based' Borough allocation of additional NCL ICB funding to support development, with local Borough partners working together to plan where best they should invest and agree those elements of the model best developed across the ICS, e.g. NCL-wide development of an algorithm to help identify those patients at risk. In Haringey, this led to additional non-BCF ICB investment, alongside existing BCF funding, agreed between partners at the Borough's Age Well Board. Our proactive care model is now being further localised and developed to align with our neighbourhood models to respond to the Fuller report.

We continue to collaborate across multiple Borough and across NCL to assure a more equitable level of resources to meet underlying needs across NCL and in each Borough as part of the ICB's commitment to 'level to need' in community services, some of which are part-BCF funded. For example:

- Haringey commissioners and partners at the Haringey Borough Partnership deciding on which NCL Inequalities Programme schemes are funded in the Borough in partnership with the ICS.
- The NCL Community Services and Mental Health Reviews seek to ensure there's a common 'core offer' for individual services designed locally, such as proactive care, across the ICS, and to enhance existing services in less well-resourced Boroughs (including Haringey) over the next 5 years.

National Condition 2: Enable People to Stay Well, Safe and Independent

In this and the next section, we utilise our 'care cone' to describe our response and investments to address underlying demand and need. We have included a table at the end of each section to describe how BCF investments relate to the relevant 'care cone' tier, and influence metric delivery. However, the BCF Plan is simply part of a wider investment in solutions as outlined in this Narrative.

Early Help & Prevention including 'Healthy Neighbourhoods'

We continued to invest in our 'Healthy Neighbourhoods' collaboration in the east of the Borough and now see this as a blueprint for the approach in other localities in Haringey in bringing together partners to build engagement, community assets and deliver planned and proactive care within these neighbourhoods. The neighbourhood-based approach has proved successful and is being

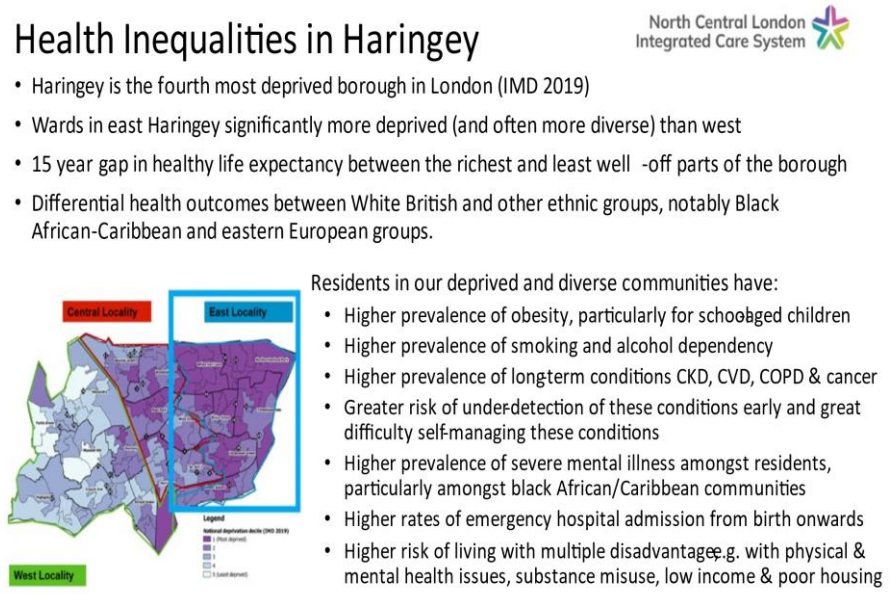
Healthy Neighbourhoods is a multi-agency collaboration between NHS, primary care, Council and VCSE partners working with under-served communities living in the east of the Borough to design and deliver a range of preventative and planned care solutions across the population to improve their health, well-being and life chances. Priorities agreed by partners from a combination of public health evidence, insight from communities and representative groups in our more deprived communities were:

- Ensuring a Best Start in Life (largely focussed on children and families)
- Improving Prevention, Diagnosis and Management of Acquired LTCs (part-BCF funded)

- Improving Mental Health/Well-Being (fully BCF funded)
- Supporting Vulnerable People including those with severe & multiple disadvantage/inclusion health to recognise even within deprived communities, there are individuals who have greater need (part-BCF funded).

A cross-cutting theme, part-BCF funded Community Empowerment, ensures there is sufficient VCSE engagement and investment to support community asset-building and co-design in the emerging models, and people in under-served communities feel better able to 'have their say' on local services.

The above priorities for east Haringey were identified from quantitative and qualitative intelligence in collaboration between partners, including public health, Council, NHS and VCSE partners in collaboration with residents, as key issues partners at the Place Board agreed to focus on in that locality (see summary below). (A similar exercise has recently started in the two other localities – see below).



The support available within the Healthy Neighbourhoods model varies depending on the theme, but, for example, the process of identifying and working with individuals living with LTCs includes:

- Primary care screening using an NCL-wide IT algorithm and local intelligence and networking between partner staff to identify residents who may need help.
- A range of partly BCF-funded VCSE organisations working with statutory colleagues to 'in reach' into under-served communities, engage, connect and support individuals, help people work through needs and how they might self-manage their condition; and help people address social issues they value help with that influence health and well-being outcomes, e.g. debt, access to benefits, housing issues etc., and this includes investment from Haringey's Community Chest.
- The statutory sector working in localities to screen patients and provide diagnosis, professional advice, treatment and interventions, and connect them to voluntary sector partners. The statutory sector will work to improve partners' knowledge on issues such as LTC self-management.

There is some evidence that our approach is beginning to deliver outcomes for participants and the system as a whole and is supporting improvements in several key metrics (see Equalities section).

To promote Healthy Neighbourhoods, the Council, ICB and our voluntary sector umbrella partners established a part-BCF funded 'Community Chest' in 2022/23 (which will be expanded in 2023-25) to provide grants to VCSE partners to support community asset-building linked to a 'call to action' for each

theme. We awarded funding to schemes to provide local activities and services, for example a local breakfast and activities club with part-BCF funded community health/primary care staff providing advice about diet, nutrition, help with physical activation and healthcare issues. The club works will people with LTCs, such as CVD/hypertension and COPD (both part of Core20Plus5 priorities), identified by health professionals as part of the LTC HN Theme, to help them better self-manage their conditions.

The Healthy Neighbourhoods funding is part of a wider investment in locality working which will be closely aligned to the development of our response to the Fuller report in 2023-25. This will ensure our locality models – east, west and central - will be developed with primary care clinical leadership and oversight from our Primary Care Networks (PCNs) and GP Federation as major partners working alongside NHS, Council and community and voluntary sector organisations to help shape preventative and proactive care solutions with our residents and patients.

We continue to enhance our part-BCF funded multi-agency locality hub working at North Tottenham and 'lifestyle hubs' at our NMUH system, both serving deprived communities in east and central Haringey. The hubs provide health-orientated information and advice, but also guidance and help with issues such as debt, housing and care to the community with the VCSE, the Council's Connected Communities and DWP.

Our housing colleagues are partners in our locality working and the Council, NHS, primary care and VCSE developed an action plan to improve the health, well-being and independence of particularly older residents living in supported accommodation such as sheltered housing. This will form part of the locality working, and we will utilise these housing facilities as 'community hubs' to support older people in nearby neighbourhoods as well as residents. The Council (non-BCF) funds a range of supported housing, including Extra Care, for older people living with frailty, with several developments planned over the next few years. The iBCF continues to fund step-down/step-up flats to facilitate discharge in conjunction with the Council's housing department.

Our response to the physical and mental health needs of individuals in our more deprived neighbourhoods also includes our non-BCF funded locality-based 'Mental Health Team Hubs' linked to primary care networks working with the MH Trust and VCSE to better support those with significant mental health needs with their conditions and physical health as part of our response to the transformation of mental health services.

One priority is to ensure people, particularly those who need early help including older people or those with LTCs, have access to the information they need to help them make positive decisions about their lifestyles and conditions. For example, our (non-BCF funded) multi-agency and online Ageing Well Guide and Resource Toolkit, co-developed with partners and residents, provides hints, tips and contacts to help people age positively, e.g. eating well, looking after mental well-being etc.. The Guide is online, but 5,000 paper copies were distributed to 50+ organisations working with older people in 2022/23.

Many people tell us they would like someone to help them connect, navigate or coordinate access to opportunities or solutions they may value to improve their health, social or housing outcomes and life-chances. 'NavNet' is our innovative community-of-practice and collaborative practical problem-solving Community Navigation network amongst volunteers and professionals who act as community navigators (including our social prescribers and care coordinators in primary care), and acts as a dynamic resource directory. NavNet members are employed by many different organisations, with different functions, job titles and specialisms, e.g. a VCSE Somali Community Navigator, Council Local Area Coordinators or Connected Communities (both part-BCF funded). NavNet members are people whose role is likely to involve 'connecting' residents/patients, help each other problem-solve individual cases, alert each other to opportunities and activities and feedback about improvements that could be made to support– a key community asset and invaluable 'eyes and ears' in local communities. The BCF funds a dedicated post to coordinate the development and infrastructure of 'NavNet', which currently has 220 members, a 30% increase in membership since the postholder started in Q3 2022/23.

In 2023-25, we intend to:

- Consolidate our existing BCF investment in building NavNet as our Community Navigation network (to over 400+ members) and wider VCSE infrastructure and community asset building and development initiatives over the next 18 months.
- Non-BCF support VCSE and statutory sector staff, including NavNet members, to better help people aged 50+ by developing and rolling out a tiered approach to ageing well and frailty awareness-raising and training based on the Guide's content; and encouraging greater sign-up to NavNet.
- Continue to develop our multi-agency approach to locality working in the east of the Borough including with primary care and community, as part of our response to the Fuller report. This includes sustaining and joining up our existing BCF investments in strength and balance, self-management and expert patient programmes as part of the wider development of the ageing well training and awareness-raising described and of locality developments. This includes further investment in our Community Chest-related solutions in 2023-25.
- Ensure the ICS requirements relating to the Fuller response are delivered within Haringey, with development and implementation achieved through collaborative commissioning (see previous section). We will develop our multi-agency approach around the needs of specific localities/neighbourhoods or on specific issues, including reducing risk of acquiring or improving self-management of LTCs, mental health (some of '5' priorities in 'Core20Plus5') and PCN 'Plus' priorities identified as part of our primary care clinical leadership. For example, we will progress plans to:
    - Develop non-BCF funded hubs to that in North Tottenham across Haringey in our central and west localities, including working with our housing colleagues as noted above. The priority in central Haringey is to better and more joined-up support for people with mental health issues, which reflects the Borough Partnership Executive focus on this issue and demographics in this locality. This support includes our part-BCF funded network of Local Area Coordinators that already exist across the Borough to support people with more complex health and social needs.

- Work with Primary Care Networks (PCNs) in west Haringey to better support people with frailty as part of their 'Plus' responsibilities in 'Core20Plus5' as part of community asset building. People with significant frailty are well-served through our BCF-funded proactive care solutions, so west PCNs will work with community partners and residents to codesign early help to support people with mild frailty to manage their condition/risks and age well.
- Expand development of multi-agency solutions and integration into locality working to support people with mental health issues and its root causes across Haringey, e.g. social isolation or a significant change in life circumstances such as bereavement. Particularly vulnerable groups we will focus on include those with inclusion health or severe mental health needs and those with lived experience of dementia, and carers. For example, we intend to continue to build our membership of, and community assets within, our BCF funded Dementia Friendly Haringey via our Dementia Coordinator and improve support in our BCF funded dementia 'hub-and-spoke' model linked to localities. Similarly, we intend to establish a BCF funded Carers' Support Network within our localities in response to the needs of carers of all ages as part of roll out of our Carers' Strategy.

- Continue to consolidate our approach with, and investment in, the VCSE through the next phases of our partly BCF funded Community Chest and encourage other partners to utilise this framework.
- Continue to develop our partly BCF-funded Inequalities Fund Programme in Haringey through additional investment in the schemes associated with the NMUH system (see Equalities section). We will also continue our early help investment at NMUH hospital – our BCF Funded 'Healthy Neighbourhoods in Acute' scheme.

Early Help & Prevention Funded Through BCF Plan (see also Spreadsheet; New or revised items in red font)			
Scheme ID	**Scheme**	**Reason for Change / Addition**	**Metrics**
1	Health-orientated information, advice and guidance as part of wider advice model for citizens in Healthy Neighbourhoods		All investments have potential impact on avoidable admissions & falls metric
5	Local Area Coordination to support people with complex needs in localities		
9	Integrated Health, Housing, Finance and Care Early Intervention In Hospital as part of 'Healthy Neighbourhoods in Acute'		
10	Integrated Health, Housing, Finance and Care Early Intervention Solutions to support Health Neighbourhoods in our Localities	Includes investment in Community Chest in 2023/24	
24	Support for Dementia Friendly Haringey	Increased investment in 2023/24	
25	Support for Community Navigation / Social Prescribing ('NavNet') & wider VCSE infrastructure to support engagement	Increased investment in 2023/24	
46	Carers' Support Services	Increased funding to develop locality Carers' Support Network	

Proactive and Planned Care & Support

We have substantial BCF funded investment in community health services as part of helping people to manage their LTCs. This includes significant investment in nursing and therapeutic intervention in the community and supporting people with specific LTCs such as dementia, MSK, COPD or diabetes. Community health undertakes some of these interventions solely with primary care, but several organisational partners may be needed in an integrated model to manage people with complex cases of people with frailty or multi-morbidity. We have recently re-procured our joint community equipment service between Council and NHS, partly funded via the BCF Plan. We fund an admission avoidance (Rapid Response) scheme for people in crisis to avoid hospitalisation, along with intermediate care

services such as reablement which also support people to avoid hospitalisation as long as post-discharge. Further details of this scheme can be found in Condition 3: Right Place, Right Time section.

The development of our early help and proactive care solutions are part of our commitment to place our Primary Care Networks (PCNs) at the heart of locality working as part of their new population health responsibilities and as part of our response to the Fuller report.

Haringey's mainly BCF-funded Multi-Agency Care & Coordination Team (MACCT) is our WHT/Haringey GP Federation-led proactive care model and it supported 2,000 people with moderate or severe frailty or multi-morbidity living at home over the last year. MACCT is a multi-agency and multi-disciplinary team led by a GP with nurses, therapists, pharmacists, mental health, social care and voluntary sector workers. Our model incorporates many of the features of NHSE's Proactive Care Framework. This includes utilisation of NCL-wider primacy algorithms from a common data platform (as well as referrals from trusted sources such as GPs, nurses or social workers) to triage individuals' needs into the right support stream: work with the voluntary sector or single professional to support access to the right personalised care and support and opportunities; or people with complex needs who could benefit from a 'full' MDT consultation to develop an individual's person-centred plan summary and care coordinator.

Our proactive care approach is supplemented through non-BCF funded multi-agency 'Proactive Intervention Teams' operating in PCNs in conjunction with VCSE and acute Trusts to manage the health and social needs of patients who were on the elective waitlist for some time and who are particularly vulnerable (e.g. those with severe mental health issues).

Our BCF-funded Enhanced Health in Care Homes (EHCH) model is a coloration between community health and primary care and care homes supports people with frailty or multi-morbidity living in these homes in line with NHSE's and the PCN DES's requirements for the support available. This model proved successful, and we now cover all care homes across NCL. We intend to extend the model of support for older adults living in our LD care homes through additional non-BCF investment.

We continue to improve our part BCF-funded services to support people nearing end of life to provide high-quality palliative and end-of-life care and support in their last years and days of life so they can die in the place they want, and we actively promote Advanced Care Planning in our proactive care services, including MACCT and our EHCH model.

The above more proactive solutions supported the absolute number of people admitted to hospital due to chronic ambulatory care sensitive conditions gradually decreased, including those living in the most deprived 20% areas, over the last 5 years. We also know some individuals approach crises quickly and we invested in our admission avoidance services to provide an urgent response at home (next section).

In 2023-25, we will build on our planned and proactive care response:

- Roll out our part-BCF funded reprocured community equipment service across NHS and Council. We also brought ICB funding of our Wheelchair Services into the BCF Plan for the first time in 2023/24.
- Continue to 'get the basics right': improve our response and workforce capacity to ensure people can benefit from high-quality and timely statutory assessments (e.g. Care Act, Carers', Mental Health Care Act, Continuing Health Care Assessments) to help to plan to meet their needs, with some roles being funded through the BCF Plan.
- Work across partners to improve our personalised planning and delivery of care, including further developing our model of support for people with dementia (partly BCF-funded). We will also ensure there is sufficient capacity and BCF investment to fund increases in demand and costs of public sector-funded long-term care provision across our care markets, particularly in care homes, and improve our partnership arrangements to better manage the market.
- Working with our housing partners, we will better support the physical and mental health needs of people in supported accommodation, such as sheltered housing or Extra Care, and intend to pilot an 'enhanced care in supported living' model as part of our BCF ECH/MACC Teams as a collaboration between the Council, community health and primary care in 2023-25
- Strengthen our falls pathway, including additional non-BCF investment in community health in relation to improving bone health and physical activation of patients at risk of falls or repeat falls
- Improve our proactive approach to better managing the increasingly complex adult social care and health needs of a greater number of younger adults (aged 18-64 years) living in the community in Haringey through strengthening both case management and care and support solutions.
- Integrate relevant social care, housing, community health teams, MACC and PIT Teams into locality working, alongside the early help solutions discussed above, starting in east Haringey as part of our response to the Fuller report. We will further extend the role of the MACC Teams to incorporate the needs of people with more complex LTCs (but not necessarily frail) as part of roll out of our non-BCF funded LTC Local Enhanced Service with primary care.
- Continue to develop our partly BCF-funded Inequalities Fund Programme improving Core20Plus5 LTCs. Our approach will also support early diagnosis and better utilisation of community services.
- Reprocure and further develop some of our BCF-funded carers' services in 2023/24 (see Carers' Section).

Planned & Proactive Care Funded Through BCF Plan (see also Spreadsheet; New or revised items in red font)			Influences Which Metrics				
Scheme ID	Scheme	Reason for Change / Addition from 2022/23 / Additional Comments	Admission Avoidance	Falls	Usual Place (Home)	Res/Nursing Adms	Reablement Home Outcome
3	Dementia Day Opportunities					Y	
7	Nursing services, including community matrons for MACC Team		Y	Y	Y	Y	
60	Community Health Specialised LTC Services	**New:** Investment in LTC/falls Community Health services as part of Community Services Review in 2023/24	Y	Y	Y	Y	
11-15	Multi-Agency Care & Coordination Team (multiple elements)		Y	Y	Y	Y	Y
16 & 17	First Response Social Care Team and managing complex cases	L16 combines 2 lines to support SW Teams in 2022/23 (at same funding).	Y	Y		Y	
2	COPD Exercise Scheme		Y				
4	Self-Management Support		Y				
18	Strength and Balance Service		Y	Y			
19	Enhanced Health in Care Homes & Trusted Assessor		Y	Y			
20	IBCF Supporting Long-Term Community Social Care		Y	Y		Y	Y
21	Palliative Care & Advanced Care Planning Facilitator	Services can access bereavement support	Y	Y	Y	Y	
50	Community Equipment Service (ICB Funded Only)		Y	Y	Y		
6	Disabled Facilities Grant (Major Adaptations)		Y	Y		Y	
62	Complex Case Management of Younger (18-64) Adults	**New:** Investment in case management & care solutions for ASC clients with complex needs living in community	Y	Y		Y	
52	Wheechair Services	**New:** Brought into scope of BCF Plan	Y	Y			
46	Carers' Support Services	Increased funding to develop locality Carers' Support Network	Y			Y	

Provide Right Support at Right Place at Right Time: National Condition 3
Admission Avoidance, Supporting Safe & Timely Discharge and Helping People Recover

Partners have three aims to prevent admission and/to facilitate discharge for secondary care patients:

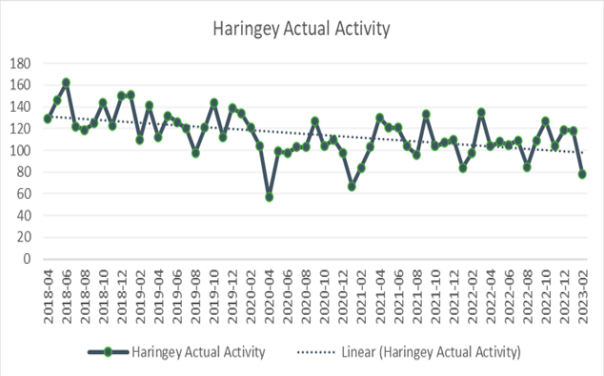
1. **Reduce the number of people presenting to hospital and/or admitted to hospital in crisis through urgent interventions at home or within A&E.** Many planned and proactive care services in the Supporting People to Remain at Home section are designed so partners working together in a coordinated and integrated way can support this aim. For example, our current review of the MACC Team suggests its intervention has a positive impact on reducing avoidable ED attendances/NEL admissions, including falls admissions, due to better managing escalating needs before a patient crisis - our estimates suggested a reduction in hospitalisation rates by as much as 25%.

   BCF-funded investments also include our community admission avoidance service, Rapid Response, connected to 111 which responds every month to c. 185 patients at crises at home in 2-24 hours (depending on urgency) without the need for avoidable ED attendance/admission – a 80% increase in the numbers pre-pandemic. We plan to further non-BCF investment in this service in 2023/24.

2. **Ensure as many patients as possible can return directly home in a timely and safe way as soon as they are fit to do so – 'Home First' – and there's support to recover health and independence.** Typically, 93% of people are discharged 'home' - to their usual place of residence. Our figures show 76% of people with reablement remain at home post-hospital discharge, and that we have increased the number of people seen in our P1 'Home First' pathways via hospital by 15% in 2022/23 compared to pre-pandemic partly enabled through Discharge Funding investment. These home-based intermediate care solutions also support admission avoidance (if patients with escalating needs are identified in the community), including falls prevention. We have set a target for this metric to reflect our improved range of P1 Home First solutions to manage more complex health and care needs at home and better support those at risk of homelessness/with challenging housing.

   We need to improve the proportion of people who receive reablement and who remained at home 91 days post-discharge. This figure needs to improve towards its pre-pandemic levels; this proportion decreased during the pandemic as there were more complex cases who were more likely to either be moved to P2/P3 long-term care and/or have longer-term admissions/readmissions.

3. **Ensure as few decisions as possible about an inpatient's long-term care take place in hospital. Every patient should be given the chance to recover post-discharge, ideally at home** or, if not, in an intermediate care bed. Individuals' long-term care needs should be assessed post-recovery. We know 1-1.5% of our patients are admitted to long-term care placements in care homes. This approach to ensuring as many people as possible can recover either pre- or post-hospitalisation has ensured we reduce the number of people admitted to Council-funded long-term care homes.



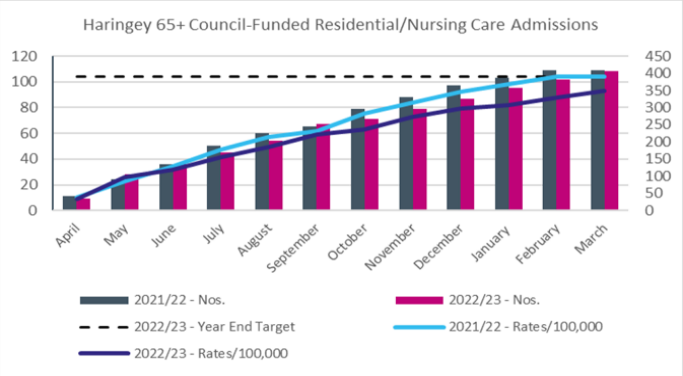


Figure 3 – Trend data for Avoidance Hospital Admissions and (b) 65+ Council-Funded Long-Term Care Home Admissions for Haringey

These objectives are beneficial for patients and mitigate the need for, and intensity of, Council or ICG-funded long-term care for individuals. We have utilised our routine monitoring of metric data in 2022/23 to inform target setting (examples in Figure 3), with our targets (once adjusted for standardised rates) adjusted to take account of the likely impact of the additional improvements in the previous and this sections. For example, expanding our planned and proactive care services (e.g. better utilising our MACC Team or expanding Rapid Response) will influence both our falls admission and avoidable admission rates *and* our long-term admissions to care homes. The table at the end of this section summarises our in BCF Admission Avoidance/Supporting Discharge investments in 2023-25. It, and the table in the Supporting People at Home section, also indicates whether these services contribute significantly to which BCF metrics.

Planning Discharges and High-Impact Change Model

We have strong arrangements for hospital discharge and intermediate care between secondary care and community partners. Staff in secondary care, in community health services, CHC teams and Councils work together to triage the needs of those hospital patients approaching discharge identified as needing care to return home through the Integrated Discharge Team (IDT) model in each hospital. This network of partners includes North Middlesex University Hospital (NMUH) and Whittington Hospital Trusts (WHT), two hospitals that admit 80+% of emergency Haringey patients, as well community health, mental health, Council social care and housing services. As system partners, we facilitate discharge via a D2A approach based on the national High-Impact Change Model (HICM). Appendix 1 summarises our progress against our HICM self-assessment in 2022/23 across NMUH and WHT with our neighbouring Boroughs and plans to make further improvements in 2023-25. The BCF partly funds the

adult social care staff working as one of these out-of-hospital discharge partners. All IDTs and partners operate 7 days a week, with additional capacity to manage surge demand.

Haringey's Council and community health services also work with IDTs in other NHS Trusts on a case-by-case basis, particularly for more complex cases, to plan and manage the discharge and ongoing recovery, care and support needs of Haringey residents in other hospitals. In addition, a non-BCF funded NCL Transfer of Care Hub (TOCH) supports the management of patients cross-Borough particularly to support discharge to, and move-on from, P2 NHS Rehab facilities access to which is open to patients from 5 Boroughs in NCL under our ICS bed-sharing agreement.

The majority of inpatients are discharged home without statutory sector care and support, i.e. P0 pathways; however, some P0 patients may value time-limited support to return and settle home via our part BCF-funded VCSE Home from Hospital schemes operating in NMUH and WHT. These schemes helped 750+ Haringey residents discharged on P0 pathways from acute hospitals to return home in 2022/23, the highest number recorded. This support provides a vital contribution to ensuring people can be discharged to their usual place of residence and we want to strengthen this support in 2023/24.

Supporting People to Recover Post-Crises – Step-Up and Step-Down Intermediate Care
The Summary highlighted the legacy of the pandemic, including the significant increase in the number of people with moderate/severe frailty in Haringey due to health and social deconditioning, particularly amongst people with pre-existing LTCs and/or difficult social circumstances. This had consequences for demand in our community system, with the community and primary care sectors, including those proactive and planned care services, absorbing a significantly increased level of activity (particularly amongst older people) in the community during the pandemic. Due to this community response, the number of people hospitalised as an emergency *decreased* pre- and post-pandemic, e.g. 30%+ decrease in NEL admissions for all ages between Apr–Mar-23 compared to Apr–Mar-19, though our data tells us this decrease has now levelled off the last 12 months.

However, we had rising acuity amongst those admitted to hospital – for example, the average number of diagnoses of conditions per patient increased by 30% at NMUH, whilst the proportion of Haringey patients who stayed longer than 14+ days increased from 12% to 14% between 2019/20 and 2022/23. This also means there are significant pressures in terms of our NHS and Council intermediate care P1-P3 'offers', with more people needing more complex support to recover (e.g. a 15% increase in P1 Home First reablement cases between 2019/20 & 2022/23), despite reductions in admissions. Our forecasts suggest these trends will continue, and much of the LA/ICB Discharge Fund will be utilised to support community and bedded intermediate care, alongside other BCF/non-BCF funding sources (see below).

We continue to ensure our discharge model emphasises 'Home First' and have extended our community-based models of support. For example, our Trusts provide a largely non-BCF funded Virtual Ward 'offer' to support acute patients with frailty/delirium to return home but under the care of an acute/community health team. The number of patients supported through our WHT Virtual Ward

service is 20 at any one time, and we are planning to extend the service capacity in response to demand. As part of this our approach, we continue to invest in remote monitoring assistive technology to support people to live as healthy, safe and independent lives as possible including within Virtual Wards.

The increased complexity of patient cases also relates to their social and environmental circumstances. For example, we know typically 20%-30% of Haringey discharge delays are due to patients living in challenging housing environment (e.g. hoarding, deep cleans etc.) or who are at risk of homelessness, and both these circumstances are more prevalent now than pre-pandemic amongst our non-acute and acute patients. We are working with housing colleagues to increase investment to address these issues:

- A joint protocol setting out housing and care staff respective responsibilities in supporting the discharge of patients at risk of homelessness through the NMUH/WHT IDTs and their partners, including shared expectations around timescales.
- BCF-funded investment in a housing liaison function in our IDT systems in 2022/23 to help coordinate, plan and support the discharge of cases of individuals living in challenging housing environments, together with procurement of an urgent deep clean/environmental service to organise rapid improvements in their homes to facilitate safe and timely discharge.
- Non-BCF-funded NCL Move-On Co-ordinators support inpatients who are rough sleeping and/or at risk of homelessness. The Co-ordinators liaise with housing needs teams and other housing colleagues to ensure smooth transition from hospital to temporary or long-term accommodation.
- Part BCF-funded (including Discharge Funding in 2024/25) short-term accommodation for secondary care patients who are rough sleepers or risk of homelessness.
- Non-BCF-funded GP-led Homeless Health Inclusion Team to work with rough sleepers in these units to help them recover physically and from homelessness and address longer-term health issues.

Much of the Discharge Fund (and BCF ICB Minimum Allocation/iBCF) was focussed on supporting P1-P3 pathways in 2022/23. We will continue to increase capacity in out-of-hospital interventions in 2023-25. The Discharge Fund has helped ensure that our capacity for intermediate care better matches the call on demand we experience across our Trusts. We know current demand for P1 Home First solutions were slightly higher than anticipated capacity in Q1 2023/24 (see Demand & Capacity spreadsheet), and the following investments in 2023-25 has enabled us to assure that demand matches capacity from Q2 2023/24:

- Partly Discharge Funded, reablement and domiciliary care and support to aid patient's recovery as part of P1 'Home First' or admission avoidance, including within Rapid Response or Virtual Wards.
- Partly Discharge Funded, health-orientated/D2A pathways prior to CHC assessments in individuals' home.
- P2 intermediate care beds including:
  - Part BCF-funded/part-ASC Discharge funded 225 P2 NCL NHS Rehabilitation beds pooled for the 5 Boroughs, with these beds shared across the 5 Boroughs (NB: see Demand & Capacity section).
  - BCF-funded short-term Haringey-based intermediate care ('P2 with reablement') beds to help people convalesce and recover their health and function in a care home, with a joint community health and adult social care MDT to support individuals recovery and move-on.

- Partly Discharge Funded, Council and NHS residential/nursing care home interim step-down/assessment for secondary care patients who cannot return home for health, social or environmental reasons, partly funded via Discharge Funding.
- Partly Discharged Funded support for ASC workforce initiatives designed to support hospital discharge, case management, review and move-on post-discharge.

In 2023-25, we will look to improve our commitment to support patients' admission avoidance and safe and timely discharges and onward recovery in the community:

- Strengthen the interface between our admission avoidance, hospital ED and discharge functions, and our planned and proactive care 'offers' post-recovery in the community. This includes expanding the MACC and EHCH Teams and falls prevention and how we make best use of both our newly opened diagnostic centre in Wood Green as a facility to triage escalating health or social needs of individuals quickly to mitigate escalating crises through responding in localities.
- Continue to invest in improving our partly BCF-funded admission avoidance solutions, particularly expanding Rapid Response functions capacity to respond in 2 hours, and further integration with our wider Urgent Care Response network including 111 to avoid conveyancing to ED, e.g. better use of the non-BCF funded NCL Frailty Car Service to care home residents as part of our 111 response.
- Progress improvements identified in the High Impact Change Model table over the next 12-18 months as system partners across our local acute and non-acute hospitals (Appendix 1).
- Reprocure our part-BCF funded Home from Hospital schemes to support the needs of P0 pathway patients, including strengthening how we help more individuals recover their health, well-being and independence once home and connect them to our wider early help and proactive care systems.
- Respond to an ICS-wide joint Council and NHS review of our future discharge interface between acute and community and onward intermediate care 'offer' and implement improvements in our joint Discharge Team (with BCF partly-funding ASC staff) models around our NCL acute and non-acute systems. This includes improving our capacity and capabilities to better identify, prepare/plan for discharge and triage the needs of people in integrated P1-P3 pathways across the ICS.
- Continue to develop and expand our BCF/DF-funded P1 NHS/Council Home First intermediate care/reablement 'offers' to ensure more patients with a greater range of needs have the support they need to return to their usual place of residents.
- Continue to progress NCL-wide improvements to NCL part-funded BCF/DF-funded P2 bedded intermediate care, interim care home step-down and fast-track arrangements. This includes funding to reduce unwarranted variation in resources across NCL acute and non-acute hospitals, expanding P2 NHS Rehabilitation bed complement and improving our MDT arrangements to best support move-on.
- Expand our part-BCF funded investment in housing-related support for patients with challenging housing behaviours or risk of homelessness to be discharged from acute or non-acute hospitals in a safe and timely way and to recover their health and address their circumstances.

Proposals for 2024/25 Discharge Fund Allocations and ICB Minimum Allocation

Our submitted plan does not include schemes and commissioner for the ICB DF for 24/25. We have agreed a process summarised below that will support the development of schemes – note that both schemes, commissioner and funding per borough for the ICB DF for 24/25 is subject to change. In developing our approach, we have engaged with our regional Better Care Manager and whilst it means we cannot identify our 24/25 spend at this stage, we are confident that our approach is fully aligned with meeting the BCF principles and outcomes.

The process we are working to locally is: The councils and the ICB in NCL have not reached agreement on the use of the discharge funding for 23/24 and 24/25. To move this forward, an alternative approach will be taken in accord with the principle we agreed for open book transparency between partners. The ICB will agree to the allocation to social care of 50% of the ICB ADF allocation as a one off in 2023-24 (£3.4m).

This is agreed on condition that we jointly appoint and fund an independent financial expert, to review both the ADF, BCF and all budgets within both social care and the ICB that the independent financial expert and CFOs feel necessary to resolve this issue, with open book financial reporting and activity counting on both sides.

This independent expert's work will report jointly to a nominated council CFO and Phill Wells as ICB CFO and they will be able to make binding recommendations to inform how the 2024-25 BCF and ADF are spent in an equitable way.

Terms of Reference, a specification and principles for the work including definitive timescales for completion will need to be jointly agreed between CFOs and the independent financial advisor before the final stages of BCF sign-off including the s75 sign offs are completed and the £3.4m one off for 23-24 is transferred to councils.

Out-of-Hospital Funded Through BCF Plan (New or revised items in red font)			Influences Which Metrics					Additionality to Capacity? (New Services)			
Scheme ID	Scheme	Reason for Change / Addition from 2022/23 / Additional Comments	Admission Avoidance	Falls	Usual Place (Home)	Res/Nursing Adms	Reablement Home Measure	P0	P1	P2	P3
8	Integrated Therapies and Therapeutic Support for Urgent Care Response including support for P1 Home First recovery	Uplifted investment in community health services. ICTT supports P1 Home First and 'step-down'	Y	Y	Y	Y	Y				
23	Alcohol Liaison Services in Hospital		Y	Y	Y						
26	Invest in Single Point of Access/IDT-support function to meet demand	Line 26 combines several lines in 2022/23 (at same funding). Supports funding of ASC staff in discharge process and 7 day working	Y	Y	Y						
29	Home from Hospital (P0 Support)		Y	Y	Y						
30 & 31	Rapid Response Service & Virtual Ward (Community Health & ASC components)	Line 30 combines 2 lines in 2022/23 (at same funding). Included here as intermediate care but is N2: Support at Home offer ('step-up')	Y	Y		Y					
33 & 36	P1 Home First Reablement Solutions & Packages of Care (iBCF & Min. NHS Contribution)	Line 33 (& seperately Line 36) consolidates several lines in 2022/23 (at same funding). Included here as intermediate care but supports 'step-down' and some 'step-up' (N2) clients	Y	Y	Y	Y	Y				
38	P1 Home First Step down flats		Y	Y	Y						
39-41, 51	P2 Community-Based Care Home Intermediate Care & Convalescence Beds (iBCF & Min. NHS Contribution)	Provides 'bedded reablement' and dedicated multi-agency MDT to support recovery & move-on	Y	Y		Y					
42 & 43	Enhanced MDT to support indivudals' recovery & move-on in (particularly care home) P2 beds		Y	Y		Y					
44	Supporting people with P1 Home First challenging housing needs to return home post-hospital discharge	DF investment in 2023/24	Y	Y	Y	Y					
54	D2A Pre-CHC Assmt P1 Home First Pathway	DF investment in 2023/24 and 2024/25 to meet demand	Y	Y	Y	Y			Y		
55	D2A Pre-CHC Assmt Interim Residential/Nursing Care Step-down beds	DF investment in 2023/24 and 2024/25 to meet demand	Y	Y						Y	Y
67	Discharge Funding for care provision to support P1 HomeFirst hospital discharge pathways	Investment from ICB element of ICB Discharge Fund to meet ASC P1 HomeFirst demand in 2023/24	Y	Y	Y	Y	Y		Y		
68	Discharge Funding to support Council-funded short-term/interim P2/P3 care placements post-hosptal discharge	Investment from ICB element of ICB Discharge Fund to meet ASC bedded intermediate care demand in 2023/24	Y	Y		Y				Y	Y
64	Discharge Funding to support workforce initiatves to support hospital discharge & post-intermediate care review	DF investment from ASC Discharge Fund to meet demand in 2023/24 & 2024/25	Y	Y	Y	Y	Y		Y	Y	Y
65	Discharge Funding for care provision to support P1 HomeFirst hospital discharge pathways	DF investment from ASC Discharge Fund to meet demand in 2023/24 & 2024/25	Y	Y	Y	Y	Y		Y		
63	Discharge Funding 2024-25 - To Be Determined	Additional investment to be agreed. NCL ICB and LAs plan to agree the final application of the Discharge Fund during 2023-24.	To Be Determined					To Be Determined but likely to add capacity to P1-P3			

Approach to Demand and Capacity Modelling – Community and Hospital

Our approach to demand and capacity modelling draws on four key data sources/methodologies:

1. Hospital discharge data from 2022/23 and 2023/24 NCL ICS Operating Plan which reflects acute demand for P0-P3 discharge pathways. We utilised the Plan's forecasts, based on historical activity projected forward which disaggregates into P0-P3 pathways.
2. Existing capacity and demand activity for intermediate care in 2022-23 and use this as the basis for an interim projection for 2023/24. We know the number of Haringey patients (demand-side) utilising, for example, P2 pathways sub-categories utilised in 2022-23. We can utilise these proportions, applied to P0-P3 projections in (1), to estimate likely demand within each sub-category.
3. (2) provides estimates of likely demand in 2023/24 without any further intervention, e.g. our additional BCF/non-BCF investments. We therefore consider how the investments in intermediate care listed in the previous section will influence demand figures along P0-P3 pathways. For example, non-BCF added investment in Rapid Response will increase the number of people who are diverted into such schemes rather than in ED; or additional capacity from BCF/DF into P1 Home-First/care home step-down schemes will draw activity into, and between, these pathways. This 'additionality' also informs our capacity calculations, e.g. further Rapid Response investment increases its capacity. As noted above, this showed that our demand was slightly greater than capacity in Q1 2023/24 prior to implementation of our additional solutions funded through 2023-25 BCF Plan investments. This helped inform our BCF schedule for the Discharge Funding to assure that our capacity better matched demand from Q2 2023/24 onwards.

4. Some services are linked to admission avoidance (community), others to discharge. However, others (e.g. reablement) are utilised by both routes, and where this is the case, a simple pro-rota estimate of cases from community/hospital is used to estimate demand and capacity.

The above considerations were included in the BCF Demand and Capacity profile for Haringey. The BCF schemes in the table in the previous section shows where they impact as 'additionality'.

We continue to work with partners as part of an NCL ICS, rather than simply Borough-based, development of intermediate care solutions. However, this ICS-wide approach leads to some issues in terms of matching P2 demand to capacity, particularly for rehab beds. Haringey has never had rehab beds in its Borough boundaries, with its patients utilising nearby P2 NHS rehab facilities in 3 other NCL Boroughs. Boroughs in NCL agreed to report their Rehab capacity in the spreadsheet in terms of the facility's geographical host Borough (though demand comes from multiple Boroughs), which means Haringey is reporting a '0' capacity in the template. Any analysis regionally of demand/capacity should pool information on bedded rehab across 5 NCL Borough returns to fully understand the ICS position.

We reviewed our learning from our 2022/23 ASC Discharge Fund scheduled investment across both acute and non-acute systems. We were largely able to deliver against targets as reported in Year End submission. Key learning points are the need to improve and invest via BCF/non-BCF/DF in:

- Admission avoidance/Home First solutions in 2023-25 including expanding Rapid Response, and our P1 'offers' such as reablement, health-orientated solutions and case management, including Virtual Wards. We saw rising levels of complexity of cases, which meant we were under-target for the number of reablement cases delivered – due to higher costs per case.
- NCL-wide bedded support in several ways (see previous section):
  - Currently reviewing our NCL-wide P2 bed capacity and bed-sharing arrangements and the oversight via TOCH to ensure beds are utilised in a more effective way to increase throughput.
  - Patients awaiting P2/P3 provision had a greater complexity of rehabilitation needs, long-term health issues and complex social and housing situations. This made these individuals difficult to place sometimes within our local systems, e.g. step-down to care homes, which slowed discharge.
  - Continue to invest in supporting interim care home step-down arrangements, but to preferentially to better utilise other MDT-supported P2 options to help patients recover and prevent long-term deconditioning – particularly as occupancy in care homes is 95%+.
- Our homelessness and housing needs solutions (see previous section).
- Governance and oversight between parties of sign-off of returns and submissions to the BCF Team for the fortnightly returns in 2023-25 – progress now formally agreed.

Support for Unpaid Carers

The BCF Plan continues to invest in solutions to identify and support unpaid carers as part of Haringey's wider multi-agency Adult Carers' Strategy. Its aim is to ensure that *all carers, of all ages, are recognised, respected and supported* to ensure anyone who provides unpaid care and support is:

- Able to identify themselves and recognised as carer
- Supported to continue to be a carer
- Supported to maintain or improve health & wellbeing
- Supported to have a life of their own

- Provided with information, advice and guidance, with priorities relating to housing and finances.

We continue to progress the resulting action plan, but have made progress since the last BCF Narrative:

- Council and NHS partners have improved their engagement, identification and support for carers as part of wider NCL development of 'anchor institutions' approach to enhance care and support organisations' roles as civic leaders. For example, the Dementia Reference Group, which brings together people with lived experience with dementia including carers with statutory partners, held a series of 'You Say, We Do' workshops in 2022/23 on topics such as safeguarding and post-diagnostic support. This proved a successful and popular approach with carers.
- Increased the number of people supported through activities facilitated through our VCSE carers partners' activities, including 1:1 support including on topics such as health, well-being, managing caring role etc., and improving awareness of the support available for carers in Haringey through 'NavNet' and via regular newsletters to carers known to the Council.
- A focus on supporting carers from under-served communities to shape solutions and opportunities with them – these specific requirements are integrated into the Strategy's action plan.

The BCF Plan funds key services to support carers in Haringey including:

- Carers' First contract as our key VCSE carers' partner to hold the Councils' Carers' Register and identify and support carers. In 2023-25, we will re-procure our VCSE carers' service. We will ensure that the needs of carers are integrated into our locality-based development and plan additional BCF investment in carers' support workers in localities during 2023-24
- Short-break care for carers to provide them with respite from caring responsibilities, and provision of Direct Payments (which increased by 80+% over the last 3 years) to support them in their role. BCF investment in carers' breaks is significant (highest of 5 NCL Boroughs).
- In 2023-25, we intend to increase our investment in supporting carers by over one-third. We will utilise the funding to establish a Carers' Support Network to better support and assess the needs of carers for all client groups as part of our roll out of locality working as part of our response to the Fuller report.

Disabled Facilities Grant and Wider Housing Services

Disabled Facilities Grant

One of overall aims in terms of housing-related support is to better utilise home aids/adaptations and technologies to support people in their own homes to improve outcomes across health, social and housing. This includes partly BCF-funded community equipment and wheelchair services (included in Supporting People to Remain Home) and provision of major adaptations of people's homes to help them to live independently for longer, funded through the DFG via the Better Care Fund.

Demand for DFG funded adaptations across all tenures and for residents of all ages continues to be high, particularly in deprived areas, and we have utilised the funding flexibly in the way the RRO offers for several years. The Council administers all aspects of the DFG process, including OT assessments, following referral, working in conjunction with housing, Registered Social and private landlords, and a

delivery provider framework. We routinely review delivery, quality, performance and spend during the year, but, as in previous years, we anticipate funding will be fully committed in 2023/24.

We are exploring setting up a Handyperson Service from the DFG allocation in 2023/24 to support people living in the community who need minor adaptations or repairs. We will utilise the service to support people to live at home and as part of our overall housing hospital discharge 'offer' (see below).

Engagement with Housing Services
Our partnerships incorporate health, social care and housing-related services. We shared our plans with our supported housing and housing needs colleagues within the Council's housing department, who we work with to shape our approach and delivery as part of our plans for locality working and support to promote discharges and move-on for people with challenging housing environments/at risk of homelessness. Our wider work with housing colleagues since the last BCF is included in previous sections of the Narrative.

Equality & Health Inequalities

As noted last year, we conducted an Equality Impact Assessment based around the Protected Characteristics plus socio-economic deprivation for the BCF/ Ageing Well Strategy and the impact of the pandemic on amplifying social gradient of inequalities, which helped shaped our delivery plans.

There was pre-pandemic social gradient of up to 17 years in healthy life expectancy between the least and most deprived (and often most ethnically diverse) areas. Residents from the 20% most deprived neighbourhoods are 2-3x as likely (from birth to 75 years) to be hospitalised as their affluent peers, with notably higher rates amongst people from Black Caribbean/African and eastern European backgrounds. We know the impact of the pandemic and other 'system shocks' such as the rising cost of living and energy prices affected people in under-served communities than other groups. For example, our local intelligence and national reporting tells us people in under-served communities are now more at risk of being moderate/severe frailty than their age peers in better-served communities. As the Summary notes, there is good evidence our Haringey community services have responded well to rising demand, and this helped people manage their conditions. For example, the number of Haringey GP consultations increased by one-third between 2019/20 and 2022/23, with the number for people living in the 20% most deprived areas/from the above ethnic backgrounds rising by a similar proportion.

NCL ICS reaffirmed its commitment to improve equity of access and outcomes to under-served communities, particularly those living in deprived neighbourhoods in 2023/24. The ICB committed non-BCF £5m Inequalities Fund Programme (c. £1.8m targeted at Haringey's under-served communities) to fund solutions to address these issues and improve the health and life chances of people in the 20% most deprived neighbourhoods. The Programme's most significant investment is in Haringey's Healthy Neighbourhoods collaboration between NHS, Council, VCSE and residents in our deprived communities. Our BCF partly funds VCSE activities in the model through our Community Chest (see Early Help section).

The table below shows the full distribution of funding within the Inequalities Fund Programme projects and additional BCF Plan investment.

The Programme was focussed largely on addressing the 'Core20Plus5' issues within the 20% most deprived neighbourhoods: alongside other sources of funding, such as the MH Transformation Fund, the Programme includes investments in projects supporting people living with SMI, those with or at risk of LTCs, such as cancer, COPD, CVD/hypertension, and inclusion health. We have engaged with PCNs to support the 'Plus' component, including frailty in the west (see previous sections).

A stock-take of the Programme undertaken in 2022/23 was promising. For example, one non-BCF project supporting 150 people with heart failure living in the 20% most deprived neighbourhoods through an MDT approach including the VCSE, markedly improved health outcomes, including self-management, for participants. It also reduced re-admissions for its participants by 22% with overall HF admissions in these deprived communities reducing by 6%.

Due to the improvements in engagement and support between residents/patients, VCSE and statutory services in the community, including within the IF Programme, over the last 2 years, we have seen a *decrease* in the number of people living in Haringey's 20% most deprived communities NEL admissions to hospital – a reduction of over 30% between 2019/20 and 2022/23.

We continue to roll out our approach to determine the extent to which BCF and ICB-funded services are equitable for those patients and residents they serve including through:

- Ensuring we incorporate the views of particularly under-served communities and groups in the delivery or involve people in co-design of solutions. For example, partners, led by the VCSE, collaborated with specific communities (e.g. people from black African/Caribbean groups) as part of the (entirely BCF-funded) mental well-being theme of our Healthy Neighbourhoods to shape solutions they might value. This led to an approach in which people engaged with a range of arts and sports activities they might value *before* discussing their underlying mental health issues.
- We used our IF Programme funded community ambassador network into specific under-served groups and wider engagement network led through our VCSE partners to improve delivery of healthcare services. For example, we recently engaged with the Turkish/Kurdish community on a range of healthcare-related issues, including ensuring services the support people with LTCs receive (e.g. in BCF-funded nursing or proactive care services) is culturally sensitive and in settings closer to the community. We will continue to build our social capital network and infrastructure in 2023-25
- We continue to roll out monitoring equity of access and outcomes of key services through 'equity ratios'. These ratios measure the extent to which services, such as our MACCT, are accessible to residents with particular characteristics, e.g. defined by age, ethnicity or circumstance (e.g. those living alone, carers etc.), with the expectation action will be taken to address under-representation with those groups under-served. We have started to create deprivation, age and ethnicity-based equity ratios for our performance metrics, including BCF metrics, in line with HIID's proposed approach to metric development.

Our commitment to the concept of 'equity' goes beyond Protected Characteristics. For example, the BCF Plan has continued to invest in:

- A BCF-funded Coordinator to work with organisations to grow our Haringey Dementia-Friendly Communities. The Co-ordinator works with deprived and diverse communities to improve awareness of the condition and connect people to solutions they may value.
- BCF part-funded IF projects in a range of communities and collaborations in our most deprived communities - many focus on specific under-served groups, e.g. improved support for young people from black ethnic backgrounds with mental health issues, including those recovering from crisis.
- The BCF part funds a model to support discharge of people with severe mental health needs from non-acute secondary care to return home and recover in the community as part of our MH IDT.
- Support for people with multiple disadvantage and those at risk of homelessness as part of our Healthy Neighbourhoods IF, BCF Discharge Fund investments and other funding to:
    - Help up to 50 people per annum with complex physical and mental health issues better manage their lives and health needs in the community as part of locality working, including non-BCF Department for Levelling Up, Housing & Communities Rough Sleeping Initiative funding to support care coordinators in 2023-25 and a substantial non-BCF funded Health Homelessness Inclusion Team to manage the health needs of people at risk of homelessness.
    - Support c. 120 people per annum who are High-Impact Users within our local ED acute hospital to better manage their lives and health through a dedicated multi-professional MDT led by a dedicated care coordinator, a non-BCF IF project with promising outcomes for patients. We estimate a 15% reduction in ED attendances so far from this group, with over 800 ED attendances and 80 NEL admissions mitigated per year.
    - Support c. 30 people per annum admitted to non-acute or acute hospital to recover their health and from homelessness through extending the number of non-BCF-funded step-down provision and supporting their subsequent move-on into long-term accommodation.

In 2023-25, we intend to continue our focus on addressing equity of access, outcomes and experience:

- Continue with our Healthy Neighbourhoods and IF Programme projects as part of the locality working in east Haringey in 2023/24 and beyond.
- Continue to extend and develop our BCF and non-BCF investments for people with dementia, mental health and people living with severe and multiple disadvantage.
- With Enfield, look to extend our non-BCF IF Programme around our NMUH system reaching jointly into east Haringey & Enfield. This system was selected for additional investment as it is the acute hospital, whose patients live in the most diverse and deprived NCL neighbourhoods.
- Ensure our future developments in this Narrative proactively consider equity as part of their codesign and implementation, including engaging with under-served residents and patients (e.g. in locality development). We will then utilise 'equity ratios' and resident/patient feedback to monitor the success and impact of these services/projects, including those relating to BCF and its metrics.

APPENDIX 1 - SUMMARY OF HARINGEY HIGH-IMPACT CHANGE MODEL LOCAL SELF-ASSESSMENT UPDATE

High-Impact Change Model Self-Assessment Summary

Impact change	Maturity Status	Position in Sep-22	Actions to improve	Updated Position May-22	Actions to improve in 2023-25
Change 1: Early discharge planning	**Established** but needs to be more systematically embedded	Flow meetings take place daily led by the respective Integrated Discharge Teams (IDTs) in NMUH, WHT and other acute sites. Patients placed on the discharge list for care-aided (P1-P3) support includes patients who are pre-medically optimized to facilitate early discharge planning including virtual ward.	More consistent identification of patients: introduce RAG rating for discharge needs based on complexity in 48 hours of admission; and to embed EDD as planning tool within wards NMUH trialed ED admission identification tool & intend to implement systematically	Criteria to reside approach (inclusive of MDT ward rounds) rolled out in training across acute Trusts	Creation of detailed CTR dashboard in development to manage & track patients and support with identifying complex discharges early.
Change 2: Monitoring and responding to system demand and capacity	**Established** & working towards more sophisticated operational real-time & strategic models to become Mature	All NCL acute Trusts and IDTs have robust mechanisms in place to monitor & share operational pre-MO/MO cases on a patient-by-patient basis with partners.	Continue to refine patient-level information and information-sharing between partners	Patient-level information & information sharing between partners shared twice daily as 'pre-MO/MO list' and discussed on daily calls but continued recognition solutions need to improve.	To identify and develop a robust centralised system for sharing information to minimise patient delays. NCL ICS will review options for partners to improve real-time sharing/tracking of information, assigning case management & progress on discharge preparation, including through the Optica platform in local Trusts.
		Partners utilise & share aggregated data from all NCL Trusts to understand flow across system, including discharge pathway utilization, bed utilization, LOS and delays, and this is utilised operationally & by executives to understand acute & out-of-hospital capacity & demand. Strategic analysis & predictive modelling supports decision-making on capacity including future system resilience.	Continue to refine strategic analysis and predictive modelling on discharge pathways and support in community	Forecast Modelling reporting now taking place at NCL and local level with regular submission and presentation to AEDB.	Further refinement of modelling including scenario-building in event of continued deconditioning due to legacy of pandemic and 'system shots'
Change 3: Multi-disciplinary working	**Well-Established** & planning to work towards more mature models as part of NCL Review	Our Community Health-led multi-disciplinary IDTs in each acute Trust manage cases jointly between NHS acute and community health, CHC and adult social care partners. Each P1-P3 case is allocated to the most appropriate professional to oversee the planning for discharge.	Review current model between partners to ensure we are identifying potential barriers to discharge early; with senior management oversight and to support frontline led review of ways of working	Completed a joint Council/NHS ICS-wide review of discharge arrangements between parties and parties are planning implementation of findings. This includes redevelopment of IDTs to have a multi-agency Borough base and development of a NCL ICS-wide multi-disciplinary Transfer of Care Hub (TOCH) to manage cross-boundary/P2 cases. Quick win improvements also made: LBH social care are now onsite in acutes/P2 facilities	Implement recommedations of review and set up revised Discharge Teams/TOCHs across Haringey and across ICS, and further progress quick win opportunities
			Build on existing partnership safeguarding & quality of care framework to implement NCL ICS response to 'potential harm' events as reportable incidents associated with delayed transfers prior to winter in our local system	DATIX reporting and statutory safeguarding procedures in place across partners involved in discharge, with lessons learnt discussed in partnership	Need to continue to strengthen safeguarding & quality of care arrangements & training and onward learning across partners, including as part of redesign of IDTs
Change 4: Home first	**Well-Established** & planning to work towards more mature models as part of NCL Review	Discharge-to-Assess policies and processes are well-established in all our NCL acute systems, and in WHT and NMUH. IDTs have a pivotal role in working across partners to decide the next steps for the patient post-discharge with a clear 'Home First' policy via our D2A.	Make best use of existing solutions (e.g. Virtual Wards) and increase BCF investment in reablement to manage demand in 2022/23 Progress development of the joint Community Health/LBH Urgent Care Response project to better manage the cases of 'Home First' discharged patients. Review current model of case management between partners (Change 3)	Increased investment and operational improvements in reablement pathways in 2022/23 and health-orientated P1 HomeFirst pathways (including VWs) now operating. This led to changes in case management responsibilities for some cases between ASC and Health. NCL-wide improvements relating to UCR/111 response, e.g. Frailty Car etc. also in	Redesign P1 HomeFirst triaging and HomeFirst streaming into best fit for patient needs as part of ICS joint review. Continue to invest in reablement and increased investment in VW/Rapid Response and health-orientated P1 Home First offer between Council and community health.
Change 5: Flexible working patterns	**Established** & planning to work towards more mature systematic approach	IDT model in each Trust operates 7 days per week and has daily meetings at the weekend. Community partners also operate 7 days/week	Increase discharge rates more consistently at weekend including via community projects (e.g. Virtual Wards) to support flexible working.	7 day working across partners in place but could be strengthened/modified in response to NCL-wide review	Part of NCL-wide review includes stregnthening DTs/TOCHs on multi-agency 7-day basis
Change 6: Trusted assessment	Working towards **Established** & planning to work towards more mature systematic approach as part of NCL Review	IDT model in each Trust assigns case to the most appropriate agency to undertake the relevant assessment. Where more than one partner's input is needed, this is facilitated in discussion between partners with the lead responsible for coordination, so the case is as well-coordinated as possible Trusted Assessor role for care home assessments funded via the BCF Plan (see Change 8) and their assessments are	Review current model of case management for more complex discharges and move-on between partners as part of frontline led improvements, and revise processes and procedures to support approach (Change 3)	Trusted Assessor model strengthened in 2022/23 through full implementation of Enhanced Health in Care Homes model which includes TA role in Haringey and its local system linked to other Boroughs TA solutions	Strengthen multi-disciplinary, multi-agency discharge teams/TOCHs and P1 HomeFirst case management across local system & ICS in response to review, including case management responsibilities (see Home First)
Change 7: Engagement and choice	**Established** & planning to work towards more mature systematic approach to choice	Our systems have information packs for patients and families to help explain the discharge process and 'what happens next'. We have also revised our Choice Policy for those patients who need care solutions so that we can work with them and their families to find the right community services, but which emphasises the need to proactively make timely and reasonable decisions with those professionals managing the discharge	Ensure more consistent engagement and application of the policy across our acute systems. Implement updated Choice Policy and enhance training for ward staff on engagement with patients and families, including on policy.	Choice Policy rolled out across NCL. Process being refined by each individual Trust. Improvements to Policy currently being trialled at NMUH.	Learning and development including upskilling acute staff in local system on applying the NCL Choice Policy will continue into 2023/24 - seen as important element of changes to discharge processes
		Voluntary sector Home from Hospital scheme in place to facilitate discharge and return home on P0 pathways	Ensure we make best use of our VCSE 'offer' within NMUH and WHT hospitals in winter	750+ Haringey residents helped to return home via Home from Hospital in 2023/24, highest ever recorded	Reprocure and redesign Home from Hospital schemes in Haringey in 2023/24 in light of NCL-wide review
Change 8: Improved discharge to care homes	**Well-Established** & planning to work towards more mature models	BCF-funded Enhanced Health in Care Homes (EHCH) Teams operate alongside the relevant GP clinical lead in all older people's care homes as outlined in the EHCH Framework. Our model includes a nurse Trusted Assessor within our acute hospitals to assess the needs of patients who are scheduled to move to care homes, with assessments generally accepted by the care home.	Actively engaging with homes to recognise need to increase abilities of homes to place/return more complex patients in homes via Complex Care Project across NCL. This will include ensuring our trusted assessor arrangements are more widely accepted and robust.	Complex Care/in reach nurse post at NMUH to link with EHCH Teams and care homes to better manage seamless discharge to care homes. See TA update above	Strengthen TA/care home support for triaging the needs of people who will be discharged to care homes. Strengthen join up with EHCH Teams working in community to improve follow up
Change 9: Housing and related services	Well-Established & planning to work towards more mature models	Our systems identify people with challenging housing situations or at risk of homelessness as part of early discharge planning. We have housing liaison care coordinators in each our NCL acute systems, developed protocols with Borough housing needs teams & expanding our challenging housing function (see DFG Section).	Better identify people with complex housing needs as part of Early Discharge Planning (Change 1)	Pilot for Challenging Housing Environment Coordinator concluded successfully - continuing investment agreed	Strengthen model of support for people living in challenging housing environment in 2023/24
			Progress planning and utilisation of our available resources to support discharged patients with housing issues in community for winter	Move-on Coordinator for people post concluded in 2023/24 - plan to continue to investment from ASC Discharge Fund schemes in 2022/23	Continue investment and strengthen model of support for people at risk of homelessness in 2023/24

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Haringey	
Completed by:	Paul Allen	
E-mail:	paul.allen14@nhs.net	
Contact number:	07742605254	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Wed 20/09/2023	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair		Lucia	Das Neves	lucia.dasneves@haringey.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Frances	O'Callaghan	frances.o'callaghan@nhs.net
	Additional ICB(s) contacts if relevant		Rachel	Lissaeur	r.lissaeur2@nhs.net
	Local Authority Chief Executive		Donald	Andy	andy.donald@haringey.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Beverley	Tarka	Beverley.Tarka@haringey.gov.uk
	Better Care Fund Lead Official		Paul	Allen	paul.allen14@nhs.net
	LA Section 151 Officer		John	Warlow	john.warlow@nhs.net
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	Local Authority Director of Adult Social Services (or equivalent)		Vicky	Murphy	vicky.murphy@haringey.gov.uk

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

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Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Haringey

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,678,851	£2,678,851	£2,678,851	£2,678,851	£0
Minimum NHS Contribution	£23,467,763	£24,796,038	£23,467,763	£24,796,038	£0
iBCF	£9,806,399	£9,806,399	£9,806,399	£9,806,399	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,374,842	£2,295,986	£1,374,842	£2,295,986	£0
ICB Discharge Funding	£1,161,600	£2,394,206	£1,161,599	£2,394,206	£1
Total	**£38,489,454**	**£41,971,480**	**£38,489,454**	**£41,971,480**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£6,668,873	£7,046,331
Planned spend	£15,643,480	£16,535,468

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£7,708,259	£8,144,546
Planned spend	£7,708,259	£8,144,546

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	133.0	128.0	126.0	120.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,819.0	1,608.0
	Count	509	450
	Population	27961	27961

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.0%	93.5%	94.2%	95.0%

Residential Admissions

	2021-22 Actual	2023-24 Plan

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	388	371

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	78.2%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

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Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Haringey

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Haringey	£2,678,851	£2,678,851
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,678,851**	**£2,678,851**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Haringey	£1,374,842	£2,295,986

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS North Central London ICB	£1,161,600	£2,394,206
Total ICB Discharge Fund Contribution	£1,161,600	£2,394,206

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Haringey	£9,806,399	£9,806,399
Total iBCF Contribution	**£9,806,399**	**£9,806,399**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

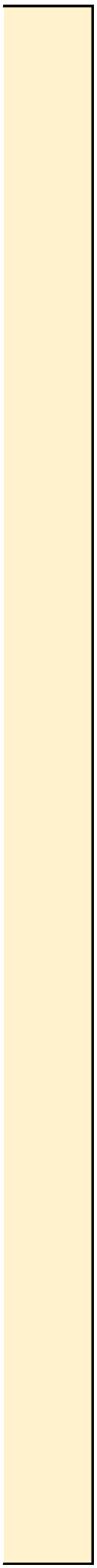
NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS North Central London ICB	£23,467,763	£24,796,038
Total NHS Minimum Contribution	**£23,467,763**	**£24,796,038**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£23,467,763**	**£24,796,038**	

	2023-24	2024-25
Total BCF Pooled Budget	**£38,489,454**	**£41,971,480**

Funding Contributions Comments Optional for any useful detail e.g. Carry over



Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Haringey

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,678,851	£2,678,851	£0	£2,678,851	£2,678,851	£0
Minimum NHS Contribution	£23,467,763	£23,467,763	£0	£24,796,038	£24,796,038	£0
iBCF	£9,806,399	£9,806,399	£0	£9,806,399	£9,806,399	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,374,842	£1,374,842	£0	£2,295,986	£2,295,986	£0
ICB Discharge Funding	£1,161,600	£1,161,599		£2,394,206	£2,394,206	£0
Total	**£38,489,454**	**£38,489,454**	**£0**	**£41,971,480**	**£41,971,480**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£6,668,873	£15,643,480	£0	£7,046,331	£16,535,468	£0
Adult Social Care services spend from the minimum ICB allocations	£7,708,259	£7,708,259	£0	£8,144,546	£8,144,546	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 86, 87, 88, 90, 93, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 112, 113, 114, 115, 116, 117

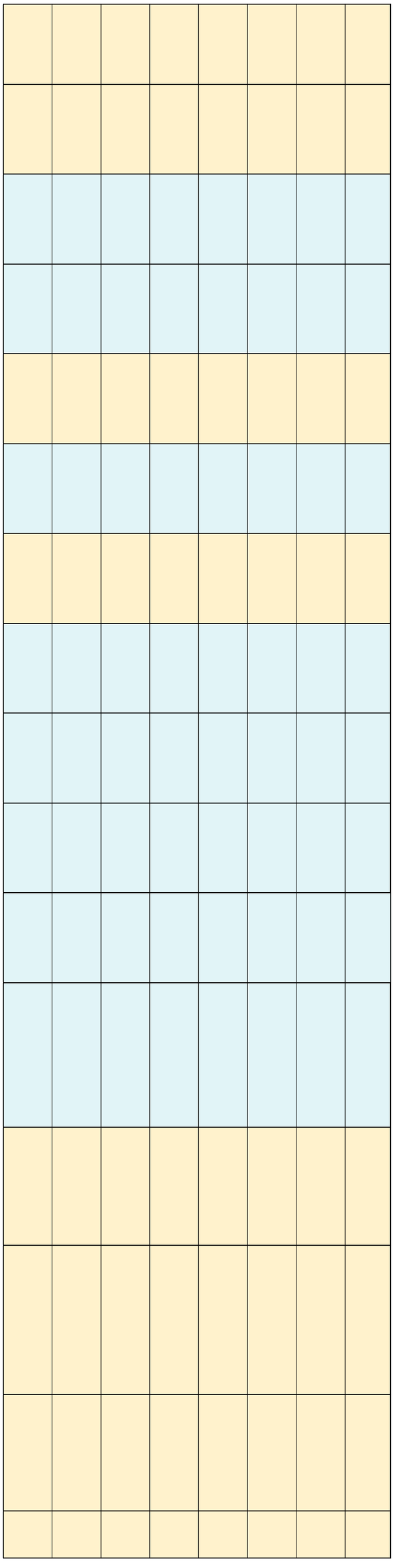
									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Health-orientated information, advice and guidance as part	Voluntary sector provision of advice, information, signposting and/or guidance	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution

2	COPD Exercise Programme	Community-based exercise groups for suitable COPD patients referred via health	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
3	Dementia Day Opportunities	LBH commissioned services to support people with dementia with facility- or	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	Minimum NHS Contribution
4	Self-Management Support	Structured programme of courses for patients interested in condition self-	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
5	Local Area Coordination element of locality working and	Voluntary sector coordinators to provide advice, information and signposting	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Minimum NHS Contribution
6	Disabled facilities grant	LBH commissioned provider undertaking major adaptations of individuals'	DFG Related Schemes	Adaptations, including statutory DFG grants		380	425	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG
7	Nursing services, including community matrons for MACC	District nursing for non-ambulant patients at home and community matrons to	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
8	Whittington Integrated Therapies and Therapeutic Support	Multi-disciplinary therapy to support patients, including intermediate	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
9	Integrated Health, Housing, Finance and Care Early Intervention	Solutions to provide early help to people to help manage finances, housing	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Minimum NHS Contribution
10	Integrated Health, Housing, Finance and Care Early Intervention	Solutions to provide early help to people to help manage finances, housing,	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution
11	Multi-Agency Care & Coordination Team (GP Federation	MACC Team is GP-led multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution
12	Multi-Agency Care & Coordination Team (Additional Nursing &	MACC Team multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
13	Multi-Agency Care & Coordination Team (Mental Health	MACC Team multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
14	Multi-Agency Care & Coordination Team (Social Care Element)	MACC Team multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		NHS			Local Authority	Minimum NHS Contribution
15	Multi-Agency Care & Coordination Team (MDT Teleconference	MACC Team multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution
16	Social Care Team	LBH posts to increase capacity in community first response, initial triaging &	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution
18	Strength and Balance Opportunities	Strengthening & balancing classes and exercises for individuals who professionals	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
19	Enhanced Health in Care Homes & Trusted Assessor	EHCH Model and Trusted Assessor across Haringey to support care homes, their	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
20	IBCF Supporting Social Care	Bulk of spend on providing packages of care (predominantly but not	Home Care or Domiciliary Care	Domiciliary care packages		391770	368837	Hours of care	Social Care		LA			Private Sector	iBCF
21	Palliative Care & Advanced Care Planning Facilitator	NMUH-led multi-agency approach to support range of community-, hospital- & bed-	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
52	Wheelchair Services	NHS commissioned long-term patient wheelchair assessment, delivery and	Assistive Technologies and Equipment	Community based equipment		2353	2424	Number of beneficiaries	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
23	Alcohol Liaison Services	Council commissioned Alcohol Liaison Nurses & Support Worker to support	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
24	Support for Dementia Friendly Haringey	Council Dementia Coordinator to take forward development of DFH & help	Prevention / Early Intervention	Other	Social capital development				Social Care		LA			Local Authority	Minimum NHS Contribution

25	Support for Community Navigation / Social Prescribing	Council commissioned support for community navigation/social prescribing	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
26	Increase Single Point of Access/IDT-support function to meet	Contribution to ASC component of IDT/associated discharge planning including	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution
50	Community Equipment Provision (ICB Component)	ICB/Health-related financial contribution to LBH commissioned Community	Assistive Technologies and Equipment	Community based equipment		10562	10752	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution
29	Home from Hospital	Voluntary sector scheme to support hospital patients (who do not need public-	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
30	Rapid Response Service (inc at NMUH) & Virtual Ward -	Multi-disciplinary nursing & therapies team to respond quickly when people are at	Urgent Community Response						Other	Community Health and Primary Care	NHS			NHS Community Provider	Minimum NHS Contribution
31	Rapid Response Service - ASC Element	Funding for rapid access to packages of care to support individuals at home at crisis -	Urgent Community Response						Social Care		LA			Private Sector	Minimum NHS Contribution
33	Reablement Solutions	LBH time-limited community-based enablement & therapist staff to facilitate	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		2200	2400	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
36	iBCF Short-term packages of care to support people to	Funding for packages of care available to facilitate reablement in response to	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		54	49	Packages	Social Care		LA			Private Sector	iBCF
38	Step down flats	Investment in step down flats for hospital discharge patients needing reablement	Housing Related Schemes						Social Care		LA			Local Authority	iBCF
39	Care Home Intermediate Care Beds (iBCF-funded)	Intermediate care P2 beds at care home supported by MDT (see MDT line)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		68	71	Number of Placements	Social Care		LA			Private Sector	iBCF
40	Care Home Intermediate Care Beds (Minimum CCG	Intermediate care P2 beds at care home supported by MDT (see MDT line)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		17	17	Number of Placements	Continuing Care		LA			Private Sector	Minimum NHS Contribution
41	Community-Based Nursing & Care Home Intermediate Care	Intermediate care P2 beds focussed on convalescence at care home supported by MDT	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support admissions		50	52	Number of Placements	Community Health		LA			Private Sector	Minimum NHS Contribution
42	Enhanced MDT to support patient recovery & move-on in	Multi-disciplinary team, including nursing, therapies and social workers, to work	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
43	Enhanced MDT to support indivudals' recovery & move-on in	Multi-disciplinary team, including therapies and social workers, to work with EHCH	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		NHS			Local Authority	Minimum NHS Contribution
44	Supporting people with challenging housing needs to	LBH-commissioned Housing Liaison Worker & rapid deployment of housing-	High Impact Change Model for Managing Transfer of Care	Housing and related services					Social Care		LA			Local Authority	Minimum NHS Contribution
51	Additional Care Home Intermediate Care Beds (Minimum CCG	Additional intermediate care P2 beds at care home supported by MDT (see MDT	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		18	18	Number of Placements	Social Care		LA			Private Sector	Minimum NHS Contribution

46	Carers' Support	Range of carers' solutions depending on intensity of need: identifying carers, undertaking assessment of needs and support through to carers' respite. Providers are Local Authority and Voluntary Sector	Carers Services	Other	Includes carers' advice, IAG, care planning, respite services & DPs	1995	2100	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
47	Principal Social Worker	To provide quality assurance and plan workforce development for social care	Enablers for Integration	Workforce development					Social Care		LA			Local Authority	Minimum NHS Contribution
48	Commissioning Support	To provide multi-disciplinary and multi-agency commissioning support for	Enablers for Integration	Joint commissioning infrastructure					Social Care		Joint	50.0%	50.0%	Local Authority	Minimum NHS Contribution
49	IBCF Market Management	Staff and other resources to manage brokerage and quality assurance of	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	iBCF
54	D2A Pre-CHC Assmt P1 Home First Pathway	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		8727	0	Hours of care	Community Health		NHS			NHS Community Provider	ICB Discharge Funding
55	D2A Pre-CHC Assmt Interim Res/Nursing Care Step-down beds	Short-term residential/nursing care for someone likely to require a	Residential Placements	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
64	Discharge Funding 2023-24 - Workforce	Funding allocated to a number of propsed workforce Initiatives, focusing on the hospital discharge processes and reviews	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge Funding
65	Discharge Funding 2023-24 - Care Purchasing	Funding for propsed P1 Provisions (proposed 9884 P1 hours in 2023/24)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		9884	56000	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge Funding
67	Discharge Funding 2023-24 - Care Purchasing	Funding for P1 care provisions (proposed 7259 P1 hours for additional hospital demand) Shirt Term	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		7259	0	Hours of care	Social Care		LA			Private Sector	ICB Discharge Funding
60	Community Health Specialised LTC Services	Investment in planned/crisis management CH investments in LTC pathways (e.g.	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
61	Bereavement Support	Interventions to support VCSE development, community empowerment,	Personalised Care at Home	Mental health /wellbeing					Other	Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
62	Complex Case Management	Funding to support complex cases, to deal with the increase in demand and acuity within Adult Social Care in the community (transition, hospital avoidance- but not exclusive to) in younger adults.	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution
63	Discharge Funding 2024-25 - To Be Determined	TO BE DETERMINED. NCL ICB and LAs plan to agree the final application of the Discharge Fund during 2023-24. All information in this line is placeholder only.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Other	To be confirmed in 2023/24 between partners					ICB Discharge Funding

68	Discharge Funding 2023-24 - Care Purchasing	Funding for P2/P3 care provisions (335 weeks worth of P2/P3 for additional hospital demand)	Residential Placements	Short-term residential/nursing care for someone likely to require a longer-term care home replacement					Social Care		LA			Private Sector	ICB Discharge Funding



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Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Haringey

<< Link to summary sheet

	2023-24			2024-25		
Running Balances	Income	Expenditure	Balance	Income	Expenditure	Balance
DFG	£2,678,851	£2,678,851	£0	£2,678,851	£2,678,851	£0
Minimum NHS Contribution	£23,467,763	£23,467,763	£0	£24,796,038	£24,796,038	£0
iBCF	£9,806,399	£9,806,399	£0	£9,806,399	£9,806,399	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,374,842	£1,374,842	£0	£2,295,986	£2,295,986	£0
ICB Discharge Funding	£1,161,600	£1,161,599		£2,394,206	£2,394,206	£0
Total	**£38,489,454**	**£38,489,454**	**£0**	**£41,971,480**	**£41,971,480**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24			2024-25		
	Minimum Required Spend	Planned Spend	Under Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£6,668,873	£15,643,480	£0	£7,046,331	£16,535,468	£0
Adult Social Care services spend from the minimum ICB allocations	£7,708,259	£7,708,259	£0	£8,144,546	£8,144,546	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 86, 87, 88, 90, 93, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 112, 113, 114, 115, 116, 117

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Health-orientated information, advice and guidance as part	Voluntary sector provision of advice, information, signposting and/or guidance	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution

2	COPD Exercise Programme	Community-based exercise groups for suitable COPD patients referred via health	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
3	Dementia Day Opportunities	LBH commissioned services to support people with dementia with facility- or	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	Minimum NHS Contribution
4	Self-Management Support	Structured programme of courses for patients interested in condition self-	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
5	Local Area Coordination element of locality working and	Voluntary sector coordinators to provide advice, information and signposting	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Minimum NHS Contribution
6	Disabled facilities grant	LBH commissioned provider undertaking major adaptations of individuals'	DFG Related Schemes	Adaptations, including statutory DFG grants		380	425	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG
7	Nursing services, including community matrons for MACC	District nursing for non-ambulant patients at home and community matrons to	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
8	Whittington Integrated Therapies and Therapeutic Support	Multi-disciplinary therapy to support patients, including intermediate	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
9	Integrated Health, Housing, Finance and Care Early Intervention	Solutions to provide early help to people to help manage finances, housing	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Minimum NHS Contribution
10	Integrated Health, Housing, Finance and Care Early Intervention	Solutions to provide early help to people to help manage finances, housing,	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution
11	Multi-Agency Care & Coordination Team (GP Federation	MACC Team is GP-led multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution
12	Multi-Agency Care & Coordination Team (Additional Nursing &	MACC Team multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
13	Multi-Agency Care & Coordination Team (Mental Health	MACC Team multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
14	Multi-Agency Care & Coordination Team (Social Care Element)	MACC Team multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		NHS			Local Authority	Minimum NHS Contribution
15	Multi-Agency Care & Coordination Team (MDT Teleconference	MACC Team multi-disciplinary team works in anticipatory care team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution
16	Social Care Team	LBH posts to increase capacity in community first response, initial triaging &	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution
18	Strength and Balance Opportunities	Strengthening & balancing classes and exercises for individuals who professionals	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
19	Enhanced Health in Care Homes & Trusted Assessor	EHCH Model and Trusted Assessor across Haringey to support care homes, their	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
20	IBCF Supporting Social Care	Bulk of spend on providing packages of care (predominantly but not	Home Care or Domiciliary Care	Domiciliary care packages		391770	368837	Hours of care	Social Care		LA			Private Sector	iBCF
21	Palliative Care & Advanced Care Planning Facilitator	NMUH-led multi-agency approach to support range of community-, hospital- & bed-	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
52	Wheelchair Services	NHS commissioned long-term patient wheelchair assessment, delivery and	Assistive Technologies and Equipment	Community based equipment		2353	2424	Number of beneficiaries	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
23	Alcohol Liaison Services	Council commissioned Alcohol Liaison Nurses & Support Worker to support	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
24	Support for Dementia Friendly Haringey	Council Dementia Coordinator to take forward development of DFH & help	Prevention / Early Intervention	Other	Social capital development				Social Care		LA			Local Authority	Minimum NHS Contribution

25	Support for Community Navigation / Social Prescribing	Council commissioned support for community navigation/social prescribing	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
26	Increase Single Point of Access/IDT-support function to meet	Contribution to ASC component of IDT/associated discharge planning including	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution
50	Community Equipment Provision (ICB Component)	ICB/Health-related financial contribution to LBH commissioned Community	Assistive Technologies and Equipment	Community based equipment		10562	10752	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution
29	Home from Hospital	Voluntary sector scheme to support hospital patients (who do not need public-	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
30	Rapid Response Service (inc at NMUH) & Virtual Ward -	Multi-disciplinary nursing & therapies team to respond quickly when people are at	Urgent Community Response						Other	Community Health and Primary Care	NHS			NHS Community Provider	Minimum NHS Contribution
31	Rapid Response Service - ASC Element	Funding for rapid access to packages of care to support individuals at home at crisis -	Urgent Community Response						Social Care		LA			Private Sector	Minimum NHS Contribution
33	Reablement Solutions	LBH time-limited community-based enablement & therapist staff to facilitate	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		2200	2400	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
36	iBCF Short-term packages of care to support people to	Funding for packages of care available to facilitate reablement in response to	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		54	49	Packages	Social Care		LA			Private Sector	iBCF
38	Step down flats	Investment in step down flats for hospital discharge patients needing reablement	Housing Related Schemes						Social Care		LA			Local Authority	iBCF
39	Care Home Intermediate Care Beds (iBCF-funded)	Intermediate care P2 beds at care home supported by MDT (see MDT line)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		68	71	Number of Placements	Social Care		LA			Private Sector	iBCF
40	Care Home Intermediate Care Beds (Minimum CCG	Intermediate care P2 beds at care home supported by MDT (see MDT line)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		17	17	Number of Placements	Continuing Care		LA			Private Sector	Minimum NHS Contribution
41	Community-Based Nursing & Care Home Intermediate Care	Intermediate care P2 beds focussed on convalescence at care home supported by MDT	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support admissions		50	52	Number of Placements	Community Health		LA			Private Sector	Minimum NHS Contribution
42	Enhanced MDT to support patient recovery & move-on in	Multi-disciplinary team, including nursing, therapies and social workers, to work	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
43	Enhanced MDT to support indivudals' recovery & move-on in	Multi-disciplinary team, including therapies and social workers, to work with EHCH	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		NHS			Local Authority	Minimum NHS Contribution
44	Supporting people with challenging housing needs to	LBH-commissioned Housing Liaison Worker & rapid deployment of housing-	High Impact Change Model for Managing Transfer of Care	Housing and related services					Social Care		LA			Local Authority	Minimum NHS Contribution
51	Additional Care Home Intermediate Care Beds (Minimum CCG	Additional intermediate care P2 beds at care home supported by MDT (see MDT	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		18	18	Number of Placements	Social Care		LA			Private Sector	Minimum NHS Contribution

46	Carers' Support	Range of carers' solutions depending on intensity of need: identifying carers, undertaking assessment of needs and support through to carers' respite. Providers are Local Authority and Voluntary Sector	Carers Services	Other	Includes carers' advice, IAG, care planning, respite services & DPs	1995	2100	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
47	Principal Social Worker	To provide quality assurance and plan workforce development for social care	Enablers for Integration	Workforce development					Social Care		LA			Local Authority	Minimum NHS Contribution
48	Commissioning Support	To provide multi-disciplinary and multi-agency commissioning support for	Enablers for Integration	Joint commissioning infrastructure					Social Care		Joint	50.0%	50.0%	Local Authority	Minimum NHS Contribution
49	IBCF Market Management	Staff and other resources to manage brokerage and quality assurance of	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	iBCF
54	D2A Pre-CHC Assmt P1 Home First Pathway	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		8727	0	Hours of care	Community Health		NHS			NHS Community Provider	ICB Discharge Funding
55	D2A Pre-CHC Assmt Interim Res/Nursing Care Step-down beds	Short-term residential/nursing care for someone likely to require a	Residential Placements	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
64	Discharge Funding 2023-24 - Workforce	Funding allocated to a number of propsed workforce Initiatives, focusing on the hospital discharge processes and reviews	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge Funding
65	Discharge Funding 2023-24 - Care Purchasing	Funding for propsed P1 Provisions (proposed 9884 P1 hours in 2023/24)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		9884	56000	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge Funding
67	Discharge Funding 2023-24 - Care Purchasing	Funding for P1 care provisions (proposed 7259 P1 hours for additional hospital demand) Shirt Term	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		7259	0	Hours of care	Social Care		LA			Private Sector	ICB Discharge Funding
60	Community Health Specialised LTC Services	Investment in planned/crisis management CH investments in LTC pathways (e.g.	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
61	Bereavement Support	Interventions to support VCSE development, community empowerment,	Personalised Care at Home	Mental health /wellbeing					Other	Voluntary Sector	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
62	Complex Case Management	Funding to support complex cases, to deal with the increase in demand and acuity within Adult Social Care in the community (transition, hospital avoidance- but not exclusive to) in younger adults.	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution
63	Discharge Funding 2024-25 - To Be Determined	TO BE DETERMINED. NCL ICB and LAs plan to agree the final application of the Discharge Fund during 2023-24. All information in this line is placeholder only.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Other	To be confirmed in 2023/24 between partners					ICB Discharge Funding

68	Discharge Funding 2023-24 - Care Purchasing	Funding for P2/P3 care provisions (335 weeks worth of P2/P3 for additional hospital demand)	Residential Placements	Short-term residential/nursing care for someone likely to require a longer-term care home replacement					Social Care		LA			Private Sector	ICB Discharge Funding

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Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.

11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.

18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Haringey

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	159.6	139.7	157.1	134.0	Q1 23/24 figures are being compiled, but limited window to influence outputs. Plan for Q2-Q4 shows gradual improvement, even though we anticipate seasonal variations over remaining three quarters. Anticipate gradual annual ISR improvement due to investment in community solutions & engagement with commuities - see tables	See BCF Narrative which maps solutions to influence metrics - many of our community solutions enable people to come forward for triaging, diagnosis & help earlier and to enhance proactive management of conditions & independence, including self-management
	Number of Admissions	330	289	325	-		
	Population	268,647	268,647	268,647	268,647		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	133	128	126	120		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,857.4	1,819.0	1,608.0	Q1 23/24 figures are being compiled, but limited window to influence outputs. Plan for Q2-Q4 is to improve as we invest in our AW awareness raising (which includes module on improving falls management) and roll out of our falls prevention programme in 2023/24. See tables in BCF Narrative to map schemes to metrics	See BCF Narrative which maps solutions to influence metrics. We believe that our early help/preventative community solutions (e.g active ageing) etc. will improve people's risk of falls, alongside some wider specific falls prevention services being developed for 2023/24 (outside of BCF Plan) - see BCF Narrative Proactive & Planned Care sub-section
	Count	490	509	450		
	Population	27,961	27961	27961		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.3%	93.1%	93.1%	94.2%	Q1 23/24 figures are being compiled, but limited window to influence outputs. Plan for Q2-Q4 is to improve as we invest in our P1 Home First solutions (see Local Plan). See tables in BCF Narrative to map schemes to metrics.	See BCF Narrative - our current and planned investment in Home First, P2 beds and longer-term community solutions enable people to return and stay at home rather than move to long-term care home provision on discharge.
	Numerator	3,770	3,871	3,864	3,670		
	Denominator	4,085	4,158	4,152	3,896		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	93.0%	93.5%	94.2%	95.0%		
	Numerator	3,854	3,760	4,008	3,875		

	Denominator	4,144	4,021	4,255	4,079		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	387.9	341.8	374.6	371.4	2022-22 estimate based on actual return. Anticipated to make steady progress on reducing care home admissions in 2022-23 as part of our continued drive towards Home First solutions; at same time, but we are seeing increase complexity of cases of	See BCF Narrative - our current and planned investment in Home First, P2 beds and longer-term community solutions enable people to return and stay at home rather than move to long-term care home provision. However, we are aware of
	Numerator	111	104	114	116		
	Denominator	28,618	30,430	30,430	31,234		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)		75.2%	75.6%	78.2%	2022-23 estimate figure based on sample of cases.	See BCF Narrative - our current and planned investment in Home First, P2 beds and longer-term community solutions enable people to return and stay at home rather than move to long-term care home provision or return to hospital.
	Numerator	0	173	180	223		
	Denominator	0	230	238	285		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan

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Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Haringey

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different
Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Complete:

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	We reviewed historical & seasonal patterns in terms of P0-P3 to project numbers forward, taking account our HICM aspirations/additional investments planned as part of BCF and individual

3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Dischar Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
(Please select Trust/s.....)	Social support (including VCS) (pathway 0)												
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST		50	49	50	49	50	49	50	49	50	49	49	49
ROYAL FREE LONDON NHS FOUNDATION TRUST		3	3	3	3	3	3	3	3	3	3	3	3
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
WHITTINGTON HEALTH NHS TRUST		24	24	24	24	24	24	24	24	24	24	23	24
(Please select Trust/s.....)	Reablement at home (pathway 1)												
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST		42	37	43	48	26	45	32	45	44	41	47	24
ROYAL FREE LONDON NHS FOUNDATION TRUST		29	31	25	28	21	22	21	22	22	28	25	33
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		26	22	19	24	17	23	26	22	25	23	22	23
WHITTINGTON HEALTH NHS TRUST		34	34	45	32	28	34	39	31	32	33	29	34
(Please select Trust/s.....)	Rehabilitation at home (pathway 1)												
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST		0	2	2	2	2	3	4	4	4	5	4	4
ROYAL FREE LONDON NHS FOUNDATION TRUST		0	0	1	1	1	1	1	1	1	1	1	1
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
WHITTINGTON HEALTH NHS TRUST		2	2	3	3	8	7	8	8	8	8	8	8
(Please select Trust/s.....)	Short term domiciliary care (pathway 1)												
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST		2	2	2	3	2	2	2	3	2	2	2	3
ROYAL FREE LONDON NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
WHITTINGTON HEALTH NHS TRUST		2	3	2	2	2	3	2	2	2	3	2	2
(Please select Trust/s.....)	Reablement in a bedded setting (pathway 2)												
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST		4	4	4	5	6	6	7	7	7	7	7	7
ROYAL FREE LONDON NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		1	1	1	2	2	2	2	2	2	2	2	2
WHITTINGTON HEALTH NHS TRUST		2	2	2	2	3	3	4	4	4	4	4	4
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)												
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST		4	3	4	3	4	3	5	5	5	5	5	5
ROYAL FREE LONDON NHS FOUNDATION TRUST		2	2	2	2	2	2	3	3	3	3	3	3
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	1	0	1	0	1	1	1	1	1	1	1
WHITTINGTON HEALTH NHS TRUST		2	2	2	2	2	2	3	3	3	3	3	3
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST		41	38	37	52	27	43	32	22	37	30	24	26
ROYAL FREE LONDON NHS FOUNDATION TRUST		7	7	5	7	5	6	5	6	7	8	6	7
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		8	7	5	9	6	7	5	7	8	8	6	5
WHITTINGTON HEALTH NHS TRUST		15	12	14	22	9	11	7	11	14	12	11	8

3.2 Demand - Community

Demand - Intermediate Ca Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	40	40	40	40	40	40	45	48	48	50	50	50
Urgent Community Response	173	173	173	191	191	181	179	179	191	204	204	204
Reablement at home	17	14	15	17	10	17	13	14	17	16	15	14
Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting	1	1	1	1	1	1	1	1	1	1	1	1
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge														Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity.	80	80	80	80	80	80	80	80	80	80	80	80	0%	100%	0%
	Number of new clients.															
Reablement at Home	Monthly capacity.	120	120	120	120	120	120	120	120	120	120	120	120	0%	100%	0%
	Number of new clients.															
Rehabilitation at home	Monthly capacity.	2	4	6	6	11	11	13	13	13	14	13	13	100%	0%	0%
	Number of new clients.															
Short term domiciliary care	Monthly capacity.	7	7	7	7	7	7	7	7	7	7	7	7	100%	0%	0%
	Number of new clients.															
Reablement in a bedded setting	Monthly capacity.	13	13	13	13	13	13	14	14	14	14	14	14	0%	100%	0%
	Number of new clients.															
Rehabilitation in a bedded setting	Monthly capacity.	0	0	0	0	0	0	0	0	0	0	0	0	100%	0%	0%
	Number of new clients.															
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity.	15	15	15	15	15	15	15	15	15	15	15	15	14%	86%	0%
	Number of new clients.															

3.4 Capacity - Community

Capacity - Community														Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity.	40	40	40	40	40	40	50	50	50	50	50	50	20%	80%	0%
	Number of new clients.															
Urgent Community Response	Monthly capacity.	173	173	173	191	191	181	179	179	191	204	204	204	100%	0%	0%
	Number of new clients.															
Reablement at Home	Monthly capacity.	11	11	11	11	11	11	11	11	11	11	11	11	0%	100%	0%
	Number of new clients.															
Rehabilitation at home	Monthly capacity.	4	5	5	6	6	6	7	8	9	8	7	7	100%	0%	0%
	Number of new clients.															
Reablement in a bedded setting	Monthly capacity.	1	1	1	1	1	1	1	1	1	1	1	1	0%	100%	0%
	Number of new clients.															
Rehabilitation in a bedded setting	Monthly capacity.	0	0	0	0	0	0	0	0	0	0	0	0	100%	0%	0%
	Number of new clients.															
Other short-term social care	Monthly capacity.	0	0	0	0	0	0	0	0	0	0	0	0	0%	100%	0%
	Number of new clients.															

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Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

1. Guidance for Quarter 2

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell

Pre-populated cells

Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed

National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Refresh

Please use this section to update both capacity and demand (C&D) estimates for the period November 2023 to March 2024.
This section is split into 3 separate tabs:

5.1 C&D Guidance & Assumptions

Contains guidance notes including how to calculate demand/capacity as well as 6 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs and ongoing data issues.

5.2 C&D Hospital Discharge

Please use this section to enter updated demand and capacity related to Hospital Discharge in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. expected capacity and demand from your original planning template has been populated for reference. If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

In Capacity and Demand plans for 2023-24, areas were advised not to include capacity you would expect to spot purchase. This is in line with guidance on intermediate care, including the new Intermediate Care Framework. However, for this exercise we are collecting the number of packages of intermediate/short term care that you expect to spot purchase to meet demand for facilitated hospital discharge. This is being collected in a separate set of fields. You should therefore:

- record revised demand for hospital discharge by the type of support needed from row 30 onwards
- record current commissioned capacity by service type (not including spot purchasing) in cells K22 to O26
- record the amount of capacity you expect to spot purchase to meet demand in cells P22 to T26.

Spot purchased capacity should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 C&D Community

Please use this section to enter updated demand and capacity related to referrals from community sources in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. The same period's figures has been extracted from your planning template for reference.

If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

Data from assured BCF plans has been pre-populated in tabs 5.2 and 5.3. If these do not match with your final plan, please let your BCM and the national team know so that we can update out records and note the discrepancy in your response to question 1 on tab 5.1. Enter your current expected demand and capacity as normal in tabs 5.2 and 5.3.

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HM Government

NHS England

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Haringey	
Completed by:	Paul Allen	
E-mail:	paul.allen14@nhs.net	
Contact number:	07742 605254	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Wed 15/11/2023	<< Please enter using the format, DD/MM/YYYY

Checklist	Complete:
	Yes
	Yes
	Yes
	Yes
	Yes
	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Haringey

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	

Confirmation of National Conditions			
National Conditions	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:**	**Checklist** Complete:
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

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Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Haringey

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	133.0	128.0	126.0	120.0	152.8	Not on track to meet target	Our system had somewhat higher levels of avoidable admissions in Q1 (though there's often seasonal component to admissions). Community health systems reaching capacity in rapid response & UCR in	BCF Rapid Response, Enhanced Health in Care Homes, Community Health Services & proactive care MACC Team in community all functioning well with good outcomes, e.g. 40% reduction in NEL admissions pre- and	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.0%	93.5%	94.2%	95.0%	92.90%	On track to meet target	Biggest challenge is consistently improving from an already high level of performance (>92.5%) each quarter given monthly warranted fluctations in complexity of cases in P0-P3 pathways within Haringey.	Positive progress was made on measure. We continue to utilise BCF Plan investments in relation to P0 & P1 (including Discharge Fund). This includes additional investment in P1 NHS HomeFirst investment.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,608.0	324.4	On track to meet target	Our system is doing well, but could better support people with short non-crises interventions relating to information, advice and signposting to services & solutions that could avoid crises or mitigate	Positive progress made on measure, and we are building on our strong position to further development our partly BCF funded Community Health falls service and wider falls network working between NHS, Council	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				371		On track to meet target	Strong performance despite 15+% increase in people with moderate/severe frailty post-pandemic, i.e. typical acuity of cases in the community - & typical resources to meet these cases - continues to increase.	Our system is performing well as our intention is to help as many people to live independently for as long as possible, including supporting those to recover (ideally at home) following hospitalisation.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				78.2%		On track to meet target	Strong performance despite 15+% increase in people with moderate/severe frailty post-pandemic, i.e. typical acuity of cases in the community - & typical resources to meet these cases - continues to increase. This	Our system continues to improve due to effective BCF-funded reablement and proactive care models of support in community post-reablement. Successfully improved a number of operational issues in	Yes

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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Haringey

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?	
We anticipate a small increase in demand in P1 (6%) and short-term residential/nursing care placements (3%) from hospital discharge (with no change to P0 or P2). This is due to our revised projections which now ref	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)	
Demand:	
We originally reviewed historical & seasonal patterns in terms of P0-P3 to project numbers forward, taking account our HICM aspirations/additional investments planned as part of BCF and individual Trust NHS Ops Activity Plans. We sub-categorised P1-P3 pathways according to the categories described below to produce the table below. We expect variations in numbers at individual Trusts from the planned figures even if overall totals are more robust. All refreshed projections were calculated on the same basis as for the original projections:	Yes
Capacity:	
Taking the revised demand, we re-considered and re-calculated our capacity, including length of involvement during intermediate care episodes. We expect variations in numbers at individual Trusts from the planned figures even if overall totals are more robust. All refreshed projections were calculated on the same basis as for the original projections and please note our Q6 comments: - Community capacity (P0-P3) and P0 (HD) remains unchanged from the original projections as there's no change to community and P0 (HD) respectively.	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?	
Our interventions progressed as anticipated which supported us to meet demand Apr-Sep-23 and we continue to do so during winter. Specific elements of support available, which has been factored into the capacity, include: -Additional capacity for P1, P2 & interim care home placements funded through ICB & Council BCF DF allocation and via Council and ICB additional mainstream funding	Yes
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
There are operational concerns over system capacity in terms of triaging, case managing and discharging of patients into the available intermediate care capacity in P1, P2 & interim care home placements during particularly peak demand periods for acute hospitals. This issue plus particularly limitations in the number of short/long-term care home placement capacity across NCL, together with the complexity of cases of patients discharged from hospital (including those who need temporary accommodation such as those who are at risk of homelessness), are the main reasons our system is under pressure.	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).	
Our figures are based on actual demand & capacity figures up to Aug/Sep-23 and we have little issues with data quality. It should be noted however that the capacity figures for individual Trusts are estimates only and	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
The figures for P2 and short-term residential/nursing care placements suggest our demand outstrips supply. However, Haringey's figures will need to be interpreted alongside all 4 other NCL Boroughs returns to gain a true understanding of our demand v. capacity match as we stated in our original BCF submission. As reported in the original BCF submission, the position is as follows: -Although we have P2 reablement beds in Haringey, our capacity for P2 NHS Rehab is '0': Haringey has no rehab beds in its Borough boundaries. Its patients utilise at least 3 neighbouring NCL Borough P2 facilities. Boroughs in NCL agreed to report their Rehab capacity in their spreadsheet in terms of the facility's geographical host Borough (though demand comes from multiple Boroughs). Any analysis regionally of	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

5.1 Assumptions

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6/7 months of the year
- modelling and agreed changes to services as part of Winter planning or following the Market Sustainability and Improvement Fund announcement
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

5.2 and 5.3 Summary Tables

The tables at the top of the next two tabs show a direct comparison of the demand and capacity for each area, by showing = (capacity) – (demand). These figures are pre-populated from the previous template as well as calculating new refreshed figures as you complete the template below. **Negative figures show insufficient capacity and positive figures show that capacity exceeds demand.**

5.2 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record their refreshed expectations of monthly demand for supported discharge by discharge pathway.

Data from the previous capacity and demand plans will be auto-populated, split by trust referral source. You will be able to enter your refreshed number of expected discharges from each trust alongside these. The first table may include some extra rows to allow for areas who are recording demand from a larger number of referral sources. If this does not apply to your area, please ignore the extra lines.

This section in the previous template asked for expected demand for rehabilitation and reablement as two separate figures. It was found that, by and large, this did not work well for areas so the prepopulated figures for these service types have been combined into one row. Please enter your refreshed expectations for rehabilitation and reablement as one total figure as well.

Virtual wards should not be included in intermediate care capacity because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list.

From the capacity and demand plans collected in June 2023, it emerged that some areas had difficulty with estimating demand and capacity for Pathway 0 (social support). By social support, we are referring to lower level support provide outside of formal rehabilitation and reablement or domiciliary care. This is often provided by the voluntary and community sector. Demand estimates for this service type should only include discharges on Pathway 0 that require some level of commissioned low-level support and not all discharges on Pathway 0. If it is not possible to estimate figures in relation to this please put 0 rather than defaulting to all Pathway 0 discharges.

5.2 Capacity - Hospital Discharge

This section collects refreshed expectations of capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS) (pathway 0)
- Reablement & Rehabilitation at home (pathway 1)
- Short term domiciliary care (pathway 1)
- Reablement & Rehabilitation in a bedded setting (pathway 2)
- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

The recently published Intermediate Care Framework sets out guidance on improving capacity, and use of this capacity. You should refer to this in developing your refreshed BCF Capacity and Demand plans.

As with the 2023-24 template, please consider the below factors in determining the capacity calculation. Typically, this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

The template now asks for the amount of capacity you expect to secure through spot purchasing. This should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it may impact on people's outcomes and is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 Demand - Community

This section collects refreshed expectations of demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. As with the previous template, referrals are not collected by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the 2023-25 Planning Requirements.

The units can simply be the number of referrals.

As with all other sections, figures from the 2023-24 template will be auto-populated into this section.

5.3 Capacity - Community

This section collects refreshed expectations of capacity for community services. You should input the expected available capacity across health and social care for different service types. As with the hospital discharge sheet, data entered in the assured BCF plan template has been prepopulated for reference. You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to
support recovery, including Urgent Community Response and VCS support. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Please see the guidance on 'Demand – Hospital Discharge' for information on why the capacity and demand estimates for rehabilitation and reablement services is now being collected as one combined figure. Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay.

Caseload (No. of people who can be looked after at any given time).

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility.

Please consider using median or mode for Length of Stay where there are significant outliers.

"Peak Occupancy (percentage) - What was the highest levels of occupancy expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services."

Complete:

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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Haringey

Hospital Discharge

Capacity - Demand (positive is Surplus)	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	3	2	3	4	3	3	2	3	4	3	3	2	3	4	3
Reablement & Rehabilitation at home (pathway 1)	0	-3	-5	-3	6	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	1	0	1	0	-7	-6	-7	-6	-7	0	1	0	1	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-12	-12	-12	-12	-12	-13	-13	-13	-13	-13	-13	-13	-13	-13	-13
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-31	-51	-43	-32	-31	-57	-69	-63	-60	-68	-39	-50	-44	-42	-48

Capacity - Hospital Discharge

Service Area	Metric	Prepopulated from plan:					Refreshed planned capacity (not including spot purchased capacity					Capacity that you expect to secure through spot purchasing					Checklist Complete:
		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	80	80	80	80	80	80	80	80	80	80	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	133	133	134	133	133	145	147	157	157	157	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	7	7	7	7	7	0	0	0	0	0	7	7	7	7	7	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	14	14	14	14	14	15	15	15	15	15	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	15	15	15	15	15	0	0	0	0	0	18	19	19	18	20	Yes

Demand - Hospital Discharge

Pathway	Trust Referral Source	Prepopulated from plan:					Please enter refreshed expected no. of referrals:					Checklist
		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS) (pathway 0)	**Total**	**77**	**78**	**77**	**76**	**77**	**77**	**78**	**77**	**76**	**77**	
	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	49	50	49	49	49	49	50	49	49	49	Yes
	ROYAL FREE LONDON NHS FOUNDATION TRUST	3	3	3	3	3	3	3	3	3	3	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1	Yes
	WHITTINGTON HEALTH NHS TRUST	24	24	24	23	24	24	24	24	23	24	Yes
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Reablement & Rehabilitation at home (pathway 1)	**Total**	**133**	**136**	**139**	**136**	**127**	**145**	**147**	**157**	**157**	**157**	Yes
	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	49	48	46	51	28	55	53	52	52	52	Yes
	ROYAL FREE LONDON NHS FOUNDATION TRUST	23	23	29	26	34	25	25	33	33	33	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	22	25	23	22	23	24	27	26	26	26	Yes
	WHITTINGTON HEALTH NHS TRUST	39	40	41	37	42	41	42	46	46	46	Yes
	(blank)											Yes
	(blank)											Yes
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Short term domiciliary care (pathway 1)	**Total**	**7**	**6**	**7**	**6**	**7**	**7**	**6**	**7**	**6**	**7**	Yes
	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	3	2	2	2	3	3	2	2	2	3	Yes
	ROYAL FREE LONDON NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1	Yes
	WHITTINGTON HEALTH NHS TRUST	2	2	3	2	2	2	2	3	2	2	Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**26**	**26**	**26**	**26**	**26**	**28**	**28**	**28**	**28**	**28**	Yes
	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	12	12	12	12	12	13	13	13	13	13	Yes
	ROYAL FREE LONDON NHS FOUNDATION TRUST	4	4	4	4	4	4	4	4	4	4	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	3	3	3	3	3	3	3	3	3	3	Yes
	WHITTINGTON HEALTH NHS TRUST	7	7	7	7	7	8	8	8	8	8	Yes
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**46**	**66**	**58**	**47**	**46**	**57**	**69**	**63**	**60**	**68**	Yes
	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	22	37	30	24	26	27	38	33	31	38	Yes
	ROYAL FREE LONDON NHS FOUNDATION TRUST	6	7	8	6	7	7	7	8	7	10	Yes
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	7	8	8	6	5	8	8	8	7	7	Yes
	WHITTINGTON HEALTH NHS TRUST	11	14	12	11	8	15	16	14	15	13	Yes
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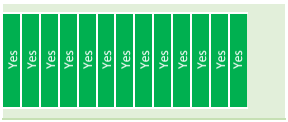
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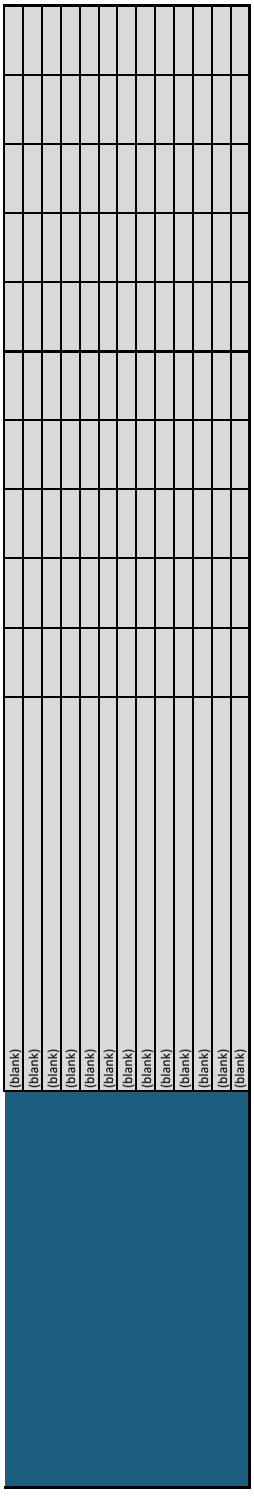
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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Haringey

Community	Previous plan					Refreshed capacity surplus:				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	2	2	0	0	0	2	2	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	5	3	3	3	4	5	3	3	3	4
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:					Checklist
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Complete:
Social support (including VCS)	Monthly capacity. Number of new clients.	50	50	50	50	50	50	50	50	50	50	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	179	191	204	204	204	179	191	204	204	204	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	19	20	19	18	18	19	20	19	18	18	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	1	1	1	1	1	1	1	1	1	1	Yes
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	Yes

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:					
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS)	48	48	50	50	50	48	48	50	50	50	Yes
Urgent Community Response	179	191	204	204	204	179	191	204	204	204	Yes
Reablement & Rehabilitation at home	14	17	16	15	14	14	17	16	15	14	Yes
Reablement & Rehabilitation in a bedded setting	1	1	1	1	1	1	1	1	1	1	Yes
Other short-term social care	0	0	0	0	0	0	0	0	0	0	Yes

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HARINGEY BOROUGH PARTNERSHIP UPDATE

Borough Partnership Summary

- Significant progress in developing outcomes framework and monitoring arrangements for each life cohort board
- Highlights from partnership boards
  - Start well – new, co-produced primary school speech, language and communications pathway launched & each mental health provider presented to Start Well Board
  - Live well – large scale employment support programme targeting support for people with long term conditions being mobilised, inclusion health summit held on 14th September, operations group in place

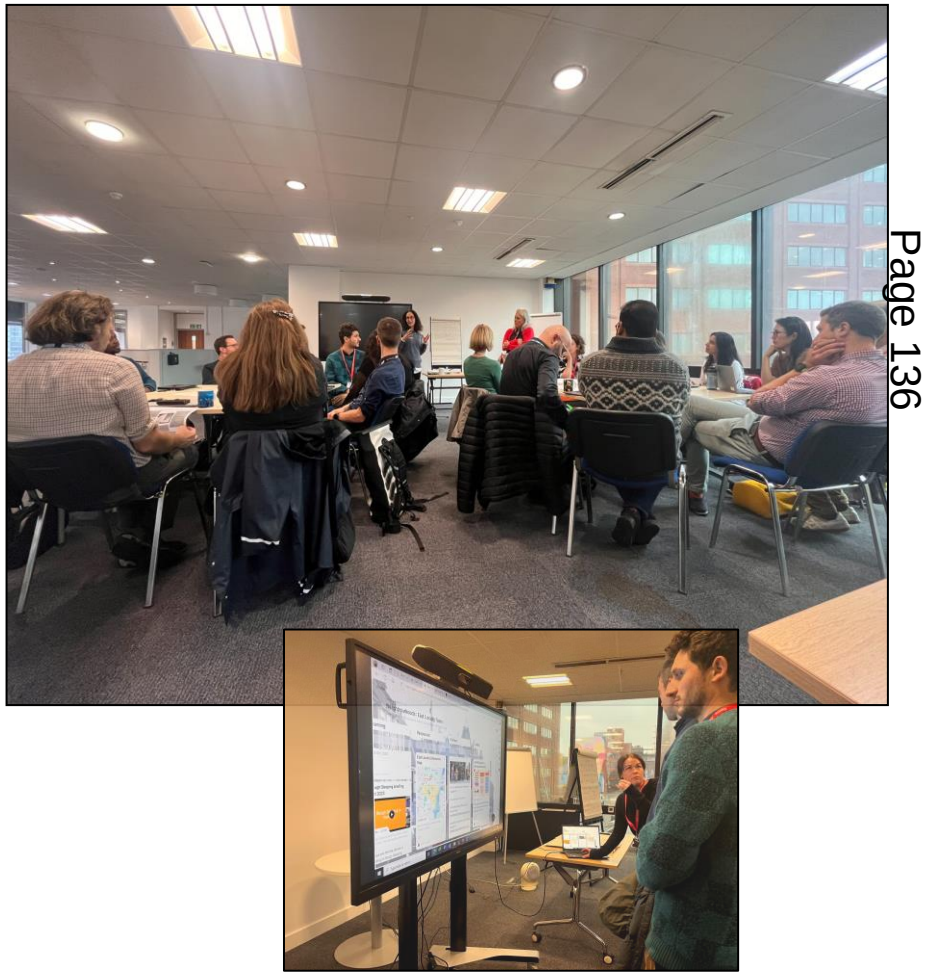
Borough Partnership Summary

- Age Well – continued positive work on reablement capacity supporting people at home after discharge from hospital, outcomes framework developed, dementia friendly Haringey progressing, positive outcomes from the multi-agency care coordination team evaluation
- Neighbourhoods – very positive clinical lead progress for all neighbourhoods including:
  - MDT development for children and young people
  - Piloting addition to existing MDT teleconference to cover people with mental health concerns
  - Development of new digital offer for locality-based teams
  - Next community chest programme under development
  - Northumberland Park Hub refurbishment approved for feasibility, significant increases in footfall and utilisation
  - Wood Green business case approved by Whittington Health Trust Board, subject to final capital funding

Clinical Lead & Integration

Updates from the quarterly Workshop with health partners sharing the progress made on integrated and neighbourhood working across Haringey.

- Virtual clinics between primary care and the mental health trust to improve support on escalation/step down and medicine management
- New MDT meetings that ensure a holistic offer of support for residents with mental health conditions
- The new trusted referrer process that allows council staff and other non-clinical professionals to refer cases direct to the North London Mental Health Trust
- Implementing a new walk-in offer for CAHMS
- Developing an integrated paediatric service
- Frailty project aimed at supporting those with mild frailty
- Range of projects to address health inequalities
- Plans to become a dementia friendly Haringey
- The development our new digital offer for locality-based teams that will be extended to VCS partners



Borough Partnership Exec Highlights

- Right Care Right Person
- Children and Young People Mental Health
- Adult Mental Health

North London Mental Health Partnership

NHS
Barnet, Enfield and Haringey Mental Health NHS Trust
Camden and Islington NHS Foundation Trust

Right Care, Right Person

A new way of working with the Metropolitan Police Service

Better Mental Health. Better Lives. Better Communities.

WHAT IS RIGHT CARE, RIGHT PERSON?

RCRP is an operational model that provides guidance on the way the **MPS responds to health related calls.**

RCRP is aimed at making sure the **right agency deals with health-related calls, instead of the police being the default first responder** where there is a concern about a person's physical or mental health.

RCRP CONTEXT

2020 — RCRP introduced and piloted by **Humberside** in 2020 in a phased approach

Feb 2023 — **Letter from Home Secretary** announcing the intention for a **National Partnership agreement to implement RCRP**

May 2023 — **MPS Commissioner** confirms to London's Health & Social Care providers that the **MPS will introduce RCRP by Autumn 2023**

July 2023 — **RCRP National Partnership Agreement** signed by Home Office, NPCC, APCC, CoP, NHS, and Dept. for Health & Social Care

Sept 2023 — **MPS RCRP policy written,** legal advice received and formally signed off by MPS Management Board

1st Nov 2023 — **MPS operational go-live for RCRP**

THE FOUR PILLARS OF RCRP

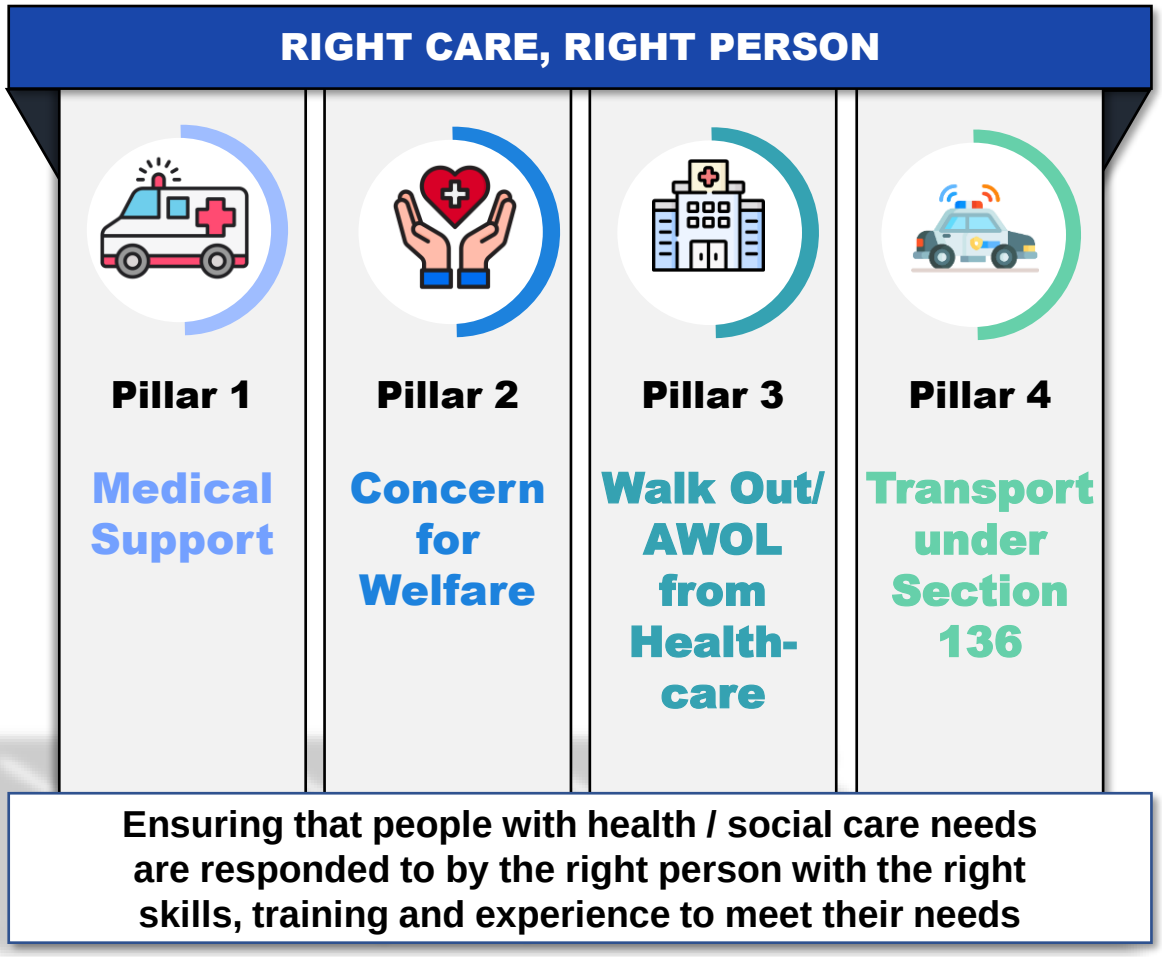
The MPS RCRP policy applies to four health-related pillars only

PILLAR 1:
MEDICAL SUPPORT

When a member of the public requests medical support Incidents in which police are already present when medical support is requested or required

PILLAR 2:
CONCERN FOR WELFARE

When a member of the public or partner agency reports a concern for the welfare of a person and requests that police visit the individual



PILLAR 3:
WALK-OUT / AWOL

When a person has walked out from a healthcare setting, has abandoned medical care / treatment or is absent without leave (AWOL) from mental health services

PILLAR 4:
TRANSPORT UNDER S136

Transporting a person detained under s136 to a health based place of safety and undertaking a timely handover to a medical professional

North London Mental Health Partnership

NHS
Barnet, Enfield and Haringey Mental Health NHS Trust
Camden and Islington NHS Foundation Trust

Right Care, Right Person

What are the issues and Risks?

Issues and Risks- Concerns, Myths and Legends??

- ✓ **Is this right time to introduce RCRP-** Our services are facing significant challenges in providing timely and quality care to our service users.

- ✓ We are experiencing high levels of demand, staff shortages, funding cuts and bed pressures

- ✓ We currently rely on the police to assist us in situations where there is a risk of violence, self-harm, suicide, or absconding and detain people under section 136 of the Mental Health Act when they are in a public place and appear to be suffering from a mental disorder. These powers are essential to protect the safety and dignity of people in mental health crisis and to facilitate their access to assessment and treatment.

- ✓ Without police involvement, many people may not receive the help they need and will end up in worse situations. We are also worried that our staff will be exposed to increased levels of stress, violence and injury when responding to mental health calls without police backup.

- ✓ The time scale is not enough time to prepare for such a radical change in policy and practice. We need more time and resources to implement the RCRP scheme effectively and safely.

- ✓ We need to recruit and train more mental health professionals, develop new pathways and protocols, enhance our crisis resolution and home treatment teams, increase our community and voluntary sector capacity, and improve our communication and information sharing systems.

- ✓ Having said this there are some things we can do to start to bring our house to order. We must be careful not to make changes that will impact elsewhere in the system. We need to work at pace, but we need to be measured and organised in our approach and fully engage our partners.

- ✓ **Service users/ carers/ staff:** Doing nothing is not an option in this instance, The withdrawal of Police officers without mitigations in place could have profound impacts on community safety and safeguarding of individuals (both for staff, those who use our services and members of the public).

- ✓ **Financial implications:** **There** maybe both immediate costs (for security. Extra staffing, Data Improvement etc) to ensure safety of staff and others and longer-term costs which might fall out of changes to the system.

- ✓ **Legal and regulatory implications:** There may be immediate breaches by the police of the Mental Health Act. Failure to act by the partnership could be regarded as the trusts breach of their duty of care (and the Police).

- ✓ **Equality, diversity and human rights**: These unilateral changes could be regarded as a breach of human rights. An assessment will need to be carried out for each process or policy change. This report will affect racial groups, people of different ages, people with a disability or men and women differently/ reduce health inequalities/ promote good race relations

What we are doing to prepare?

AWOL Policy :

- We are working with the 9 other Mental Health Trusts in the London region to ensure our AWOL polices are standardised and each area is working from the same baseline. This is the first policy to be completed and includes detailed assistance for staff on what to do following an incident which leads to a possible AWOL on a ward or walk out from a heath care facility.
- An Quick read flow chart will be available over the next week supported locally with RCRP Cascade Training via webinars delivered by your local management teams

Welfare checks SOP:

- We are working with the 9 other Mental Health Trusts in the London region to ensure our Welfare Check policies are standardised and each area is working from the same baseline.
- The working group will be made up of a wide group of stakeholders and partners (Adults and Childrens Social Care/London Ambulance/The Fire and Rescue Service and the voluntary sector) . This is likely to be developed over the next 3 to 4 weeks. Once completed we will again roll out Cascade Training for staff via Local Management Teams

Section 136:

- Major changes will be taking place to the way people are admitted to Health Based Places of Safety from Monday. A new support hub and telephone number for police will open to help officers make a considered decision about “sectioning” or diverting to alternative resources.
- This will have few changes for staff on 1st November but we intend to keep you fully updated at this time of major change.

Key Messages

- RCRP goes beyond just how we seek police assistance to support our staff in crisis. It starts to address some fundamentals about how we change our approaches to Mental Health and well being
- It challenges us to look at the concepts of how we decriminalise Mental Health and properly distinguish between anti social behaviour, our understanding of the pyscho social elements of health and well being and organic menta illness
- It drives us to review the skill sets of our multi agency and multi skilled work force and encourages us to specify what skills are needed when and where
- It demands better communication and Partnership working at a borough level by promoting better outcomes for individuals but avoiding territorialism
- Partnership boards will be key to monitoring how and what we do we people are in crisis
- Training and will be critical at a local level ensuring that we enable staff to accurately risk assess crisis situations and people without prejudice and in line with the human rights act and, core policing responsibilities

Borough Partnership Response

- X2 daily pace-setter calls to monitor impact and respond – all partners will be able to feed in and will be made aware of any emergent issues
- Organisations need to reach frontline staff to clarify new process and procedures, particularly in relation to people who go missing and welfare checks
- This is in progress, BP exec identified this will happen within organisations, a system-wide group will oversee updates, particular need to connect with primary care, public and voluntary sector staff.
- Agreed to establish task-and-finish to ensure within local system organisations, policies and processes are in place, consider operational implications and understand how impact is being measured

Children and Young People's Mental Health

Summary

Early identification and support for children's mental health is one of the key priorities for Haringey Start Well, along with autism and SEND. It will be a key focus for 24/25.

We will replicate some of the intense focus we have used in 23/24 for SEND in order to:

- Build a deeper, shared understanding of the areas of strength and weakness in our current mental health provision for children and young people
- Listen and be visible, talking to children, schools, providers, parents and understanding the needs of different communities. Undertaking audits and notes reviews to deepen shared knowledge
- Build connections to increase insight into the impact of targeted and mainstream initiatives (e.g. inequalities fund schemes), local visibility of NCL investment and to inform key planned developments, like Single Point of Access.
- Define a clearer whole system offer including SEMH support in schools, population level support and specialist CAMHS services, raise awareness of offer through all agencies' websites & communications

There is a lot of development within Haringey, across BEH and across NCL around CAMHS. A new senior management team is in place in Haringey CAMHS, with all posts filled, and a tri-borough division in BEH transforming services across all 3 boroughs. This is now mobilising and change starting to take effect.

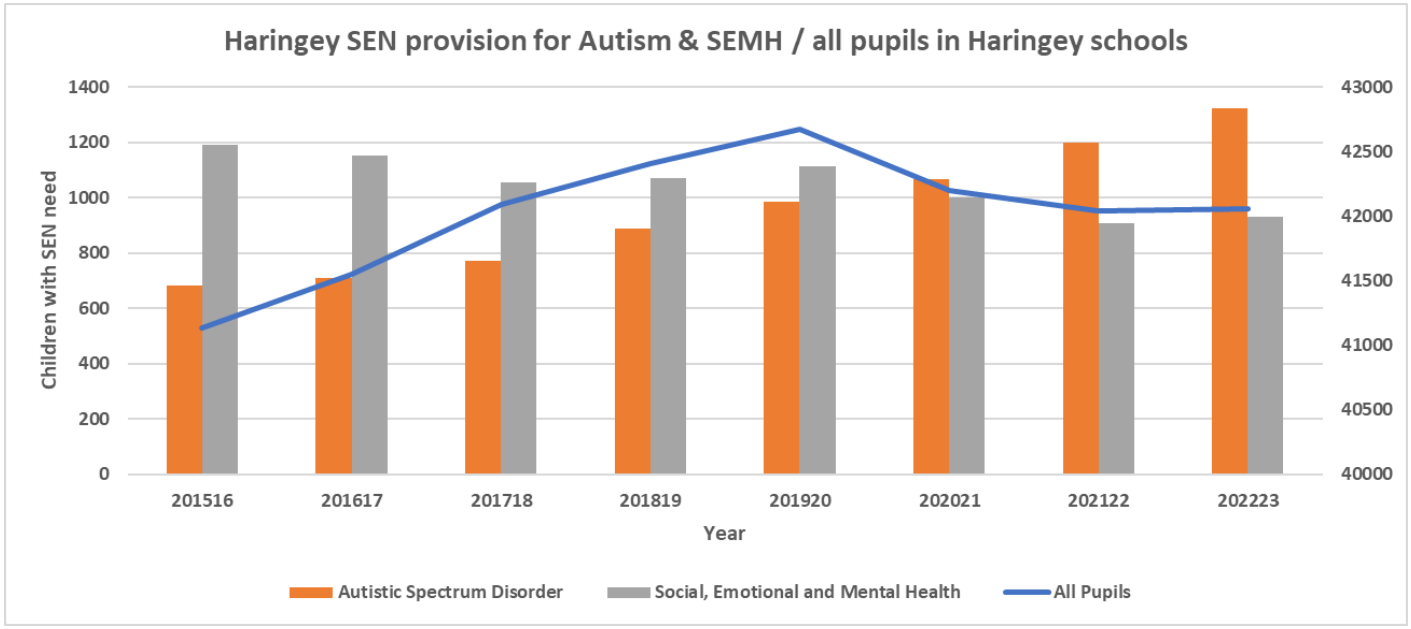
Profile of Haringey

In the 2021 Census, there were **59,800 children and young people** aged 0-19 in Haringey, a fall of 5.7% since 2011.

There are 62 primary, infant and junior schools in Haringey, and 12 secondary schools. **42,060 children go to school in Haringey**.

It is estimated that around **4,800 children and young people aged 5-15 years have a diagnosable mental health condition,** and around **5,700 young people aged 16-24 years** have a diagnosable common mental health condition in Haringey.

Since 2015/16, Special Education Needs data shows Social, Emotional and Mental Health **(SEMH) provision* has fallen by 28%**, whilst **Autism provision has risen by 95%**



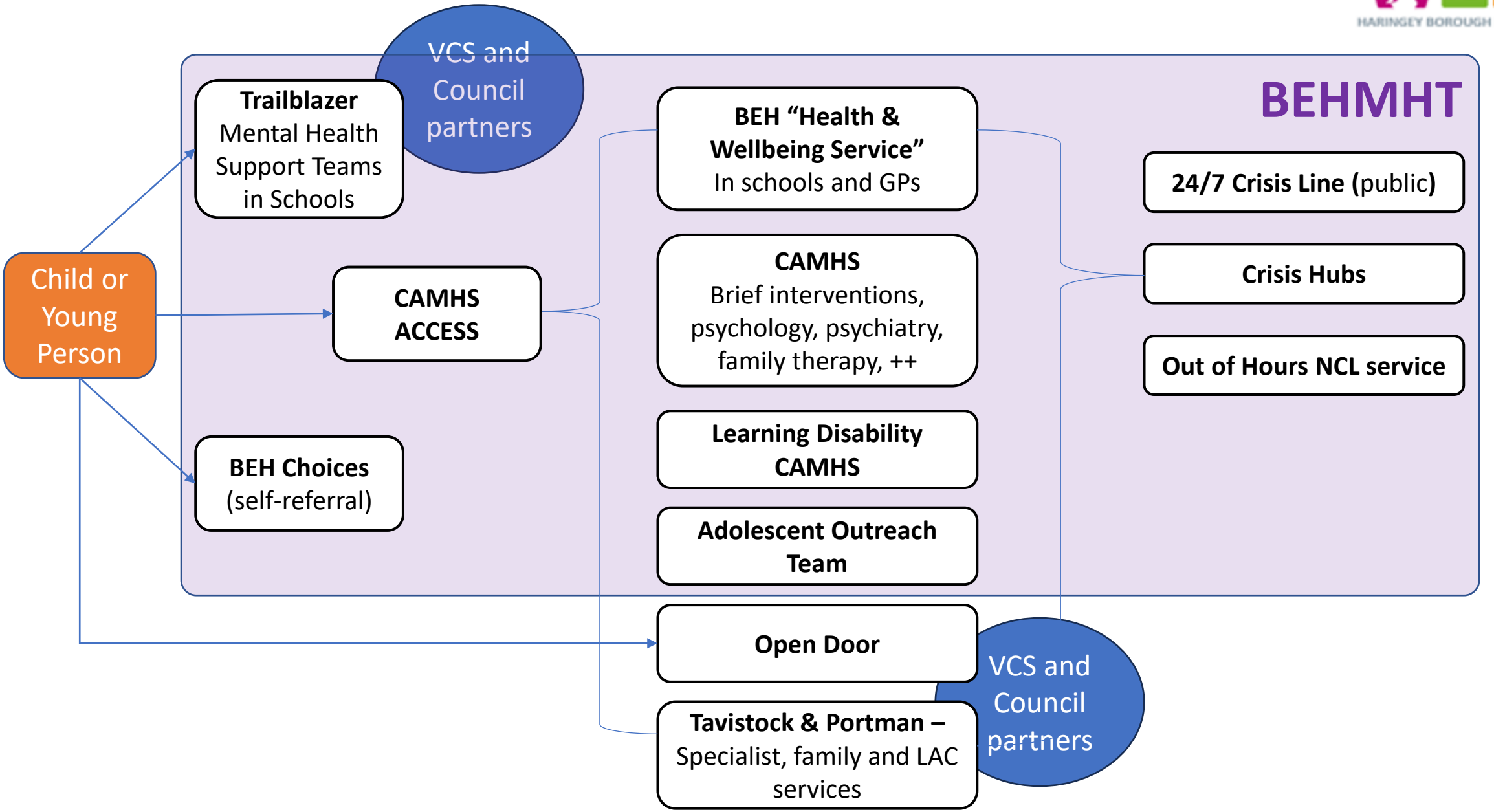
* 'Provision' = SEN support in schools or a statutory education, health and care plan.

Provider profile

Haringey has 4 main providers of CAMHS services and a range of voluntary sector organisations plus Council activity.

Barnet Enfield and Haringey MH Trust	Tavistock and Portman NHS Trust	Open Door	Royal Free NHS Trust	Whittington NHS Trust	Haringey Council	Other VCS
Community and inpatient CAMHS services, including schools teams, general teams, crisis teams and specialist services. ADHD pathway	Specialist family services including foster/adoption support, and embedded service in the Looked After Children team. Autism pathway for 12+	Local charity providing psychological support 12+, including family work and expertise in neuro-diversity	NCL wide community and in patient eating disorder service. NCL wide crisis service in-reaching to acute wards	Parent –infant specialist team, now expanding as part of Family Hubs. Autism pathway 0-11	SEND services including Education Psychology in schools and funded school support. Anchor Approach for whole school change	A range of smaller services in partnership with the larger organisations, including drama therapy, sports inclusion and schools / communty work.
~1000 caseload	~500 caseload	~900 / year				~250 / year

Overview of Haringey's Children & YP MH services



NCL have agreed to focus on 6 priorities for CYP MH

1. Primary prevention

through building **mental health literacy**, **targeted** to reach out to parts of our communities that traditionally access services at a lower rate than average/where **inequalities** are stark, together with **targeted early intervention through** e.g. identification of families with complex needs with children at risk of developing mental health problems.

2. Digital innovation

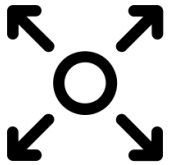
including support for **self support and navigation**, **AI to support referral management and segmentation**, and therapeutic treatment via **digital apps**. Looking to test use of **'Waiting Room'** app to complement patient held records.

3. Standardisation of the clinical model

informed by **evidence and best practice**, with initial focus on the '**front door**' and **standardised triage**, screening and access into pathways. Establishing the **system wide PTL** will both drive and support this. We will **review the current service configuration** to address fragmentation.

4. Developing the workforce model

including new roles that meet the needs of CYP and complement 'hard to recruit' roles.



5. Expanding and establishing services to increase capacity

reduce waiting times and support effective **treatment in the community** (reducing pressure on crisis, emergency and inpatient services.) Priorities for 2023/24 include roll out of **Home treatment teams across NCL**, and further investment into core community services. **Resources will be directed to address historic under-investment** in northern boroughs.

6. Further developing the research and evidence base

particularly around **prevention**.

NCL ICB investment in CAMHS 23/24

NHS services benefiting Haringey

In 2023/24, NCL ICB plan to additionally invest the following recurrent SDF/MHIS funded schemes:

- **Waiting times to 1st appointment in 4 weeks** should improve; across NCL an additional 3,149 CYP will be seen from £5.6m funding.
- **£260k in Haringey for looked after children (LAC) to address gaps in provision, reduce crisis presentations, placement breakdown** and increase total young people supported and seen within target timeframe, addressing health inequalities.
- £1.2m for a full NCL wide roll out of the **intensive home treatment/hospital at home provision** (HTT), 8am-8pm x 7 days to see 85 young people, reducing inpatient bed usage and address over-representation of identified inpatient (gender, LD&A, ethnicity) groups, delivering a saving of £431k per year to the system.
- **£180k to north of NCL to assess and respond to CYP in MH crisis** including consultation to professionals between 8pm and 8am daily. This will contribute to addressing the gaps in the NHS Long-Term Plan target for a 24/7 CYP MH crisis response pathway in NCL.
- **£700k split across Barnet, Enfield, and Haringey to fund central point(s) of access / integrated front door approach for north NCL CYP MH.** This will address inequalities in access, outcomes, and experience e.g., in BAME groups, reduce crisis presentations, and contribute to an increase in CYP MH access of 1769, and over 85% waiting less than 4 weeks to 1st appointment.
- **£580k (£685k FYE from 24/25) for 'Tri-borough Early Years (0-5)' provision in Barnet, Enfield, and Haringey**, to address gaps in the pathway, increasing MH access by 500 CYP per year, improving performance against waiting times (Barnet, Enfield, and Haringey), and addressing adverse childhood experiences (ACEs), child protection, LAC, physical/MH integration.
- **£125k to embed co-production** for NCL with CYP and families, to drive and sustain THRIVE maturity for the NCL CYPMH system. This collaboration focused quality improvement will enable benefits, improving equity of access, experience, and outcomes.

Funding related priorities for the year ahead:

- Neurodevelopmental disorder diagnosis – **review the NDD hub impact** and plan to address continued waits and fragmented pathway(s).
- **Eating Difficulties** and ARFID (EDAS) – understand and address identified pressures on the service from increased demand Vs capacity.
- **0-25 system maturity** – focus on meeting the needs of the full CYPMH age range including '0-5' early years and '16-25' young adults.

THRIVE: Getting Advice - Single Point of Access

Barnet Borough
Integrated Front Door 24/25

Enfield Borough
Integrated Front Door 24/25

Haringey Borough
Integrated Front Door 24/25

North London Mental Health Partnership

THRIVE: Getting Advice
BEH SPA 'No Wrong Front Door'

24/7 functionality SPA linked to Crisis Line and NHS 111.
Triage, intake, clinical assessment undertaken quickly to identify needs early to include 1st assessment, Extended assessment and up to 6 sessions brief intervention. Specialist ND triage. Advice, guidance and support for CYP, their families and other professionals working with CYP.
Online referral form, integrated with EMIS and with IA technology to support screening.
Signposting to service according to Thrive needs-based grouping. Outcome scores and clear SOP's to inform decision making.

Getting Help Pathways in all 3 divisions

Getting More Help Pathways in all 3 divisions

Getting Risk Support/ Enhanced Care

Urgent and Emergency Care In Patient

Tri Borough/NCL wide ND Assessment pathway

What is new?

Single point of access for all divisions with one contact number aligned to crisis number. Digital referral form, CAMHS Triage team carrying out assessments/Triage/signposting supporting referrers and self-referral. Principle of no wrong front door. Patient facing service delivering assessment and brief intervention. Centralised collation of outcome measures and scoring used to determine pathways in conjunction with Shared Decision Making. New walk-in clinics. Choose and Book.

Haringey CAMHS Good News Stories

North London Mental Health Partnership

START • LIVE • AGE WELL HARINGEY BOROUGH PARTNERSHIP

1. Developed a **Walk-in Clinic,** starting in Clinic in Bounds Green GP surgery – on Thursdays to offer combination of drop and early access to CAMHs including signposting and initial screening and triage.
2. Successful **recruitment of borough Clinical Lead** to support depth and strengthen of clinical leadership, modalities of treatment, clinical expertise and robust oversight of psychological therapies. The role will embed a more sustainable level of clinical leadership in Haringey CAMHs and support the wider alignment across the tri borough division.
3. **Single Point of Access Haringey** stakeholder event held on 18th Sept to support GAP analysis of Mental Health modelling and where BEH could interface or sit with resourcing an integrated from door model across the borough and BEHMHT.
4. **Trailblazer (MHST) roll out to West of borough with 8 primary schools and 5 Secondary schools offered an assigned trainee/practitioner to provide targeted interventions and whole school approach**. Secondary school receive a full day and half a day for primary.
5. **Haringey CAMHs participated in recruitment campaig**n specifically for CAMHs and following up on recruitment the expressed interest in roles from over 79 attendees and engaged in interview rounds and selection for a range of roles.

Open Door

Open Door's 22/23 annual service evaluation found -

- 78% showed improvement on clinical outcome measures, which compares very well with internationally reported outcomes.
- Most showed improvement in other aspects of their lives including relationships, educational engagement and social isolation.
- 95% reported progress in at least one Goal Based Outcome
- 99% agreed that the help they had received had been good.

Trust Key Challenges and Next Steps

Key Challenges	• **Recruitment of Consultant Psychiatrists**, of 5.1 establishment posts, 2.9 are vacant and 2.3 locum • **Limited workforce capacity to deliver short term interventions**, (6-8 sessions). The average minimum wait to access this is 3 months. • Similar challenge for CYP that require specialist disciplines – the **average minimum wait is about 8 months**. • 8 cases of **longest waits are for ADHD assessment, currently 12 months with average of 9-10 months**
Mitigations	• The ADHD waiting list are offering weekend digital access - 12 patients assessed per month supported by an additional locum Consultant Psychiatrist to clear the backlog, anticipate this will be cleared by Autumn 2023. • Psychology roles out to recruit or onboarding which in time will reduce waits once capacity is in. • Group work has been implemented to reduce the waiting time for intervention. • Major recruitment campaigns and open days leading to falling vacancy rate.
Next Steps	• Continued support and collaboration with Council's Family Hub development • Further recovery in the ADHD pathway and wider partnership resilience • Implementing the CAMHS transformation care pathways • Mobilisation of 23/24 investment across Borough and BEH • Developing a sustainable workforce strategy • Maintaining local staff wellbeing initiatives • Strengthening QI within the service to improve flow and patient experience

Start Well and Haringey Perspective on Key Challenges and Opportunities

Key Challenges	• Perceptions and **relationships between CAMHS and the community, schools and Council services** • SEND system seeing high level of **rising demand from SEMH** need • Rising levels of **emotionally-based school avoidance** • **Variation in offers across Haringey in different schools,** neighbourhoods • Financial constraints across all services – s75 review needs to optimise available funding • Move away from joint commissioning to aligned commissioning – also an opportunity?
Key opportunities	• A strong VCS, with **contracts needing to be reprocured to start April 25** – a chance to strengthen our approach and implement a sustainable early intervention and prevention model • The SEND Safety Valve programme includes projects to develop the SEMH / Inclusion Pathway in schools, and the introduction of Resource Hubs for children with SEMH • To hear more from children to shape our next phase – e.g. Beewell census?

Borough Partnership Response

- Endorsement for Start Well focus on children and young people's mental health and wellbeing
- Recognition of the need to be clearer for residents about what is available
- Strength of VCS offer recognised
- Recognition and appreciation of new senior leadership team within CAMHS under North London Mental Health Partners
- Discussion of particular challenges facing CAMHS e.g. workforce challenges and contribution to waiting times, clarity on inclusion/exclusion criteria

Adults and Older Adults Mental Health 2023-25

Haringey Adult Mental Health

Haringey has been putting in place borough plans for many years as it seeks to balance high need and low historic investment patterns.

Through the NHS long term plan investment, NHS services have grown significantly seeing investment and capacity to transform community services. This is resulting in unprecedented **growth of NHS capacity in Haringey and diversification of the model to include peer support, employment support and VCS teams as well as new clinical roles.**

As part of the ICS transition from central planning to borough delivery, this work has now been translated into a borough programme. Over 22-23 Haringey has been integrating this with the joint & Council led work on early help and prevention, public health and adult social care priority areas to form a single programme.

This can and will iterate over time but **starts to provide the foundation for an integrated programme of work in Haringey going forward.**

The Executive are invited to **explore the plan and its prioritisation and actions, but also to consider areas on slide overleaf as topics for development of exploration.** The board may want to consider how the new structures in commissioning support redesigning services and addressing budget challenges.

START • LIVE • AGE
WELL
HARINGEY BOROUGH PARTNERSHIP

2023-25 Adult Mental Health Delivery Plan for Haringey

Background & Context

The Haringey Borough Partnership has identified mental health the priority area of focus in recognition of the level of need and feedback from residents.
The COVID pandemic amplified long-standing inequalities impacting on access, outcomes and experiences for groups of our community, in particular people from black and other minority ethnic groups.

This 2023/25 Haringey Adult Mental Health Programme builds on progress made to date and reflects feedback from engagement events with system partners, patients and residents. It describes Haringey's Borough Partnership approach to completing delivery of the NHS Long Term Plan for community mental health, and the mental health NHS core offer and our borough improvement in prevention, wellbeing and adult social care.

The objectives for improved mental health include but are not limited to:

- Improved early identification and early support particularly for those who are 'rising risk'.
- Improved experience of crisis pathways
- An offer that residents feel is accessible to them and easy to navigate.

These objectives align with the NCL Integrated Care System Population Health & Integrated Care Strategy and the associated Population Health Outcomes Framework for working age adults, as well as the priorities set out in the

Council's Borough Plan.

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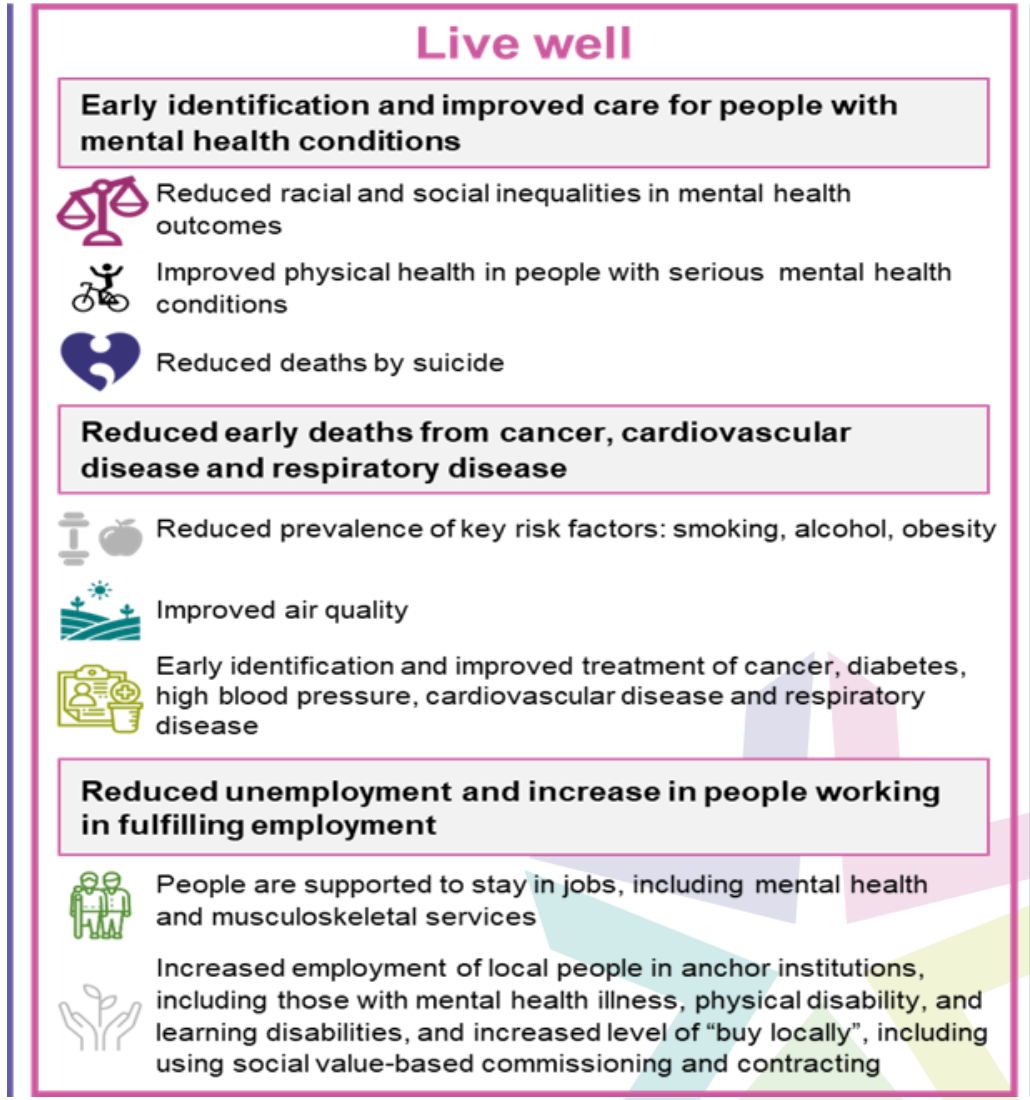
NCL Population Health Outcome Framework- Live Well



Case For Change - Mental Health Need in Haringey

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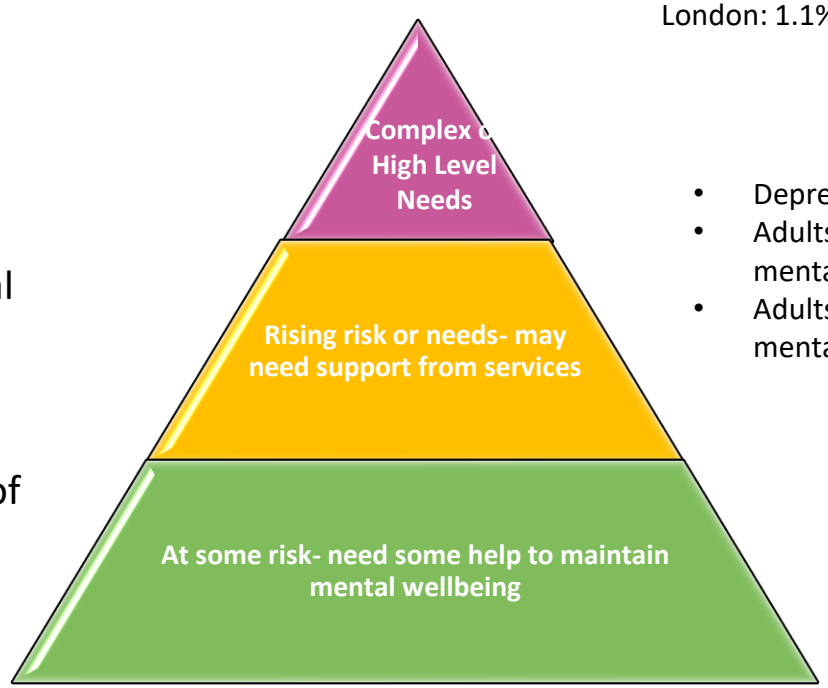
- Significant health inequalities exists including significant disparity by ethnicity – the black population are higher users of acute MH services, with 27% of admitted patients being black, though representing 11% of the NCL population.
- Over 50% of people with SMI have one or more Long Term Condition
- Half of patients admitted to mental health hospital care are unknown to services; particularly high among black population groups
- Dementia diagnosis rates vary significantly - 67% of the estimated population with dementia have a diagnosis in Haringey, compared to 88% in Enfield
- Haringey is the 4th most deprived Council area in London, and 49th of the 317 in England (IMD, 2019)



- **50 deaths** from suicide were reported in Haringey in 2019-21, a rate of 7.2 per 100,000
- SMI in Haringey: **1.3% or 4,143 people** (compared to London: 1.1% and England, 0.9%)

- Depression prevalence (18yrs+): **9%**
- Adults entering drug treatment identified as having a mental health treatment need: **63%**
- Adults entering alcohol treatment identified as having a mental health treatment need: **78%**

- Adult population: **191,300 residents aged 15 to 64yrs** (2021 Census)
- **27,700 residents aged 65+** (2021 Census)
- Adults reporting social isolation: **46%**
- Adults reporting loneliness: **34%**

Development of Borough Adult Mental Health Plans for 2023/24 onwards

North Central London Integrated Care System

Listening sessions and co-production

The Council has reviewed its **adult mental health offer**

Borough partners undertook **gap analysis reviews against the ICS Core Offer.** They reviewed this alongside their **population needs,** non-NHS service provision and local operational priorities in engagement sessions with local system partners facilitated by the ICB PMO and LBH Public Health Team

Borough used the outputs to develop plans with mental health trust

The Haringey plan set out the delivery requirements for 23/24 and beyond, including

- Ongoing mobilisation of existing Long Term Plan (LTP) / Core Offer implementation
- New priorities
- Related change projects supporting delivery of transformed mental health service pathways, e.g. primary care integrated team changes, interfaces with IAPT, co-delivery of VCS services.

Themes and Issues from Engagement Events

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Focus on early help and prevention

- Good mental health cannot exist without addressing the **wider determinants** of mental health, i.e., physical health, housing, strong familial networks, employment and income security etc and the **disparities faced by people from black and other minoritized groups**
- Use of **digital wellbeing apps** to support self-management and sustain wellbeing
- Need for **clear accessible information and care navigation** on the mental health offer
- **Mental health stigma** is a barrier to people seeking help
- **Services are fragmented** and difficult to access. Need for a '**No Wrong Door'** approach- based on **inter-agency MDTs at neighbourhood/PCN level** to prevent residents 'bouncing between services', or '**falling through gaps,**' and repetition of narrative
- **Needs for the provision of more culturally appropriate/informed talking therapies, treatment and services,** – not one size fits all.
- Co-ordination and working together including **strengthening links with grass-roots organisations**

Improve access to mental health care and treatment

- People experience **long waits** when seeking help- reduce waits; implement **'while you wait offers'**
- Concern about **the disproportionate use of anti-psychotic medication** and the **Mental Health Act** detentions- young black men.
- More psychological therapies and improved access to other socially prescribed opportunities.
- **Reducing handoffs** and re-referrals
- **High level of Adult Social Care mental health spend** when benchmarked against comparators
- **Safety netting** in the form of dynamic step up/step down arrangements, case management and key working to **prevent and resolve crisis as well as**
- Current offer could benefit from increased holistic MDT response.
- **Mental Health Liaison Services and MH CAS-** Historic challenge to meet Core24 in the north
- There remains a **lack of trust in statutory services** in BAME communities resulting in crisis presentations
- Provide **more community-based alternatives** to hospital admission/AE & crisis presentation

Both themes would also focus on reducing the inequalities faced by people from Black and other racially minoritised communities and other protected groups

Theme- Focus on early intervention and prevention

North Central London Integrated Care System

2023-25 Priorities

- Collaborate with the Council to co-design and develop **locality based integrated multi-disciplinary hubs** to improve access to help- **'No Wrong Door'** approach.
- Expand access to crisis and hospital alternatives -**Crisis Café and Crisis Prevention House** interface with **BEHMHT CHRTT, AEL, LAS etc**
- Relocate and integrate the Crisis Prevention House, Crisis Café and Clarendon Recovery College at the **Roger Sylvester Centre @ Canning Crescent**
- Maintain and maximise **inequalities focus** including within Inequality Fund
- Remodelling and recommissioning of **early help and prevention services** run by the VCS to support . We will do this in partnership with the council, patients, residents, clinicians etc.
- Review and update of information about the **mental health offer** available in borough and promoting digital apps to support self-management
- **Funding and mental health training** provided to community organisations to increase their capacity and confidence to offer help to members of their communities
- Preventing homeless and implementation of a '**Home First**' approach to hospital admissions and discharges
- Expand support available to residents to **find and keep work**
- Expand access to evidence-based and culturally appropriate **talking therapies and trauma informed practice and interventions.**

Theme- Improved access to mental health care and treatment

North Central London Integrated Care System

Excellence for service users *(Patient experience care in areas that matter most to them)*	Empowerment for Staff *(Staff are valued and developed.)*
Partnership with others *(Least intensive and clinically appropriate care closer to home)*	Innovation in Services *(Support more people with SMI in our communities)*

2023-25 Priorities

- Implementation and integration of **PCN based Mental Health Practitioners (ARRS)** to support clients who previously fell into a gap between primary care, IAPT and secondary care.
- Recruiting more clinicians to reduce number of admissions and keep more people with SMI in their communities and ensure effective and timely review of **anti-psychotic medication**
- Rapid access to mental health services **providing treatment within 4 weeks** including to social care by undertaking **timely Care Act assessments**, Mental Capacity assessments etc.
- Holistic personalised care plans for all service users using **Dialog +**
- **Physical health** screening and support for people with Severe Mental Illness
- Involve system partners in completing the **Patient and Carers Race Equality Framework (PCREF) and develop an improvement action plan** to address findings,
- Roll out **NHS 111** for mental health and monitor impact on crisis access in light of **Right Care, right person** – in response to crisis
- Develop and implement '**Trusted Referral**' model, a **direct referral** pathway from community organisations into Core Community Teams without the need for a GP referral to reduce handoffs and delays to accessing mental health treatment
- Pathways development and implementation for **Complex Emotional needs (Eating disorders, Personality Disorders. Autism), community rehabilitation, young people (16-25s**)

Summary of Issues and Potential Discussion Areas

The adult mental health plan includes some areas which will require **additional investment or activity across partners** which are **not within current resource plans** and the Board may wish to consider the appetite and mechanism for further development of these, including: -

1. The analysis here indicates a disproportionate spend on MH from adult social care. This may be connected to a lack of **step down / admission avoidance accommodation for people with care and support needs.** Do we need to consider steps to increase alternatives to admission and implementing a **'Home First' approach** to reduce homelessness and delayed transfers of care?
2. System partners will **continue to focus on workforce recruitment and retention** strategy, for e.g., social workers, psychologists etc to support delivery of the plan.
3. **Income, home, relationships all drive mental wellbeing and ill-health** and rely on actions beyond mental health services and require greater work on how best to maximise and **fund prevention and target inequalities within the system**
4. Consider **facilitation of system leadership and operational coordination** across the partnership to build shared vision, understand our own capacity and resourcing in order to develop a shared transformation programme
5. Access to **low-cost office spaces in GP practices, libraries and locality/neighbourhood hubs** including robust IT infrastructure to improve co-location and integrated working
6. An **information and content management post to gather, curate and promote the wealth of service and community information about mental health and wellbeing** targeting residents and workforces. This would be a single online repository and newsletter supported by physical and community outreach at neighbourhood.
7. Service user and resident experience are key in shaping services and helping us to really understand how pathways are experienced. We should have a small **budget for coproduction, rewards and recognition**.

Borough Partnership Response

- Borough mental health plan was endorsed and recognised significance of having system wide mental health plan
- Recognised challenges contributing towards mental health and wellbeing and the need to work as a system to respond e.g. pressure on housing limiting scope to respond optimally to need; workforce pressures and impact on waits; risks of right care right person creating additional capacity pressures; transitions to adult mental health and meeting needs particularly for people who are neurodiverse
- Noted the need for a discussion re resources dedicated to this programme which will be taken forward

US – A Service Users Documentary

THE STORY OF 'US – A SERVICE-USERS DOCUMENTARY'.

Tim Mercier is a local filmmaker who has struggled with his mental health for decades. He proposed a six-month film storytelling 'co-production' to the trust, a film made with other service-users like himself, about 'the service-user experience'.

Tottenham Talking, a community mental health project in the St. Ann's neighbourhood became the project's base. All of us, the participants in the project, agreed to name the film 'US' - yet also agreed that there should be no "them and us" - because our stories are about all of us.

We came to the making of the film from diverse backgrounds, perspectives, and motivations for joining the project, some of us happy to be identifiable in the film, others wanted to contribute their story but preferred to remain anonymous.

Creativity was at the centre of the telling of each of our stories, each bringing ideas for how our stories might be told, aspects of our lives and parts of ourselves around and beyond our mental health challenges: camping and other outdoor 'play' activities; costume making; drawing and painting; hairdressing and nail art; poetry; music; mental health activism and more. For all of us, it was the process of working together with a common cause, building trust and friendships with one another that became as important as any outcome.

The film is layered with the wealth of our lived experience. It speaks to the impact of childhood and adulthood trauma, the stigma that is experienced in living with a mental illness in familial, work, healthcare, social and societal environments. It speaks to gender issues too, the impact of racism in our healthcare systems, the influence of a person's culture on their lives, the impact of war, poverty, border control and related traumas, and of our experiences, good and bad, while accessing mental health services. The film is full of fun, hope and triumph too - and while the journey has been full of challenges for us, and has taken over a year to complete, we are so proud that our film is now ready to share with you.

Our film is designed to deepen reflection and widen conversations about mental health and its challenges, within both mental health trusts and in the wider community. We really hope that viewers remember the vulnerability we risked by deciding to be part of the project, and the courage it took for us to share such intimate and personal stories of suffering and challenge. We also hope that by sharing our views and perspectives in this way, we might open up opportunities for vitally important conversations amongst those who watch the film, whether they be mental health professionals or everyday people like us, about mental health.

We therefore invite viewers to remember, better still be inspired by the bravery we have shown by sharing our stories with you, when offering and sharing your reflections and questions in discussions or workshops after a screening of the film. We also invite viewers to be as creative in their response to the film as we sought to be in making it. The film link and password are shown below and there are contact details for you to connect with your thoughts on the film and how it might be used to assist further discussion within mental health

Video Link: (Hold down Ctrl and place curser over link below to click into it)
https://vimeo.com/854487392?share=copy
Password FILMUS01

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North Central London Integrated Care System

North Central London Integrated Care Partnership

Tuesday 3 October 2023; 15:00-17:00

Council Chamber, First Floor, Crowndale Centre, 218 Eversholt Street, London, NW1 1BD

	Item	Page	Time	Lead
1.	**Welcome and Introductions**	*Oral*	15:00	Chair
2.	**Minutes and Actions**	Page 3	15:05	Chair
3.	**Population Health and Integrated Care Strategy – Delivery** **1. Borough Partnerships and ICP** **2. System-wide work**	*1. Oral* 2. Page 14	15:10	1. John Hooton 2. Penny Mitchell
4.	**SEND and Alternative Provision in North Central London**	Page 20	15:25	Chris Munday
5.	**Longer Lives – Improving the physical health of adults with severe mental illness in North Central London**	Page 47	16:00	Sarah Mansuralli
6.	**Heart Health – Verbal Update**	*Oral*	16:35	Will Maimaris and Amy Bowen
7.	**Family Help in Early Years – Verbal Update**	*Oral*	16:45	Jon Abbey

North Central London Integrated Care System

8.	**AOB**	Oral	16:55	Chair

Next meeting: Tuesday 16th January

North Central London ICS
Integrated Care Partnership Meeting
3 October 2023 - Action Log

North Central London Integrated Care System

On Agenda	
Needs Urgent Update	
In Progress	
Completed	

Meeting Date	Action Number	Minutes Reference	Action	Lead	Deadline	Update
18.04.23	1	**Paragraph 2.1.8**	**Childhood Immunisations – Test and Learn** To provide a summary of the immunisations work to the ICB Board.	Dan Glasgow	**TBC**	**11 July 23** - It is planned to take a summary to a future meeting of the Place Editorial Board.
18.04.23	2	**Paragraph 3.3.2**	**Discussion – challenges and opportunities for 2023/24** To bring a paper on the position with regards to the development of place based working and Borough Partnerships (opportunities and challenges) to a future meeting.	Sarah McDonnell-Davies/ Dawn Wakeling	**January 2024**	**3 October 23** - Borough Partnership Chairs have agreed to bottom-up approach to delivery of the Population Health and Integrated Care Strategy (linked to Action 9). Borough Partnership Chairs will be reconvened in Autumn 2023 to discuss areas of commonality and opportunities for scaling up.
18.04.23	3	**Paragraph 4.1.3**	**Population Health and Integrated Care Strategy** To facilitate a discussion on the Population Health and Integrated Care Strategy delivery plan, timescales and milestones.	Sarah Mansuralli/ Will Maimaris	**September 2023**	This action has been closed as it has been superseded by action 9.

11.07.23	4	**Paragraph 4.8**	**Minutes and Actions** To engage DCSs (Directors of Children's Services) on priorities for collaboration on 'School Readiness' ahead of the next meeting.	Richard Taylor-Elphick	**October 2023**	**3 October 23 –** Verbal update to be provided on 3 October, ahead of a substantive agenda item at next meeting on 16 January under the theme of Family Help in Early Years.
11.07.23	5	**Paragraph 4.8**	**Mental Health – CAMHS Deep Dive** To hold a discussion between DCSs and Sarah Mansuralli's team to map existing good practice on work that can be scaled up and applied across the system.	Richard Taylor-Elphick & Sarah Mansuralli	**October 2023**	**3 October 23 –** Agenda item on SEND and AP Change Programme on 3 October.
11.07.23	6	**Paragraph 4.9**	**Mental Health – Adult Mental Health Emergency Pathway** To apply the learning from work across mental health and inequalities in NCL. Next steps to be discussed by Mike Cooke, Richard Taylor-Elphick and Dan Sheaff.	Mike Cooke, Richard Taylor-Elphick & Dan Sheaff	**October 2023**	**3 October 23 –** Agenda item on Longer Lives Programme on 3 October. Work is ongoing between LA and NHS partners to address Right Care, Right Person directive.
11.07.23	7	**Paragraph 4.10**	**Mental Health – Adult Mental Health Emergency Pathway** To circulate to ICP members the datapack produced for the recent Right Care Right Person meeting.	Sarah Mansuralli	**July 2023**	**3 October 23 –** Action completed.
11.07.23	8	**Paragraph 4.11**	**Mental Health – Adult Mental Health Emergency Pathway** To brief Jinjer Kandola on the Mental Health discussion at the meeting on 11 July 2023	Sarah Mansuralli	**July 2023**	**3 October 23 –** Action completed.
11.07.23	9	**Paragraph 5.3**	**Delivery of the Population Health and Integrated Strategy** To reflect on the conversation regarding areas of focus for the ICP (for example, mental health and school readiness) and to meet with Borough Partnership Chairs	Mike Cooke, Cllr Kaya Comer-Schwartz	**October 23**	**3 October 23 –** Agenda item on 3 October.

			to shape local delivery planning for the Population Health and Integrated Care Strategy.			Action Completed. Borough Partnership Chairs were convened on 20 September.

North Central London Integrated Care System

Draft Minutes
Meeting of North Central London Integrated Care Partnership
11 July 2023 between 12pm and 2pm
Islington Town Hall

Present:	
Mike Cooke	Chair, NCL Integrated Care Board and Chair of Meeting
Cllr Kaya Comer-Schwartz	Leader, Islington Council
Cllr Peray Ahmet	Leader, Haringey Council
Cllr Georgia Gould	Leader, Camden Council
Cllr Alev Cazimoglu	Cabinet Member, Health and Social Care, Enfield Council
Cllr Alison Moore	Portfolio Holder, Health and Wellbeing, Barnet Council
Beverley Tarka	Director of Adults, Health and Communities, Haringey Council
John Hooton	Chief Executive, Barnet Council
Linzi Roberts-Egan	Chief Executive, Islington Council
Frances O'Callaghan	Chief Executive Officer, NCL Integrated Care Board
Will Maimaris	Director of Public Health, Haringey
Phill Wells	Chief Finance Officer, NCL Integrated Care Board
Dr Jo Sauvage	Chief Medical Officer, NCL Integrated Care Board
Jon Newton	Service Director, Adults and Older People, Enfield Council
In attendance	
Sarah Mansuralli	Chief Development and Population Health Officer, NCL Integrated Care Board
Sarah McDonnell-Davies	Executive Director of Place, NCL Integrated Care Board
Dan Sheaff	ICS Policy Lead, North London Councils
Richard Taylor-Elphick	Programme Director, North London Councils
Amy Bowen	Director of System Improvement, NCL Integrated Care Board
Penny Mitchell	Director for Population Health Commissioning, NCL Integrated Care Board
Sarah D'Souza	Director of Communities, NCL Integrated Care Board
Jose Acuyo	Head of Population Health Commissioning, NCL Integrated Care Board
Lauretta Kavanagh	Programme Director for Mental Health, Learning Disability and Autism, NCL Integrated Care Board
Apologies	
Cllr Nesil Caliskan	Leader, Enfield Council
Cllr Barry Rawlings	Leader, Barnet Council
Doug Wilson	Statutory Director of Health and Adult Social Care, Enfield Council
Jinjer Kandola	Chief Executive Officer, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust
Nnenna Osuji	Chief Executive, NMUH
Baroness Julia Neuberger	Chair, UCLH and Whittington Health
Alpesh Patel	Chair, GP Provider Alliance
Dominic Dodd	Chair, UCL Health Alliance
Dr Chris Caldwell	Chief Nursing Officer, NCL Integrated Care Board
Richard Dale	Executive Director of Performance and Transformation, NCL Integrated Care Board
Minutes	
Vivienne Ahmad	Board Secretary, NCL Integrated Care Board

1.	**INTRODUCTION**
1.1	**Welcome & Apologies**
1.1.1,	The Chair welcomed attendees to the Meeting. Apologies had been received from Cllr Nesil Caliskan, Cllr Barry Rawlings, Doug Wilson, Jinjer Kandola, Nnenna Osuji, Baroness Julia Neuberger, Alpesh Patel, Dominic Dodd, Dr Chris Caldwell and Richard Dale.
2.	**Minutes and Actions**
2.1	The ICP **AGREED** the minutes of the previous meeting on 18 April 2023 as an accurate record.
2.2	Members then reviewed the action log, which contained three 'open' actions. Frances O'Callaghan highlighted that the last meeting had discussed having school readiness on the agenda of the July meeting and assurance was given that this would be included on the agenda for the next meeting. Richard Taylor-Elphick agreed to pick this up with the Directors of Children's Services outside the meeting.
2.3	The ICP **NOTED** the action log.
2.4	Action: Richard Taylor-Elphick to engage Directors of Children's Services on priorities for collaboration on 'School Readiness' ahead of the next meeting.
3	**NCL Inequalities Fund – Evaluation**
3.1	Sarah D'Souza introduced the item, noting that the focus of the ICB's Communities Team is to make the ICB's commitment to reducing health inequalities a reality as both a moral imperative and to strengthen the ICB's financial sustainability going forward. In recognition of the fact that that the most deprived communities face significantly greater health challenges, the ICB developed a £5m Inequalities Fund. The Fund is a positive example of what can be achieved when place, partnerships and the system work together.
3.2	She then gave a summary of the progress of the Fund and future plans: • The fund is focused on innovating place-based solutions to entrenched health inequalities, with lived experience and co-production at the heart, based also on the principle of proportionate universalism. • The majority of funding was allocated to the Borough Partnerships, largely proportionate to levels of deprivation. • Over 60 schemes have been implemented to date, many of which are 'test and learn' • Evaluation has been challenging due to the variety of the schemes and the difficulty in measuring cause and effect, while also needing to measure what is important to communities. Analysis has therefore focused on direct impact and system impact to obtain a rounded understanding. Alongside this, Middlesex University are reviewing the effectiveness of the co-production work. • The evaluation shows that 83% of the schemes met their intended outcomes, ranging from 800 fewer A&E attendances to providing safer environments for young black men to discuss mental health issues. • The Fund has provided an early blueprint for future Borough Partnership and system working, such as combining strong data on need with local insights and delivery approaches, as well as sharing learning. It has also helped to develop community assets – more than 50% of these schemes are delivered by voluntary and community services. • The programme is being extended and is seen as a vehicle for building further investments and galvanising local thinking • Consideration is being given to how the current schemes might be scaled up and deepened and how the wider learning can be applied more systematically to the system, as well as applying an 'equity lens' to data on spend and performance to facilitate discussions on how resources are being used

	• It is recognised that poverty is one of the key determinants for poor health outcomes and in addition to the ongoing work on the London Living Wage, there is the opportunity to be more systematic about pathways into employment in health and care.
3.3	Sarah D'Souza then posed four key questions for the meeting to consider: • What actions should the Partnership take to develop an approach to aligning resources to need, building on the example of the Inequalities Fund? • What approaches should we use to demonstrate improvement in equity for our population at system, borough partnership and organisational level? • How can we apply the learning from the co-production approach and apply this more broadly to our system transformation work? • How should we build on the Inequalities Fund work as a system in the future?
3.4	ICP members then discussed the paper, making the following comments: • The quantity of work and the qualitative descriptions in the report were commended. However, it was noted that while some programmes 'flew' from the outset, others were slow to start or encountered barriers, so it would be helpful to think about what can be done to make future programmes more 'oven-ready'. • The report has taught valuable lessons around what can be done at hyper-local level to respond to communities' needs, as well as scaling-up different opportunities. The evaluation has also identified which initiatives will work best. Given this, what are the plans to do more scaling up, while also recognising that some of the hyper-local programmes are responding directly to the outcomes set in the strategy, such as helping people back into work and meaningful employment. • The funding and range of exciting projects was welcomed. However, it was questioned how the system will translate the experience that people have of these services into their experience of mainstream services. • It is important to understand the macro elements (such as cultural competency) while enabling the micro-elements to continue. • Concern was expressed about just continuing programmes as there is a risk of 'initiative-itis'. It would be helpful to know what worked and what did not, and then embed some of these approaches, turning them into 'business as usual'. In terms of co-production there are already a lot of assets in the Boroughs, such as health champions and existing health programmes which could potentially be made use of. It would also be useful to map the prevention and inequality spend across the patch to get a fuller picture of what is being invested in order to build on this in the future. • The principle of recognising the inequity of funding across NCL and the genuine sense of being listened to was welcomed. • It was questioned whether the Partnership understands the needs of its populations as well as it should, bearing in mind that some of the seldom heard communities have the greatest needs. • It was highlighted that although none of the most deprived wards across NCL are in Barnet, there is nevertheless considerable inequality at sub-ward level in the Borough. • There is strong synergy between the Inequalities Fund projects and the work that the ICB is planning to undertake with the Core20PLUS communities that have been identified as part of the Population Health and Integrated Care Strategy. The ICB is now able to refine in much greater detail the kinds of population groups that it wants to target and it may want to do that when looking again at future allocations • It was confirmed that the Borough Partnerships had also identified particular schemes which would not be continued, so this funding can potentially be re-invested elsewhere. • It was noted that the work on the Inequalities Fund had found the 'sweet spot' between shared system-level objectives, system level data and qualitative insight on the ground which can then be targeted, enabling learning at system, place and neighbourhood

	levels, while also modelling how the system might work differently together and with communities.
3.5	The Chair thanked members for their feedback and insights on the funding itself and the schemes it supports, particularly around investment and re-investment and what kind of learning can be applied. The discussion had also raised the issue of what macro learning ought to be applied to partnership working at both NCL and Borough levels. This point would be returned to under item 5.
3.6	The ICP **NOTED** the evaluation of the NCL Inequalities Fund.
4.	**Mental Health**
4.1	Sarah Mansuralli introduced the paper, which focused on Child and Adolescent Mental Health Services (CAMHS) and the Adult Mental Health Emergency Pathway. These elements would be taken in turn, so she highlighted initially the following points relating to CAMHS: • There are significant operational interfaces between the work that the NHS and local authorities do around mental health and the work of the Police and other agencies, so it is fitting that it is the focus of a partnership discussion, as there are multiple components which affect the pathway. • A discussion on the opportunities for further collaborations to improve outcomes for residents would be welcomed. • A large amount of work has taken place on developing the CAMHS 'core offer' since it was approved. Despite the demand for CAMHS services increasing exponentially across NCL and the progress made on implementing the key priorities, it is recognised that there are still significant variations in the offer and fragmentation in pathways can accentuate the waiting times experienced by residents. Multiple providers in each Borough adds to the diversity of the provision but the 'hand-offs' can add to waiting times. The system therefore needs to find a way of maintaining what is best while streamlining the pathway. • In addition to the aforementioned variations in offer, the presentation identified four other key challenges: Electronic Patient Records (EPR) systems, finance, performance and prioritising impact. • It is clear that the increased investment and trying to increase capacity against a backdrop of continuing workforce 'churn' will not be enough to hold the tide for long against increasing demand, which is being caused by a variety of factors, including greater awareness of mental health conditions, reduced stigma, the impact of the pandemic and the cost of living crisis. • There is therefore a clear need to think differently about innovation and collaboration to address these challenges.
4.2	ICP members then discussed the paper, making the following comments: • Concern was expressed about the scale of the increase in the prevalence data. It is clear that there needs to be a strong focus on prevention opportunities and it would be helpful to hear more about what is currently taking place in this area. Other contributory factors include social media, as well as drug and alcohol use and it was queried what targeted interventions are taking place to counter these. • The importance of learning from good practice within the system, such as the work in Camden around integrated transition for 16 to 25 year olds to avoid people getting lost in the system, was highlighted. • Issues around data need to be addressed in order to deepen partnership working and improve transition of people across services. • It was noted that Michael Holland, Chief Executive, Tavistock and Portman, recently reviewed the CAMHS services in Camden and was deeply impressed by the preventive work taking place. • It was queried whether there is wider learning that the ICP could consider which looks outside core therapies and has a strong evidence base that could be implemented at place and would have a significant impact. • It would be helpful to hear more about access for different communities. More broadly, it was also queried whether a medical model should be used to address children's mental health as anxiety can be provoked by a range of external factors such as the

	after-effects of not going to school during the pandemic, school tests and the fear of crime, which might be better tackled through early community-based interventions to build up resilience and avoid crises later on. • It was highlighted that a large number of schemes supported by the Inequalities Fund focus on mental health, particularly with regards to young people and BAME communities. Local authorities have the skill assets and engagement structures to be able to speak to young people and parents about mental health from a non-medical perspective. Young people need to be empowered to navigate this complex time of their lives and make decisions for themselves about whether they are medically depressed. This might also mean having different types of conversation at practice level. • It was confirmed that children's mental health is one of the top priorities for Directors of Children's Services (DCSs), so there is an 'offer' for joint work. It is clear that the case-load levels and need levels reflect more deprived communities, so there is a strong link with the previous item. • In terms of the social model, Boroughs are extremely focused on elements of the Thrive Framework and there is a general feeling that there is an opportunity to do more as a whole system in that space that would look across different types of support to address the need for preventive measures. Richard Elphick-Taylor offered to support engagement with Directors of Children's Services further outside the meeting. • The need for a targeted approach was highlighted as resilience will depend to an extent on young people's personal circumstances – those within the care system, for instance, will have very different experiences to those who have supportive families. • It was noted that this work is at the core of what the Borough Partnerships and the ICP are trying to do, as it encapsulates the mutuality between us and the need to understand prevention. • It was queried what proportion of children are having an episode and what proportion are going on to experience more severe longer-term mental health issues. Although there was a clear increase in terms of need after the pandemic, on the whole these did not become long-term pathologies. It would also be helpful to understand what the local authority commitments are in this area in order to gauge how much money is available to do things differently. If NCL succeeds in making progress in CAMHS. that would be a powerful testament to the commitment to achieving our goals. • The Mental Health Services review identified that more money is being spent on crisis than early intervention. Inroads have been made into early intervention and there is now at least one mental health support team in every Borough. However, although we are attempting to shift our funding 'downstream', this becomes increasingly difficult when confronted with rising levels of demand and acuity, so there needs to be a recognition that there is a balance to be struck. • Camden has had a slight head-start over other Boroughs through integrated provision and there are clear benefits from that model of care. Going forward, the challenge will be to replicate that model across health and social care in NCL and this will need to be worked through. • It would be helpful to build up a map of positive performance so that the learning can be extended. It would also be worth mapping the other universal support that is available – for instance, the Mayor of London is having a big push on investing in mentoring and it might be worth reflecting on this in a mental health context.
4.3	The Chair observed that Children's mental health is emerging as an important theme for the ICP to have oversight of, while recognising that the work will be done at Borough Partnership level. He welcomed Richard Taylor-Elphick's offer for the DCSs and Sarah Mansuralli's team to reflect on today's feedback, map what is happening now which is applicable more broadly and consider how we can build on the existing rich experience within the Boroughs in order to draw out from this some work that the ICP can sponsor. This would then be brought back to the next meeting and incorporated into any further reflections on our priorities as a partnership.
4.4	Sarah Mansuralli then gave an overview of the work taking place on the adult pathway, including the work with providers on inpatient services. She highlighted the following points:

	• There has been a strong focus on reducing the number of out of area placements as it is recognised that the breakdown in social and community connectiveness tends to delay recovery by lengthening the period of inpatient admission which can also lead to people 'de-conditioning' in a similar way to the negative impact of extended physical inactivity. • As a result of the above, there has also been a wider focus on admission avoidance as well as addressing hospital processes which impact on discharge and improving discharge planning. • The length of stay for 60% of admissions is below 30 days. However, the remaining 40% of admissions take up 80% of the available bed capacity and some of these acute admissions can last over a year, when they should actually be in an environment which can support their rehabilitation. If people remain inpatients for too long it can damage their ability to re-connect and lead more fulfilling lives, which in turn has multiple implications for the system. • The impact of Right Care Right Person will also have some negative consequences as there will be a tendency to be more risk-averse in terms of people going on leave from inpatient units. • The system needs to think through collaboratively whether there are things it could be doing differently, such as trying to support people coming into different kinds of discharge placements as well as looking at demand and capacity for supported living accommodation.
4.5	ICP members then discussed the paper, making the following comments: • It was noted that although people's experience of supported living is generally positive, the lack of regulation around this area has occasionally resulted in issues with providers due to the anticipated level of support not being present. • It was highlighted that new legislation around supported housing is in the offing and colleagues were encouraged to make submissions if they have any concerns. • A number of Councils had written to the Metropolitan Police regarding the way that the announcement that they will no longer routinely attend emergency calls related to mental health incidents had been made and the need for local authorities and the Police to work together, bearing in mind that the pilot which this decision was based on had received years of investment. • It was noted that Frances O'Callaghan had hosted a meeting with the three Borough Commanders and the Mental Health Trust Chief Executives the previous week, so assurance was given that work is taking place around the implications of Right Care Right Person at NCL and London level, supplemented by actions being taken at Basic Command Unit (BCU) level. It had been a positive meeting, with strong willingness by the Police to work with all parties to get this right. • A plea was made to avoid reinventing the wheel with respect to long term admissions as there has already been considerable research into this. The ICP needs to galvanise around early interventions and what keeps people thriving, building on evidence-based discussions around what works, • It was questioned whether NCL has the right partnerships in place with its community organisations with regards to prevention and early intervention, and furthermore, whether the investment in the Inequalities Fund matches our aspirations. • Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health Trust are working on a community rehabilitation review which includes looking at the support for people moving into supported housing and helping people move through the system. Mapping has taken place, including the clinical support in each Borough. NCL actually has more supported housing in NCL than it uses so it is a net importer of people from other ICPs. • A transfer protocol has been developed for people with learning disabilities that are moving to placements in other NCL boroughs and and a similar one is being developed for mental health to ensure placements can meet people's needs and that care is handed over effectively to local health teams. • Generally within NCL there is more supported housing than we directly commission (we are a net importer) and delayed transfers are largely caused by process issues so the community rehabilitation review should help to manage this. It is possible that

	there may be gaps around the more complex cohorts though this has not been identified through data analysis, despite attempts. The North London Forensic Service have expressed interest in developing new commissioning models for people with complex needs who have been in hospital for very long periods with funding following the resident. • Assurance was given that community models have been an active area of development in NCL (although not included in the slides). It was suggested that the type of need for supported accommodation is changing in light of the complexity and acuity that is being presented. The granularity of the data obtained through this focused piece of work will potentially allow us to look at the needs that are unable to be met through the current models and may result in the need to look at what is the intensive supported living offer for NCL and how we might do some market shaping to get that and then ultimately co-commission it. • A piece of demand and capacity work based on population needs is probably required for the long-term stays in hospital. • It was highlighted that the dataset produced for the Right Care Right Person discussions identified that a large number of black men are more likely to end up being detained in Section 136 suites or Emergency Departments. It was agreed that it would be helpful to circulate this datapack more widely with ICP members.
4.6	The Chair thanked members for their contributions which had highlighted a range of complicated issues and the large amount of work which is taking place. There has been a strong commitment in the meeting to keep partners informed on the changes around the Metropolitan Police. It would be helpful for Sarah Mansuralli to brief Jinjer Kandola on the discussion that has taken place in her absence. He also requested a piece of work on how we apply the learning from all of these issues to help to unpick the work at NCL and Borough level. The Chair, Richard Taylor-Elphick and Dan Sheaff would meet outside to discuss the next steps regarding this piece of work.
4.7	The ICP **NOTED** the Mental Health update.
4.8	Action: Richard Taylor- Elphick and Sarah Mansuralli to hold a discussion between DCSs and Sarah Mansuralli's team to map existing good practice on work that can be scaled up and applied across the system.
4.9	Action: Mike Cooke, Richard Taylor-Elphick and Dan Sheaff to discuss the next steps regarding applying the learning from work across mental health and inequalities in NCL.
4.10	Action; Sarah Mansuralli to circulate to ICP members the datapack produced for the recent Right Care Right Place meeting.
4.11	Action: Sarah Mansuralli to brief Jinjer Kandola on the Mental Health discussion at today's meeting.
5.	**Discussion on delivery of the NCL Population Health and Integrated Care Strategy**
5.1	John Hooton introduced the discussion. He noted that there is wide agreement across the Partnership on the quality of the Population Health and Integrated Care Strategy and the key next step is to turn the content into deliverable action plans to tackle health inequalities which are then progressed. To achieve this, it was proposed that Borough Partnerships be asked to lead on local action planning, led by the Borough Partnership Chairs and in partnership with Council leaders and Health and Wellbeing Boards. Plans would then be brought together at NCL level. This approach will ensure that the action plans contain what is important for NCL as a whole as well as at Borough level, which will probably vary to a degree.
5.2	ICP members then made the following comments in response: • There was broad enthusiasm for the proposal. • It was suggested that there would be value in bringing partners together for conversations on thematic issues to shape the development of action plans.

	• It was noted that the strength of the Population Health and Integrated Care Strategy is the broad level of engagement that went into its development. Because this is a shared document, the delivery plan requires us to work collectively, so we need to get into who is doing what at each level to make each of these pieces of work happen, given their interdependency. As part of that early planning, we need to get everybody on the same page about how we are going to plan and draw out clearly the expectation from an ICP perspective that partners can, will and are coming together at a local level to work in that way. There are also things happening at Borough level regarding population health, integration and inequalities which are not in the purview of the Borough Partnerships, so we will need to think about how we get a holistic view of everything which is happening that is feeding into the delivery of the strategy. • It was agreed that Mike Cooke, Cllr Kaya Comer-Schwartz, John Hooton, Frances O'Callaghan, Richard Taylor-Elphick and Dan Sheaff would meet to discuss the proposal outside of the meeting to shape how best to take the work forward in a ground-up way, led by the Borough Partnerships and complemented by work at system level where this adds value. • It was noted that strategies can feel fairly removed from the people on the ground that they impact, so it is important to maintain clear communication with the people on the front line who deliver them, as well as patients. • It was suggested it might be helpful to bring diverse groups of citizens together across the Boroughs to provide feedback as the work unfolds.
5.3	Action: Mike Cooke and Cllr Kaya Comer-Schwartz to reflect on the conversation regarding areas of focus for the ICP (for example, mental health and school-readiness) and to meet with Borough Partnership Chairs to shape local delivery planning for the Population Health and Integrated Care Strategy.
6.	**Any Other Business**
6.1	Frances O'Callaghan highlighted that the East Finchley ward in Barnet is one of the locations for the two year Universal Basic Income pilot and observed that it would be helpful to have a discussion about the direct outcomes from the project at a future meeting.
6.2	John Hooton and Cllr Moore confirmed that this is not a Council project as such but the local authority is supporting it and offered to share any feedback in due course.
7.	**Date of Next Meeting**
7.1	3 October 2023.

North Central London Integrated Care System

North Central London Population Health and Integrated Care Strategy

System-wide work

October 2023

Introduction

North Central London Integrated Care System

- Work is ongoing to set out the draft system-leaning delivery plans that are contributing towards the delivery of the NCL Population Health & Integrated Care Strategy. It will describe how our system transformation programmes align with and contribute towards delivery of the key priorities that are identified in the strategy, drawing out how these programmes are driving a population health approach.

- Work is also ongoing to develop delivery plans for the NCL Population Health Risks, recognising that multiple programmes of work will contribute to their delivery.

- These plans will help us to track and align our monitoring processes, to ensure successful delivery of the Population Health & Integrated Care Strategy.

- This pack provides draft examples of a system transformation programmes (LTC LCS) and a population health risk (Cancer) to demonstrate how the templates work in practice.

- As the content for these system transformation programmes and population health risks is collated, we will continue to iterate with owners.

- The delivery plans outline:
  - **Ownership:** The exec sponsor, SRO and the forum/group that oversees the programme
  - **Time horizon:** First 18 months, aligned to horizon 1
  - **Alignment to delivery areas:** Key communities and population health risks
  - **Core deliverables:** Including sub-deliverables and respective timelines and owners
  - **Health inequalities:** How the programme is addressing health inequalities
  - **Programme outcomes:** Key outcomes (or outputs) that the programme will be aiming to impact over the first 18 months
  - **NCL Outcomes Framework:** The NCL outcomes/sub-outcomes that the programme will aim to contribute towards
  - **Baseline performance:** The baseline of the key NCL Outcomes Framework outcome that the programme is aiming to contribute impact towards *(baseline data to follow)*
  - **Borough Partnership dependencies:** It will also need to be considered where corresponding borough partnership action plans are required to align and support local change as part of the system transformation programmes and population health risks.

LTC LCS

Exec sponsor – Sarah McDonnell-Davies
SRO – Amy Bowen & Sarah McIlwaine
Primary forum – LTC LCS delivery group

Time Horizon (months)	**Short:** <18

DRAFT IN DEVELOPMENT

Delivery areas alignment

Key communities

- All adult key communities
- Children with Asthma
- Core20
- BAME not captured in Core20

Population Health Risks

Heart Health | Lung Health

Across primary care in NCL, a single **Locally Commissioned Service (LCS) for Long Term Conditions (LTCs) is rolling out focussed on proactive care, personalised care and support planning, taking a multimorbidity approach and embedding population health management into delivery, monitoring and outcomes.**

Health Inequalities

How are health inequalities being addressed?

- The LTC LCS has a total cohort of over 318,000 with metabolic (e.g., Diabetes, Cardiovascular Disease, etc.) or respiratory (e.g. asthma or COPD) disease . Using our Population Health Management platform, we have created tools that allow practices, PCNs and boroughs to look at all aspects of delivery and outcomes applying demographic filters, including Core20PLUS groups to understand equity of access experience and outcomes. This will allow teams to understand where they may need to target efforts to address disparities highlighted by the data.
- Practices can generate case-finding lists based on clinical features but also demographic factors
- A weighted payment provides additional funding where there are more individuals with agreed demographic factors which reflect the differential effort needed to achieve outcomes with different communities. The payment, made to PCNs is to fund engagement activities, working closely with local VCSE partners to make sure we reach communities in ways that work for them
- Outcomes-based payments are set based on local starting points, so improvement goals are tailored to local need, with an aim to close disparities in outcomes and reduce variation

Programme outcomes

What are the key outcomes the programme will be measuring to identify impact over the first 18 months?

(to be updated)
5 outcomes from the LTC LCS outcomes framework (n=32) will be selected for incentivisation in 24-25 – 2 across NCL and 3 selected by each borough. These will be selected by end Q2 23-24

NCL Outcomes

What outcomes and sub-outcomes will this programme aim to contribute impact to?

Reduced deaths from cancer, cardiovascular disease and respiratory disease

- Reduced prevalence of key risk factors: Smoking, alcohol, obesity.
- Early identification and improved treatment of cancer, diabetes, high blood pressure, CVD and respiratory disease

All children and young people are supported to have good physical and mental health

- Improved outcomes for children with LTCs

People live as health and independent lives as possible as they age

- Early prevention, detection and management of LTCs, including dementia, in old people

Borough Partnership dependencies

What is the ask of BPs to make this programme a success?

- Partners within the BP will need to have an introduction to the LTC LCS model of care and implementation plan so that they understand how all the elements support population health improvement.
- BPs will then need to consider how they can support primary care to embed the model of care and deriving wider local system benefit from some of the deliverables within the programme, e.g. how to use the risk stratification to drive other integrated work programmes.
- BPs can support the Weighted Payment element of the LTC LCS and support PCN engagement work with key communities experiencing health inequalities, particularly focussing on how the VCSE can be a key partner in engagement
- BPs can also consider opportunities for how LA and other services could align their offer to the new model of care.

Baseline key NCL OF outcome

What is the baseline of the key NCL OF outcome you are aiming to contribute impact towards?

Early identification and improvement treatment of cancer, diabetes, high blood pressure, CVD and respiratory disease

Barnet	
Camden	
Enfield	
Haringey	
Islington	
NCL-wide	

Baselining to be added

LTC LCS

Exec sponsor – Sarah McDonnell-Davies
SRO – Amy Bowen & Sarah McIlwaine
Primary forum – LTC LCS delivery group

Time Horizon (months)	Short: <18

DRAFT IN DEVELOPMENT

Delivery areas alignment

Key communities

- All adult key communities
- Children with Asthma
- Core20
- BAME not captured in Core20

Population Health Risks

Heart Health | Lung Health

Core deliverables	Sub-deliverables	Timelines	Owner
What are the core deliverables that this programme will oversee?	**What are the parts that make up each core deliverable?**	**What are the anticipated key milestones for each deliverable?**	**Where does responsibility sit for delivery?**
Year of care model of care	**Delivered over year** -matching workforce, and frequency of contact, to level of risk. Patients will be invited based on their level of complexity. **Holistic** -includes personalised care and support planning, lifestyle interventions and care coordination alongside medical care. Will cover all the patient's LTCs, ensuring a 'whole person approach'. **Demand/capacity modelling** at practice or PCN level to support planning & optimise resources. **Not GP-centric** -wider primary care workforce contribute supporting deliverability and effective use of resources. **Complements –but does not duplicate** -NHS Health Checks, QOF etc. **Benefits primary, community and secondary care** and supports greater integration., stratification and care coordination	Launch is Q3 23-24 with remainder of the year focussed on: • embedding the model of care • PCN engagement work using the weighted payment • Case-finding (see below) • Improved recording of interpreter needed so this can be added to the weighted payment in 24-25	• GP practices and PCNs are responsible for delivery • ICB support from primary care and system improvement teams • NCL Training Hub supporting practice preparedness, including training on the model of care and PHM tools
Population Health payment model – Outcomes Framework	Payment model for the LCS is based on three elements: block, weighted and outcomes. Outcomes payment launching in 24-25	Outcomes will be incentivised from 24-25 – from the suite of 32 outcomes, 2 will be selected as system-wide and each borough will select an additional 3	• ICB supported by public health are developing the framework, tools and methodology for outcomes and goal setting
Risk stratification	Identifies patient cohorts, using nationally adopted UCLP proactive care framework, tailored for the LTC LCS with local clinical and population health input, with tools built into our population health management platform	Risk stratification is complete and all practices will be titrating model of care to individual risk level	• ICB primary care, UCLP and public health collaboration
Population Health Management tools	**Case-finding tool** – *This will generate instant patient lists reconciled across multiple LTCs, demographic and inequalities indicators which help practices stratify who to see first* **Multi-morbidity registry** – *Clinicians in MDT can use this when reviewing high-risk patients to identify at a glance which parameters are out of range for a patient across multiple LTCs.* **Outcomes dashboard** – *This will enable practices to see progress against outcomes and indicators against different demographic, geographic and clinical cohorts. The tool will also support practices to plan their workload to achieve their local outcome goals*	**Case-finding tool** – testing in August, training in September and launch in October 23 **Multi-morbidity registry** – testing in January 24, training in Feb and launch in March **Outcomes dashboard** - testing in January 24, training in Feb and launch in March	• ICB system improvement oversees development of PHM tools • Training Hub responsible for coordinating training practices on utilisation • Practices to use PHM tools as part of delivery
Case finding	Case-finding is an early priority of the programme to close the prevalence gap and bring more people with LTCs into the LCS cohort. Case-finding is prioritised and practices can use their wider workforce to reach the greatest number of people.	Focus in 23-24 will be on • CKD case-finding to support preparation for renal delegation, including a specific project on CKD and health inequalities in Enfield and Haringey • Higher priority patients identified through the case-finding tools (inc multimorbidity risk)	• ICB led clinical group responsible for defining case-finding criteria • ICB GPIT and analytics team responsible for building EMIS searches and embedding in the PHM tools

DRAFT IN DEVELOPMENT

Time Horizon (months) | **Short:** <18

North Central London Integrated Care System

Cancer

Exec sponsor – Ali Malik
SRO – Prof Geoff Bellingan
Primary forum – NCL Cancer prevention, awareness & screening delivery group, NCL Cancer Alliance Programme Board, NCL Cancer Alliance Board

Contribute towards achieving the diagnosis of 75% of cancers at stage 1 and 2.

Health Inequalities

How are health inequalities being addressed?

- Each of the deliverables have a key focus on targeting populations that have poorer cancer outcomes e.g. people with a learning disability, people with SMI, people that live in more deprived areas, to reduce the early diagnosis gap between population groups and across geographical areas.

Programme outcomes

What are the key indicators (outputs or outcomes) the programmes will be measuring to identify impact over the first 18 months?

Outputs from the primary care strategy delivery programme (e.g. recruitment of project manager, development of education prospectus etc).

Outputs from the prevention, awareness and screening strategy (e.g. inclusion of all screening programmes in annual health checks for PWLD)

Key indicators

- Screening uptake/coverage across the three programmes
- Uptake of lung health checks
- Uptake of NHS Galleri blood cancer test
- Number of people attending routine liver surveillance

NCL Outcomes

Which outcomes and sub-outcomes will this programme aim to contribute impact towards?

Reduced deaths from cancer, cardiovascular disease and respiratory disease

- Early identification and improved treatment of cancer, diabetes, high blood pressure, CVD and respiratory disease

Borough Partnership dependencies

What is the ask of BPs to contribute to delivery?

- Prevention, awareness and screening – to support the delivery of projects that are place leaning (e.g. amplification of cancer campaigns locally, utilisation of champions to promote breast screening participation).
- NHS Galleri cancer test – support the delivery to communications activities to build awareness of the pilot particularly in areas of high deprivation, which is a key focus.
- Primary care cancer strategy – formalise and strengthen links with people starting in newly appointed project roles as well as five borough GP leads; support and where needed and facilitate engagement with primary care (e.g. practices and PCNs) on cancer agenda; identify areas of collaboration within current work programmes.

Baseline key NCL OF outcome

What is the baseline of the key NCL OF outcome you are aiming to contribute impact towards?

	Outcome
Barnet	
Camden	
Enfield	
Haringey	
Islington	
NCL-wide	

Outcome and baselining to be added

DRAFT IN DEVELOPMENT

Time Horizon (months) | **Short:** <18

Cancer

Core deliverable	Sub-deliverables	Timelines	Owner
What is the core deliverable that will contribute to cancer delivery?	**What are the parts that make up the core deliverable?**	**When are the anticipated key milestones for this deliverable?**	**Where does responsibility sit for delivery?**

Cancer primary care strategy delivery programme	• Place-based engagement
	  • Build a 'place based engagement function' to enhance engagement regarding health inequalities and variation
	  • Launch the HealtheIntent Cancer Care Registry
	• Data & analytics
	  • Enable a data driven Population Health approach through primary care and population based analytics tools.
	  • Standardisation and improvements to coding of cancer information in primary care
	• Creating a community of practice & enhancing a culture of learning & development
	  • Enhance cancer education for all staff working in primary care;
	  • Improve the sharing of clinical expertise between primary and secondary care
	• Contribute to the operational performance of the overall cancer pathway
	  • Support the delivery of the 2023-24 Cancer DES and QOF requirements
		Fully in place by end of Q3 2023
		
		Initial tools in place from Q3 2023/24
		Coding project currently being scoped out
		
		Learning and development plan finalised in Q3 2023-24. Implementation to follow.
		
		Underway.
			NCL Cancer Alliance
			
			NCL Cancer Alliance with support from ICB analytics and population health teams
			
			NCL Cancer Alliance
			
			TBC- currently with ICB but may change as a result

FIT (Faecal Immunochemical Test)	• FIT compliance
	  • The national target is 80% and so we're implementing some interventions such as educational webinars and using our GP Fellow to speak to those practices with particularly low compliance.
	• Fit <10 pathway
	  • NCL is evaluating a routine pathway in secondary care to see whether carrying out a repeat FIT test and FBC on those patients whose initial FIT test was <10 can reassure the GP and patient that their chance of having CRC is so low that a 2ww referral should be avoided.
		FIT compliance
		Educational webinars – September 2023
		Reaching 80% compliance – end of Q4 23/24
		FIT<10 pathway
		Evaluation complete – Q1 24/25
			NCL Cancer Alliance

Work at place-based and system level to drive cancer prevention, improve population awareness of the signs and symptoms of cancer, encourage early presentation and increase participation in the three national screening programmes, as well as the Targeted Lung Health Checks programme.	• Develop and embed a standardised Making Every Contact Count (MECC) approach across the system that includes cancer. • Develop and deliver activities that drive timely presentation to the health system when people have worrying symptoms. • Increase participation in the bowel, breast and cervical screening programmes towards the national targets and closer to the national average. • Fully roll out the Targeted Lung Health Checks programme and increase participation to achieve the national target.	**Timely presentation and screening** National campaigns – Sept '23 to Mar '24 **Targeted lung health check** Roll out to third site – Q4 23/24 Campaign to improve uptake – Q3 and Q4 23/24	NCL Cancer Alliance, NCL ICB, Local authorities, screening services NCL Cancer Alliance
Support roll out of the NHS Galleri cancer blood test across NCL as part of the national Interim Implementation Pilot	• Work with ICS partners and NHSE to establish the project using a national specification. • Develop a communications and engagement plan to ensure good uptake of the blood test in the areas of most need (i.e. areas of highest deprivation or cancer incidence).	Launch project – Q2 24/25	NCL Cancer Alliance
Support liver services to identify more people at high risk of liver cancer and provide routine surveillance to patients	• Establish whether local providers are consistently inviting patients with cirrhosis/advanced fibrosis for ultrasound surveillance. • Support providers to establish systems and processes to invite those eligible for liver surveillance where it does not exist.	Baseline data on liver surveillance available – Q3 23/24 Systems and processes to invite eligible patients to liver surveillance established – Q4 23/24	NCL Cancer Alliance NCL liver surveillance providers

SEND and AP Change Programme.

Whole NCL ICB Approach to Children and Young People with Special Education Needs and Disability

Summary of Key Information

- The Children and Families Act (CFA) 2014 intended to improve earlier identification of need for children and young people with SEND; for their families to be more involved in decisions affecting them and for better join up between education, health and social care.
- Since then, there has been much criticism about the system from families, Councils and wider professionals., including the National Audit Office report 2019 and the Inquiry by the House of Commons Select Committee.
- In response to the widespread concerns and findings, the DfE published a Green Paper in March 2022 'SEND Review: Right Support, Right Place, Right Time'. A year later in March 2023 the DfE published its SEND and Alternative Provision (AP) Improvement Plan. This included a set of key proposals which will be piloted on a national basis across the 9 DfE regions .
- In each region there will be a Change Programme Partnership (CPP) made up of 3 or 4 LAs led by a lead Local Authority who will be required to test and trial the proposals set out in the implementation plan over a 2 year period.
- High performing Local Authorities in each area were asked to submit an Expression of Interest (EOI). Following this process Barnet was selected to be the Lead Local Authority for the London region. Enfield, Camden and Islington are the other LAs in the CPP together with the NCL ICB.

Summary of Key Information

- There is alignment with the **The North Central London Population Health & Integrated Care Strategy** through delivery of the *Start Well* objective; *Every child has the best start in life and no child is left behind*, Specifically:

Delivery area 3 – Key communities – Children and Young People

Children with Special Educational Needs and Disabilities (SEND). Pupils with SEND face barriers that make it harder for them to learn than most pupils of the same age. They often experience poorer outcomes than their peers in educational achievement, physical and mental health status, social opportunities, and transition to adulthood.

- Through working together to test out the Key Proposals we will be able to redesign the system around the needs of children and young people. Together we can address the barriers that children and young people with SEND experience on a daily basis; giving them the best start in life and improve their outcomes and lived experience through to adulthood.

DfE £70m SEND and AP 'Change Programme'

1. **In order to test out the proposals for reforms the DfE identified the top high performing LAs in each region and asked them to submit an Expression of Interest (EOI) to be the lead partner for a Regional Expert Partnership (REP) area.**

2. **The successful lead LA will work in partnership with the other DfE chosen Authorities in its region and will receive funding of £5.8m over 2 years to use across its REP to support the testing and evaluation of the proposals.**

Role of Lead LA: Expertise to Deliver Change

We want LAs who can use their experience of delivering effectively within the current SEND system to lead the testing and refining of the SEND and AP reforms across each REP. Working closely with the Department, lead LAs will have a key role in shaping the direction of the Change Programme.

Provide leadership across the REP	Drive change and share practice and learning	Delivery and monitoring progress
• Set up and lead local REP Steering Group/ Board and develop the partnership • Ensure consistent testing across the REP to help us test for a national system • Facilitate the provision of experts from across the REP for expert groups and co-production e.g. National Standards	• Facilitate REP participation in a feedback loop with DfE - providing continuous insights on learning from testing • Take a lead role in helping influence and refine the SEND and AP reforms • Use expertise and strong practice to support other LAs in the REP and, in the Taskforce phase, other LAs in the Region.	• Development of the REP Strategic Delivery Plan • Monitoring and maintaining progress against the Strategic Delivery Plan. • Identifying and resolving or escalating barriers or challenges to delivery • Managing and monitoring the use of funding

Key proposals

National standards to increase consistency at a national level.

- These are wide ranging and include what provision should be in place for different need types, identification of need, casework, communication, complaints, what is ordinarily available for children and young people with SEND but who do not have Education, Health and Care Plans (EHCPs), Alternative Provision, transitions, co-production, as well as standards such as decision making, annual reviews and mediation which the DfE proposes to make mandatory.

Establish SEND and Alternative Provision (AP) Partnerships.

- To ensure the right people at the right level undertake a needs assessment of the local area and produce a Local Area Inclusion Plan which clearly sets out what is available and will be commissioned.

Introduction of a standardised EHCP and Digitise the process.

- A standardised template will make it easier for parents who move Boroughs, or where their child attends school in a different borough and for education providers. Concern remains about the digital divide for the digitisation of the Education Health and Care Needs assessment (EHCNA) processes, especially given the links between deprivation, Free School Meals and SEND.

Key proposals

A three-tiered approach to AP

- Direct support in mainstream, short term intensive off-site placements in a Pupil Referral Unit (PRU), longer term placement in PRU with the focus on reintegration into mainstream or Further Education (FE).

Introduction of Inclusion dashboards so parents and professionals can see how the SEND system is performing at local and national level.

- These will be publicly available. It is not clear what will be reported on the dashboards but, are likely to include data already being reported such as adherence to timescales for the issue of new EHCPs and annual reviews, and exclusion and attendance data for example.

Introduce a new national framework of banding and tariffs for funding matched to levels of need and types of education provision set out in the national standards.

- Nationally, there is widespread disparity in the cost of provision and the amount of funded support available to schools at both mainstream, Additionally Resourced Provisions (ARPs) and Special. This aims to have set tariffs or bands for differing types of provision and the Special educational needs a child or young person may have.

Key proposals

Provide tailored lists to parents of suitable placements.

- The LA will draw up lists of appropriate schools for parents/carers. There is concern from parents this will reduce statutory rights.

Improve staff training.

- Through the introduction of a new leadership level SENCo (Special Educational Needs Co-ordinator) NPQ (National Professional Qualification) for schools; fund up to 5,000 early years staff to gain an accredited Level 3 early years SENCo qualification; increase the capacity of specialists, including educational psychologists.

Trial the ELSEC Pathfinder in one LA in each CPP (Barnet has been selected for this).

- The Pathfinder aims to improve early identification and support of children and young people with SLCN)in early years settings and primary schools, to reduce exacerbation of need. Speech and Language Therapy Assistants, will improve capacity and knowledge of workforce that support children with emerging/mild to moderate SLCN in early years and school settings. And be co-funded and co-led by DfE and NHSE. The pathfinders will be funded by Integrated Care Boards (ICBs) and LAs who will pool money for pathfinders.

SEND and AP Change programme funding for the London CPP

Table 2: Funding per CPP from the DfE

Activity	Year 1	Year 2 Total	Total
CPP Testing of reforms and Taskforce activities.	£1,986,666.67	£3,909,833.33	£5,896,500.00
For ELSEC Pathfinder LA* (one LA only).	£251,653.11	£251,653.11	£503,306.22
Total	**£2,238,319.78**	**£4,161,486.44**	**£6,399,806.22**

Please note that NHSE and the ICB will also contribute funding to the ELSEC programme.

Broader context in NCL

- There is significant and increasing demand in relevant services for LA and the NHS in NCL, including:
  - Variation in therapy offer by borough (LA and NHS)
  - Increasing need for therapies and MH services resulting in long waits in some areas
  - Increasing number of children diagnosed with neurodiversity
  - Average weeks wait from referral to autism diagnosis for CYP <5 is highest in Barnet at 92 weeks. For >5s the highest weeks waiting is in Islington 109 weeks
  - Given system pressures and long waits it is difficult to have confidence that we're delivering the best outcomes for young people and families (or VFM) from our current health and social care investment
  - More information on specific challenges in appendix i

Recommendations and questions for the ICP

- Confirm support from key partners for the establishment of a senior sub-regional programme to oversee this work
- Comment on the proposal that the programme looks at opportunities to transform current spend to deliver better outcomes as well as overseeing new investment
- Views on the biggest partnership opportunities within the key proposals on slides 5-7
- How can we support the development of this programme to respond to the Population Health and Integrated Care Strategy, such as
  - Increased investment in prevention and early intervention
  - Focus on communities with poorer health and wellbeing outcomes?

Appendix i: NCL Context

1. Health, Education and Social Care Context

Therapies

Background 1/2

- The 2014 SEND (special educational needs and disabilities) reforms brought about changes across education, health and care and the implementation of education, health, and care plans (EHCPs).
- Over the last 5 years demand for therapy service has increased and this has put significant pressure on services across NCL:
- In some areas, meeting statutory responsibility for an increasing number of complex children has led to children experiencing very long waiting times for initial assessment and therapy intervention
- Some children with additional needs but without an EHCP are only seen within a universal service and/or wait a long time for assessment and intervention
- The Pandemic and post-Pandemic period has seen increased demand
- There are increasing numbers of children diagnosed with neurodiversity (e.g. autism and ADHD) and children with complex needs

Background 2/2

- Barnet has a high number of Tribunal and half include appeals with regard therapy provision.
- The increased number of children identified with SEND at SEN Support or EHCPs has increased at a much higher rate than the increase in the school population.
- This has meant increases in specialist provision such as Special Schools and Additionally Resourced Provision (ARPs) as well as increasing the number of children with SEN in mainstream schools.
- There are significant differences in the capacity, demand, identified need, service offer and existing investment from both health and LA's for CYP Therapy services between the boroughs within NCL. Barnet is a particular outlier in terms of the amount of capacity in post to deliver Therapy services.
- Therapy services are joint funded by the ICB and each local authority and there is variation in the relative contributions made by the ICB and LA's in each borough, as well as funding per head.

Existing NCL therapies offer 1/2

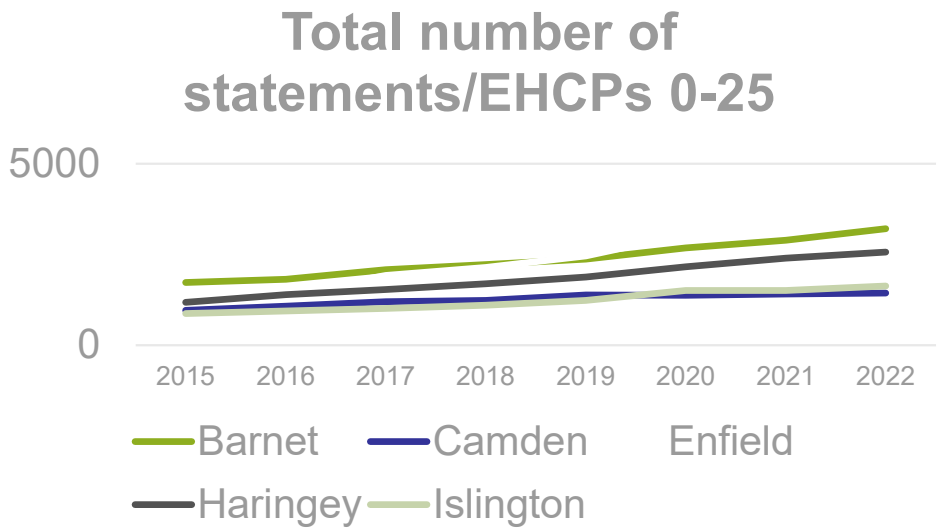
- There is an NCL core offer for therapies as part of the Community Services Review - and there is significant variation
- The offer includes speech and language therapy (SLT), occupational therapy (OT) and physiotherapy (PT).
- The offer is across early years, mainstream schools, special schools and specialist provision e.g. Pupil Referral Units, resource bases.
- All areas include a mixture of:
    - Universal Offer (borough level training; website resources; signposting, environment support)
    - Targeted support (group therapy, building capacity – e.g. training school staff, drop in sessions)
    - Individualised support (1-1; group therapy; referral triage; assessments and reports; individual group therapy).
    - Provision of services specified in EHCPs

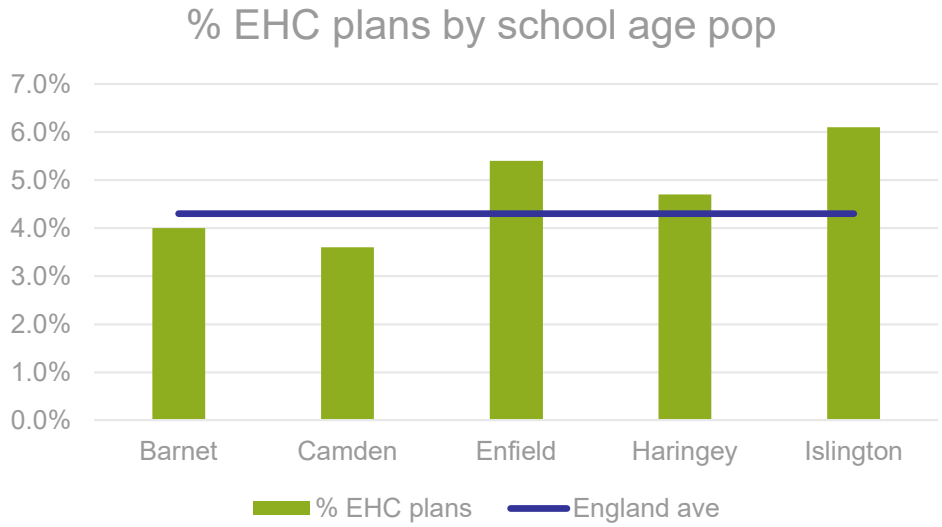
Existing NCL therapies offer 2/2

- There is variation in the models of delivery between these services, which makes it harder to compare provision. Examples of variation include:
  - In Haringey local partners agreed previously to focus on EHCP provision and a Universal Offer has not been provided
  - In Camden the waiting time target for initial assessment is 6 weeks, other areas work to a 13 or 18 week target
  - In Barnet there has been a termly approach to EHCP provision
  - In Islington there is a strong universal offer
  - In Enfield SLT education universal offer was disinvested in 2016 due to LA financial challenges and reinstated in 2020. Statutory interventions are a half termly or termly offer
- To deliver the NCL core offer for Therapies will require a sustained transformation programme over a number of years, and significant joint work between partners including NHS providers, the ICB and Local Authorities (given the interdependencies involved).

The no. of EHC plans has steadily increase since 2015

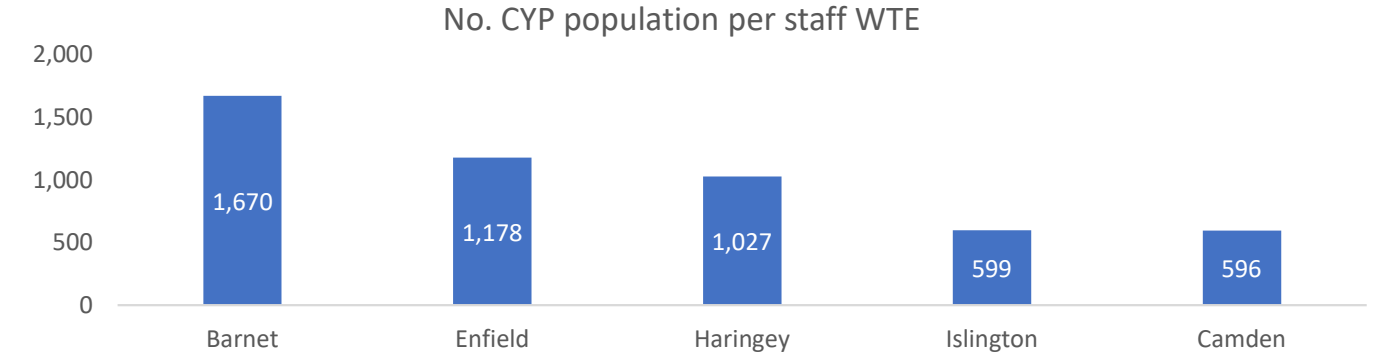
- There have been **yearly increases** in the number of children eligible for an **EHCP** across NCL, with the most significant increases seen in Enfield, Barnet and Haringey.
- There has been increase in need across the different populations of children requiring an EHCP, but the most **significant increases** are being seen in children with a diagnosis of **Autistic Spectrum Condition (ASC)** that go on to need an EHCP.
- Many of these children are now **transferring into mainstream schools** that would have previously been in special schools.

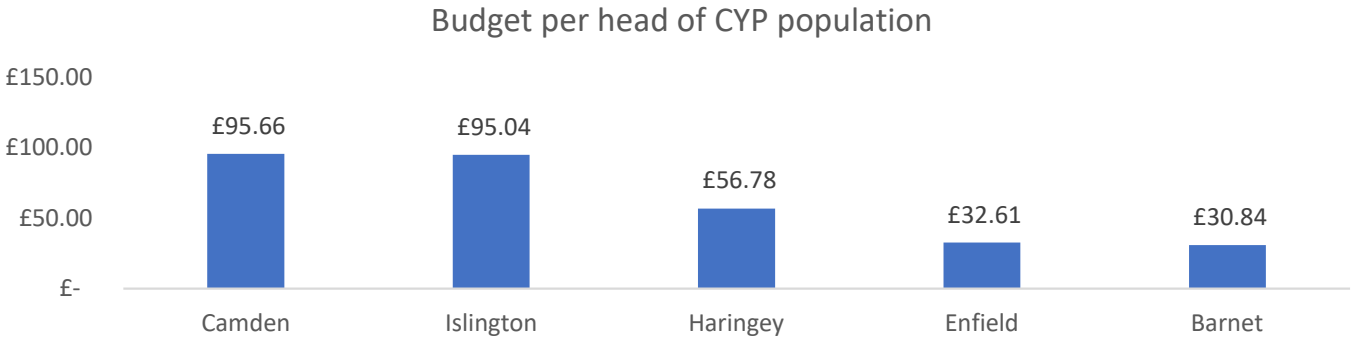




Draft for discussion

Barnet, Enfield and Haringey have fewer staff and funding to meet demand than Islington and Camden



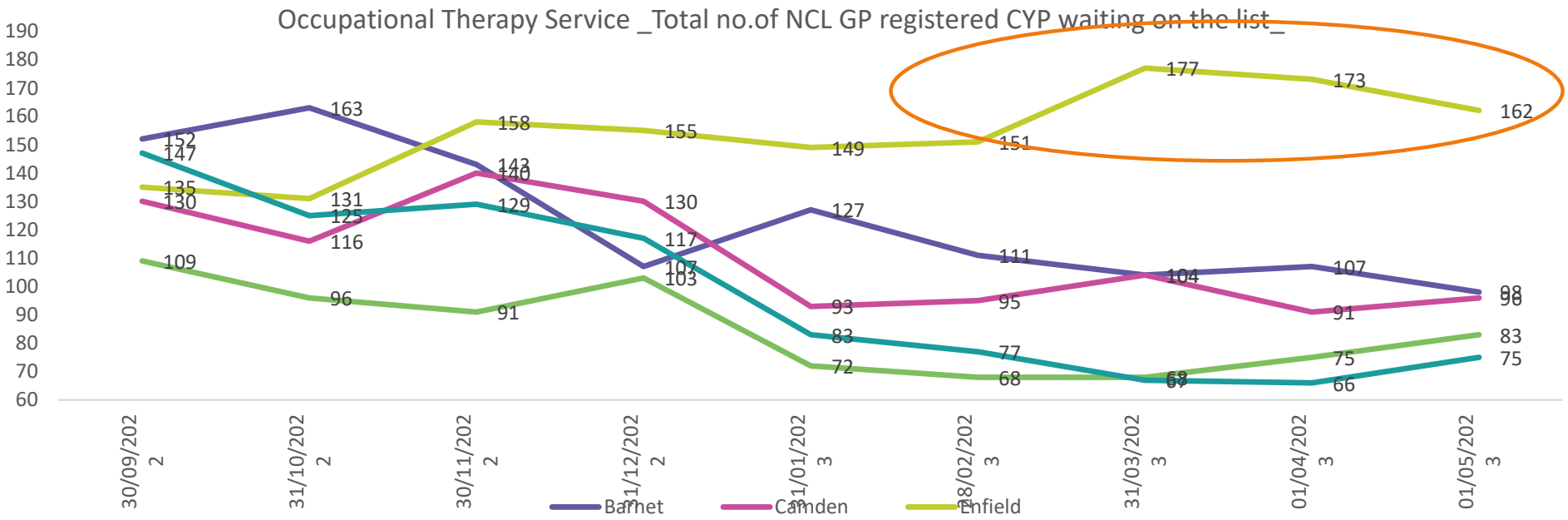


- Barnet has the least staff in NCL and the largest CYP population.
- Barnet and Enfield have the lowest pay budget in NCL despite having the highest CYP populations.
- Barnet and Enfield pay budgets are on average £2.8m, compared to £3.8m in Camden and £3.9m in Islington

Draft for discussion

Enfield's number of children waiting for an initial assessment in OT has increased since Sept 22

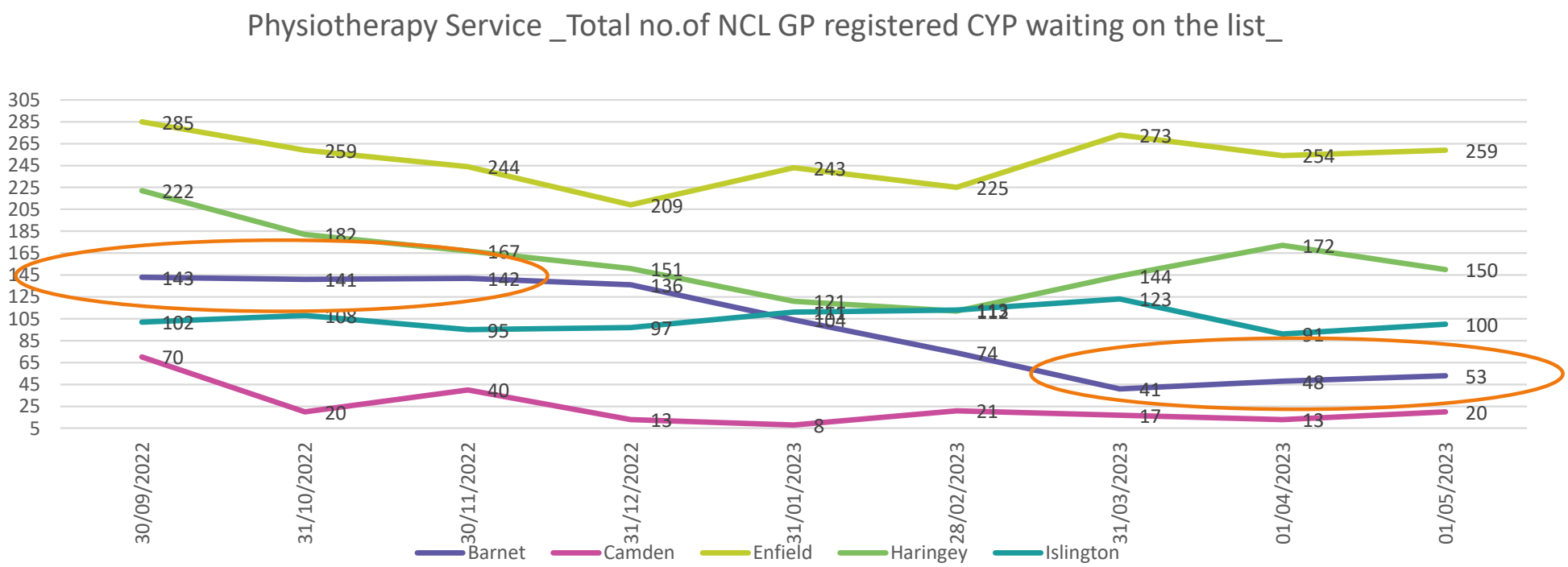
- Overall, the number of CYP waiting for initial therapy assessments across NCL has been trending down
- Numbers waiting for initial assessments in OT have significantly reduced in all but Enfield, whose numbers waiting in Sep were 135 CYP and in May there were 162 waiting.
- In Enfield this is due to workforce challenges (capacity as opposed to demand).



Draft for discussion

The number of CYP waiting for initial assessment in physio have reduced in Barnet, Camden and Haringey

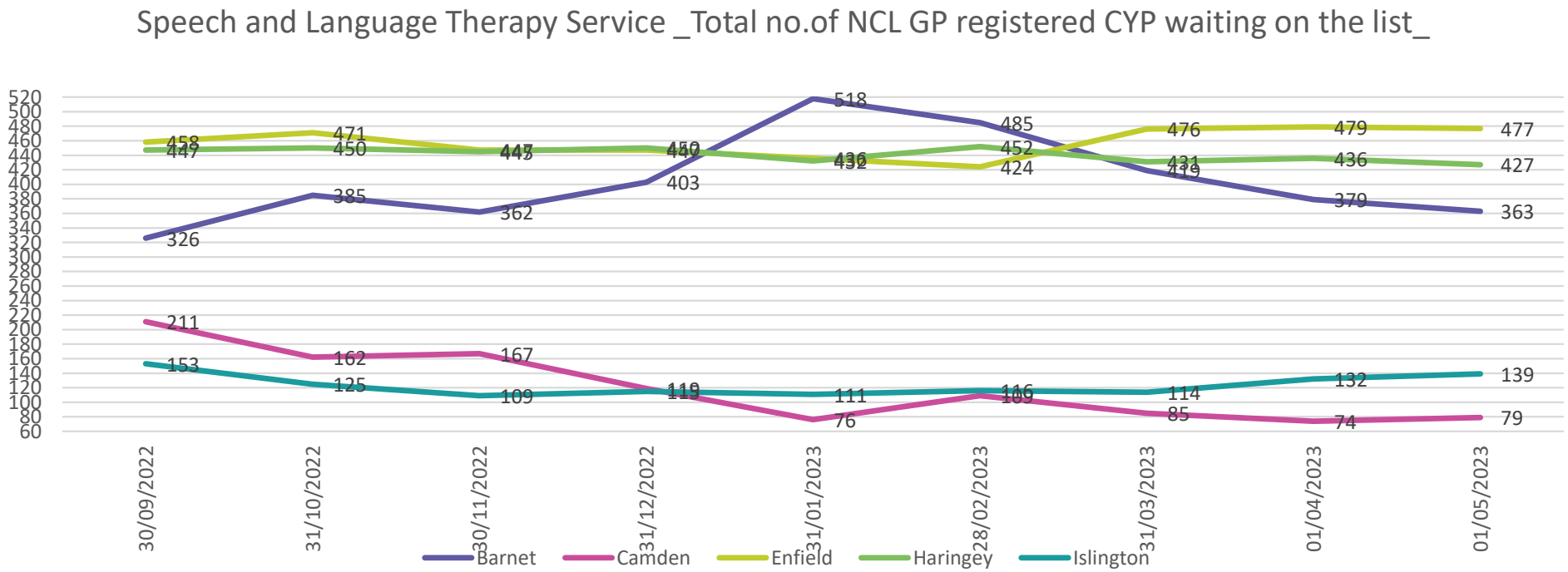
- For Physiotherapy, the numbers waiting for initial assessments have reduced since Sept 22. Barnet has seen the greatest change in overall numbers waiting



Draft for discussion

The reduction in numbers waiting for initial assessment in SLT has been more modest

- For SLT, the numbers waiting for initial assessments have remained stable with a minimal reduction. Barnet saw a significant uptick in the numbers waiting in Jan, however this has since trended downward.



Draft for discussion

BARNET LONDON BOROUGH

NCL Context

2. Health, Education and Social Care Context

Mental Health

CAMHS Spotlight (1/2)

Note slides for internal use only

North Central London Integrated Care System

1 CYP Access

Compared to Operating Plan, NCL ICS achieved 81% as of June 23. As NCL's Operating Plan (20,579) is below our LTP target (25,478), our performance against LTP target is at 70% over a 12-month period. Our Operating plan target breaks down as:

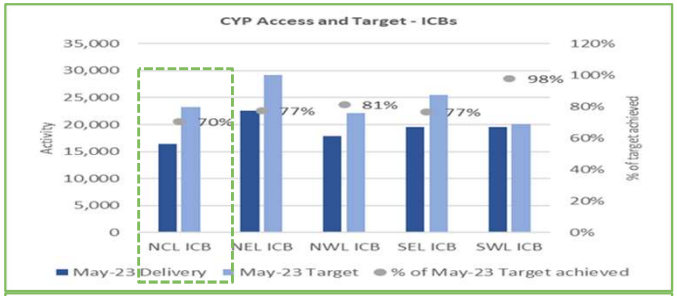
- Community: 14,989
- MHST: 5,590

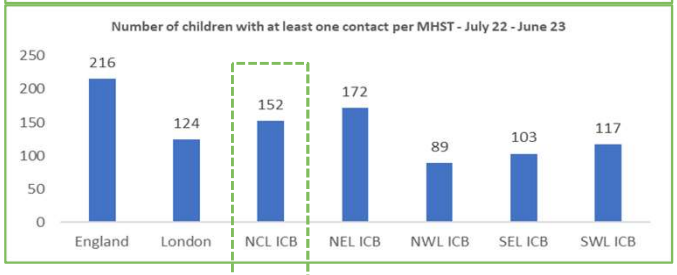
CYP Community:

- SWL ICS achieved 98% of their May 23 CYP access target, while the other ICSs each achieved between 70-81% of the LTP target.
- London is the 2nd lowest performing region, having achieved 80% of their rolling 12-month target in May 23 .

MHST:

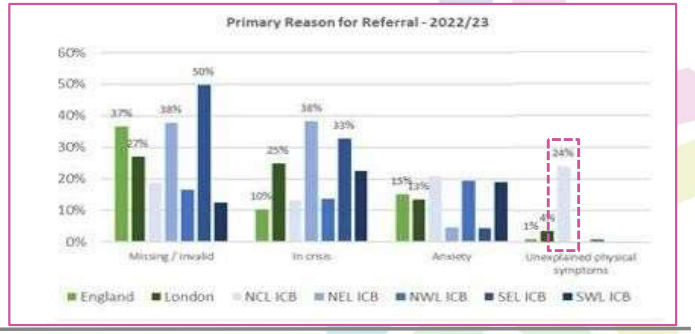
- NCL ICS had an average of 152 CYP seen per MHST, while NEL ICS had an average of 172.
- NCL ICS has seen 3,503 MHST by June 23 and remains on target to meet Operating Plan of 5,590.
- 9,400 CYP in London have accessed MHSTs in the last year, which is 10% of the total CYP seen by all CYP MH services in London (96,360). This is second lowest % of MHST contribution to the overall CYP access numbers compared to other regions.
- London had the lowest number of referrals seen per MHST in last year of the regions, at 124.
- There has been an improvement in the data flowing to MHSDS for MHSTs but there are some teams not yet submitting correctly. This is an area where work is continuing with a targeted support offer by the Regional team.





2 Referrals

- NCL has the highest proportion of referrals due to unexplained physical symptoms at 24%, compared to 0-1% for other ICSs.
- Other main reasons for NCL ICS being Anxiety (21%), Missing / Invalid (18%) and In Crisis (12%).
- NCL ICS accounts for 3,435 waiting list while SEL ICS has the largest at 7,620.



Data source: London's Mental Health Delivery Group Performance Pack

CAMHS Spotlight (2/2)

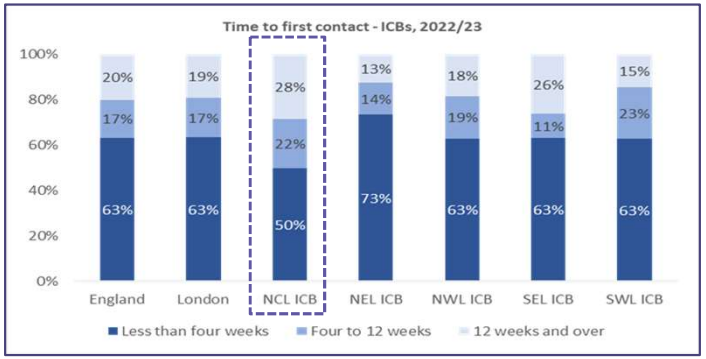
Note slides for internal use only

North Central London Integrated Care System

3 Wait time to first contact

NCL ICS is the lowest performing ICS with only 50% referrals seen within 4 weeks, 22% between four to 12 weeks and 28% waited over 12 weeks for first contact.

- Over the last year, 63% of referrals in London waited less than 4 weeks for a first contact, while 19% waited longer than 12 weeks. This is in line with the national average.
- ***Team Type:*** Autistic spectrum disorder services (20%), Neurodevelopment teams (27%) and Psychotherapy services (39%) had the lowest proportion of CYP receiving a contact within 4 weeks of referral. Crisis resolution teams and Paediatric and Psychiatric Liaison services each had between 96-97% of CYP receiving their first contact within 4 weeks of referral
- ***Demographics:*** Female CYP were more likely to have their first contact within 4 weeks of referral – 67%, compared to 57% of male CYP. Older children were more likely to have their first contact within 4 weeks of referral. 73% of 16–17-year-olds waited less than 4 weeks, compared to 46% of 0–5-year-olds, and 53% of 6–10-year-olds.



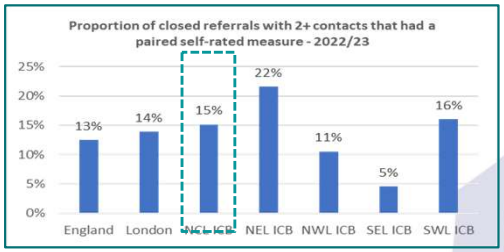
4 Outcomes

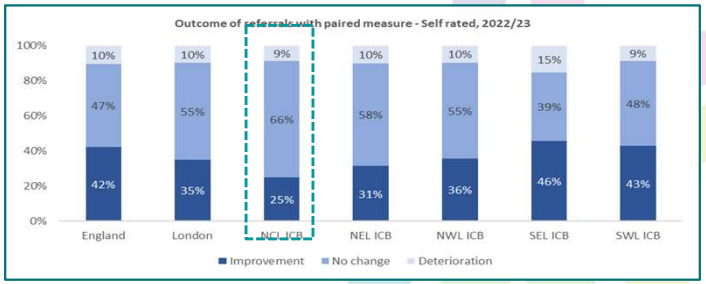
PAIRED SCORE RECORDING: Just 15% of closed referrals with 2+ contacts in NCL ICS had a paired score.

- The charts on the right show the proportion of closed referrals with a self-rated paired outcome measure, using the denominator as the closed CYP referrals that have at least two attended contacts, as it wouldn't be possible to get a paired measure with fewer contacts.
- Work needs to be done to improve this rate as we are moving to report more routinely on outcomes. However, it is worth noting that this data refers to many different pathways, some of which it may not be suitable to gather outcomes measures for – it would be useful to look further into sample sizes for different team types.

OTUCOMES: 25% of CYP living in NCL showed improvement on their paired score, compared to 43% and 46% in SWL and SEL respectively.

- London's improvement rates from self-rated measures (35%) were below the national average (42%) last year.
- The variations could be due to the different service types offered in each region/ICS, different demographics, or the different outcome measures used. Data quality should be improved in this area before conclusions should be drawn, and before further investigation can be done.





Data source: London's Mental Health Delivery Group Performance Pack, 20th September 2023

Appendix ii: Background information on national SEND and AP programme and links

The 9 DfE Regions and ICBs

Table 1: the 9 DfE regions with lead LA, CPPs and ICB.

Region	Lead LA	Supporting LAs	ICB
North East	Hartlepool	Gateshead, Durham, Stockton on Tees	North East, North Cumbria
North West	Manchester	Oldham, Rochdale, Trafford	Greater Manchester
Yorkshire & Humber	Wakefield	Bradford, Calderdale, Leeds	West Yorkshire
West Midlands	Telford & Wrekin	Shropshire, Herefordshire, Worcestershire	Shropshire, Telford & Wrekin
East England	TBC	Bedford, Central Bedfordshire, Luton	Hertfordshire, West Essex
South East	Portsmouth	West Sussex, Brighton and Hove, East Sussex	Hampshire, Isle of Wight
South West	Swindon	Gloucestershire	Banes, Swindon & Wiltshire
London	Barnet	Camden, Enfield, Islington	North Central London
East Midlands	Rutland	Leicester, Leicestershire	Leicester, Rutland, Leicestershire

Links

- National Audit Office report in SEND 2019. https://www.nao.org.uk/wp-content/uploads/2019/09/Support-for-pupils-with-special-education-needs.pdf
- Local area SEND inspections: one year on', Ofsted and Care Quality Commission, October 2017;
- https://www.gov.uk/government/publications/ofsted-annual-report-201920-education-childrens-services-and-skills
- Ofsted Annual Report 2019/20: education, children's services and skills', Ofsted, December 2020 https://www.gov.uk/government/publications/ofsted-annual-report-201920-education-childrens-services-and-skills
- Inquiry by the House of Commons Select Committee October 2019 https://publications.parliament.uk/pa/cm201919/cmselect/cmeduc/20/2002.htm
- SEND Review - right support, right place, right time (publishing.service.gov.uk)
- Special Educational Needs and Disabilities (SEND) and Alternative Provision (AP) Improvement Plan (publishing.service.gov.uk)

DfE Minister responsible for SEND and AP

Cabinet Reshuffle31 August 2023.

- New minster for SEND is David Johnston OBE MP - GOV.UK (www.gov.uk) who replaced Claire Coutinho MP - GOV.UK (www.gov.uk) (held the post for 10 months).
- Minister Johnston is the 5th minister in 2 years.

North Central London Integrated Care System

Longer Lives

Improving the physical health of adults with severe mental illness in North Central London

- **Lauretta Kavanagh**, Programme Director for MH, LD and Autism, NCL ICB
- **Ed Beveridge**, UCLP Clinical Lead for Mental Health
- **Gemma Copsey**, UCLP Implementation Manager
- **Tim Miller**, AD Commissioning Haringey Council and NCL ICB

Why this plan?

North Central London Integrated Care System

People with severe mental illnesses* are dying much earlier than the general population. Psychotic illness is strongly linked with health, race and social inequalities: prevalence is 3x higher in most deprived areas compared to the least.

In NCL, men with psychotic illness die 18 years earlier, and women die 14 years earlier

NCL has the highest prevalence of psychotic illness of any Integrated Care System in England (21,000 people)

People are dying largely from preventable, physical, health conditions (i.e. not suicide / homicide)

The ICS already is implementing the NCL Core Offer and the NHS Long Term Plan, which set out approaches to improve physical health amongst people with SMI.

However, NCL's Population Health Strategy identifies adults with SMI as a 'key community'. To shift the deep inequalities and complex issues that drive such poor outcomes, we require a more focused programme of work to deliver our population health ambition.

* e.g. schizophrenia or bi-polar disorder

The NCL Population Health Strategy set **5 key delivery areas** where we can create the biggest impact in NCL. The highlighting shows the alignment to this programme.

North Central London Integrated Care System

Focus on the **20% most deprived communities**.

- understanding of the needs of our most deprived communities
- providers will tailor services and approaches to maximise their opportunities
- strengthen links between statutory health and care services and wider support

Adult NCL communities who experience greater health inequalities and poorest outcomes.

Key Communities

- Inclusion Health Groups
- Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Adults with severe mental illness & adults with learning disabilities

Additional DASS priorities

- Family carers
- Older adults with care and support needs
- Supporting residents at risk of hospital admission
- Supporting residents to recover following hospital admissions

Focusing on the root causes of poor health.

- **Working with our communities**
- **Working with the VCSE**
- **Social Prescribing**
- **Embedding tackling wider determinants across all priority areas**

Heart Health
Cancer
Lung Health
Mental Health and Wellbeing across all ages
Childhood immunisations

Where we are now?

North Central London Integrated Care System

NCL has made major progress in scaling up services and community outreach across NCL.

The ICB has led **investment in excellent services** in each borough: **Primary Care / GP Federation led enhanced services in neighbourhoods, co-delivered with MH Trust teams including peer support, and strengthened by VCSE community outreach programmes.**

In 22/23 we completed **annual health checks for 13,322 residents** with SMI, exceeding the national target and a 3.4x rise from only 3,821 two years ago.

Some our services achieve excellence; one was nominated for an HSJ award

The plan started as a mental health service area improvement project but has been able to tap into and **galvanise ambition from a wide range of partners** to do better for this population.

UCL Partners were asked to support NCL and to:

- Articulate a clear vision and ambition
- Develop a set of key areas for action based on NCL population's priorities and the evidence base
- Build commitment to action across the wider system, including community physical health services, public health and wider partners

* e.g. schizophrenia or bi-polar disorder

How did we develop this plan?

UCLP brought together diverse people and sources of information – research, residents and clinical leaders – and used an iterative, feedback process.

1. Co-production: delivering what people across NCL say is important to them

- Longer Lives Expert by Experience reference group for extensive co-development work
- Surveys, interviews and focus groups across the five boroughs, including inpatient and community visits

2. Professional Input: using the expertise of our NCL professionals

- Wide stakeholder consultation including all key clinical networks and leaders (GP federation, respiratory consultants, diabetes network, cancer alliance, public health)
- Co-ordinated through SMI Clinical Network from primary and secondary care

3. Research: rooted in the evidence base

- Publicly available data to inform clinical focus areas
- Scoping of national and local research, innovations, and strategies

What people told us

North Central London Integrated Care System

Lived experience contributors describe some key themes around their experience of health care and support

- They do not regard physical and mental health as separate
- They can struggle to trust professionals and sense that they are "judged" not helped
- They are angry about side effects of psychiatric medications, particularly weight gain, and want earlier, more effective support for this
- They experience the GP as hugely important in their care but experience challenges when trying to access them

"[Physical conditions] mean that everything I do takes 10x the energy and time as for a regular person. Nothing is straightforward."

"I don't ask for physical health support because I feel that I'm being a burden."

"[There is an] assumption that everyone wants to be helped, but if a person has low self-esteem or life is hard, what is their motivation to live longer?"

"We need more services like Mind – where there's integration of all different types of people, these groups help us feel much better about ourselves."

Longer Lives Delivery Plan

North Central London Integrated Care System

***The Vision:** High quality care is accessible to everyone with a severe mental illness in NCL*

4 Guiding Principles

Ways to improve the quality and experience of care

1. Take time
2. Make every contact count
3. Warm handovers
4. Involve supportive others

5 Focus Areas

Improve key care and treatment pathways

i. Living well with SMI

ii. Heart disease and diabetes

iii. Lung disease

iv. Cancer

v. Reaching the extra 20% of people

1 Annual Health Check

People get consistent assessment and guidance

- A high-quality check in all boroughs
- Clear processes and outcomes
- Linking services together around the patient.

Implementation and impact

North Central London Integrated Care System

We will reduce premature mortality and multi-morbidity, to **increase the quality of life as well as its length**, enabling opportunity for people and reducing need for the services for avoidable, early frailty.

Against each area, the plan sets out
- areas for action and implementation.
- outputs and outcome measures proposed.
- prioritisation and a high-level timetable

We are developing the delivery prioritisation, planning and the governance for the programme at the moment.

Aligning health improvement activity alongside the plan – smoking cessation, health improvement, weight management etc – is key, as is ensuring people with SMI have the right, rapid and personalised access to housing, financial and social support.

What will we do?

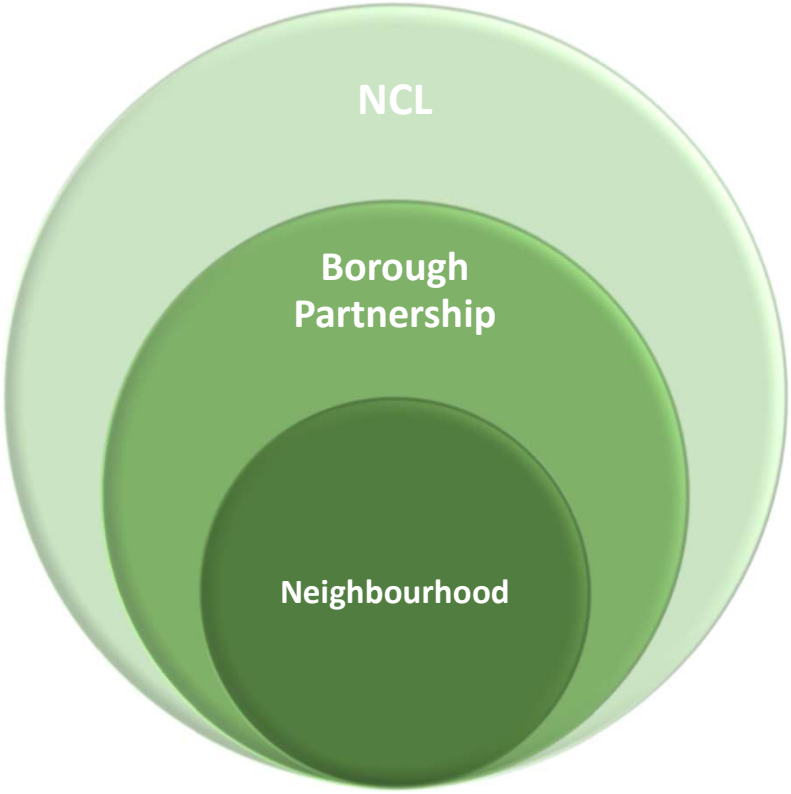
North Central London Integrated Care System

We will reduce premature mortality and multi-morbidity, to **increase the quality of life as well as its length**, enabling opportunity for people and reducing need for the services for avoidable, early frailty.

Deliverable areas	What will be delivered in the first two years?	How will the experience be different?
Living Well with SMI	• Adults with SMI have a comprehensive physical health check each year • That health-check includes health coaching, screening and other elements • Co-produced, tailored information is available for service users deployed across ICS • Increased offer and uptake of physical health and wellbeing groups	More consistent and positive experiences in General Practice
Cardio-metabolic health	• All patients who need treatment identified in their physical health check will receive it. • All patients will be offered high impact, holistic support and peer work • Increased access to prediabetes and diabetes support programmes • Include diabetes in the mental health risk assessment for people with comorbid diabetes • All MH staff working with people at risk of diabetes trained on diabetes prevention & care • Cross-referral pathways in place between MH, Diabetes and Substance misuse	More health conditions identified and treated – reducing disability
Lung Disease	• NCL staff will be offered treating tobacco dependence training • Implement smoke-free policy and offer NICE recommended treatment in all MH hospitals • Improve access to respiratory hublets and pulmonary rehab	People feel better supported to tackle health / lifestyle challenges
Cancer	• All cancer screening and treatment services will adopt trauma-informed approaches • Review, improve & standardise the support offer for patients with SMI at cancer diagnosis • Information & training on screening & symptoms to services supporting patients with SM • Improve data collection around screening engagement for people with SMI	Mental health and physical health / disability teams integrate and work together
Reaching the most marginalised 20%	• Proactive engagement plans for DNAs or non-responses • Clearer pathways and information sharing between NHS and VCS • Expand the role of VCS and grassroots organisations to deliver health promotion activities • Develop the role of neighbourhood MDTs as a route for escalation of patients	Less socially / professionally acceptable for SMI to be exclusionary

Delivery of this as an ICP / ICS programme

North Central London Integrated Care System



Purpose in Pop Health Strategy	Application in Longer Lives
System • Focuses on activities that are better undertaken at an NCL level where a larger planning footprint increase the impact of effectiveness • Creates conditions for local delivery of population health improvement through the borough partnerships	• NCL wide recurrent investment based on borough need • Engage NCL wide networks to plan delivery across system • Co-ordination of NCL wide clinical pathways • Develop resources and protocols once for NCL • Programme management and leadership • Analytics and oversight • Co-ordinate codesign
Borough Partnership • Focussed on bringing together partners to develop, integrated and co-ordinate services based on agreed priorities • Work with wider sector partners • Drives hyper local delivery	• Co-ordinates local integration across mental and physical health care services; primary and secondary care services • Prioritises this population in physical health, prevention and wellbeing plans to ensure access • Delivers workforce change and training • Oversees neighbourhood level integration and delivery • Ensure anti-stigma work addresses the needs of the most marginalised • Coproduce local implementation
Neighbourhood • Builds on the core of primary care networks through integrated multi-disciplinary teams delivering a proactive population-based approach to care at a community level	• Delivers consistent, stronger health checks & local wellbeing and support groups • Integrates support with VCSE & other partners • Draws on local MDTs to wrap care around a person • Addresses social, housing and finance barriers to health • Make every contact count

“Living Well with SMI in NCL”

North Central London Integrated Care System

One of the 5 focus areas in the Plan is ‘Living Well with SMI in NCL’. It covers a range of clinical and non-clinical actions that will make a difference to people’s lives and outcomes, and a good example of where we will require joint action across the system. Deliverables are: -

- Annual health checks will reliably prompt physical health care planning and interventions.
- Care planning is provided from the point of the health check which is holistic and uses a coaching approach, with longer appointments and peer work involvement as appropriate.
- UCLP-Primrose will roll out across NCL.
- There is information for residents with SMI which provided by all services on issues such as side effects and specific health conditions, co-produced with people with lived experience, tailored to account for health condition, ethnicity, culture, socioeconomic status, literacy, language etc. We will start with information tailored to particularly high-risk communities, e.g. Heal-D (Healthy Eating & Active Lifestyles for Diabetes in African and Caribbean communities).
- Regular (at least annual) psychiatric medications reviews will be offered to all SMI patients by a suitably experienced professional, with a holistic focus. Consideration of weight gain will be a top priority for clinicians.
- Regular mental health training and expert support available in ‘physical health’ settings e.g. acute trusts and primary care.
- Regular community health and wellbeing groups offered, with access to free exercise in a range of settings. The focus will be enjoyable activities, groups and peer support, with strong links with VCS and community groups to enable this. E.g. Inclusion Sports, run by LISA (London Inclusion Sports Academy).

Harnessing commitment to action across public heath functions, leisure and wellbeing, and care planning / delivery in adult social care people to help achieve their outcomes will be critical

Potential Asks of the ICP

North Central London Integrated Care System

1. Prioritising this delivery plan will involve all parts of our system working differently – particularly in the way that primary care, mental health/community, local authority and secondary care services work together and to support this population group. What are the next steps for borough partnerships in strengthening this important work further?
2. To explore the prioritisation of this work as an ICP priority within the delivery of the Population Health strategy
3. To discuss the opportunities of delivering change at scale and via Borough Partnerships to tackle inequalities and deliver new ways of working in neighbourhoods.
4. To consider the opportunity of partners co-leading areas of work in the programme, such as the "*Living Well with SMI in NCL*" strand.