NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Thursday, 27th March, 2025, 2.00 pm - George Meehan House, 294 High Road, Wood Green, N22 8JZ (watch the live meeting, watch the recording here)

Membership: Please see attached Membership and Quorum in Item 2

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 13).

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 (PAGES 3 - 6)

To confirm and sign the minutes of the Health and Wellbeing Board meeting held on 28 November 2024 as a correct record.

8. UPDATE ON PRIMARY CARE IN NORTH CENTRAL LONDON AND HARINGEY (PAGES 7 - 46)

To update the Board on the status of Primary Care in North Central London (NCL) and Haringey.

9. UPDATE ON COMMUNITY PHARMACY IN NORTH CENTRAL LONDON AND HARINGEY (PAGES 47 - 58)

To outline North Central London and Haringey's Community Pharmacy status.

10. NEIGHBOURHOOD MODEL OF HEALTH AND CARE (PAGES 59 - 74)

11. HARINGEY ADULT SOCIAL CARE INSPECTION BY CARE QUALITY COMMISSION - UPDATE (PAGES 75 - 96)

12. BETTER CARE FUND UPDATE (PAGES 97 - 108)

To provide the Quarter 3 update of the Better Care Fund.

13. NEW ITEMS OF URGENT BUSINESS

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

14. FUTURE AGENDA ITEMS AND MEETING DATES

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

To note the dates of future meetings:

To be confirmed in the new municipal year 2025/26.

Kodi Sprott, Principal Committee Co-Ordinator
Email: bhavya1.nair@haringey.gov.uk

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

Wednesday 19 March 2025

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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 Communities	Cllr Ajda Ovat
	Officer Representatives	4	Director of Adults, Health and Communities	Beverley Tarka (Sara Sutton from 1st April)
			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 Lead for Haringey	Nadine Jeal
			Borough Director covering Haringey	Clare Henderson
			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	Dr Clare Dollery (interim)
	Barnet, Enfield and Haringey Mental Health Trust	1	Executive Lead covering Haringey	Ben Browne
		2	Chief Executive	Tim Fox

	Haringey GP Federation		Medical Director	Dr Sheena Patel
Patient and Service User Representative	Healthwatch Haringey	1	* Chair	Sharon Grant
Voluntary Sector Representative	Haringey MIND	1	Chief Executive	Lynette Charles
Haringey Local Safeguarding Board		1	Interim Independent Chair	David Archibald

1. FILMING AT MEETINGS

The Chair referred to the filming at meetings notice and attendees noted this information.

2. WELCOME AND INTRODUCTIONS

The Health and Wellbeing Board members were senior Council officers, Cabinet Members, and representatives from Healthwatch, Bridge Renewal Trust, and the North Central London Clinical Commissioning Group.

3. APOLOGIES FOR ABSENCE

Apologies for absence had been received from Lynette Charles, Cllr Hakata, Paul Butler, Beverley Tarka and Helena Kania.

4. URGENT BUSINESS

There were no items of urgent business.

5. DECLARATIONS OF INTEREST

There were no declarations of interest.

6. QUESTIONS, DEPUTATIONS, PETITIONS

There were none.

7. MINUTES

RESOLVED

The minutes of the meetings held on 19th September and 17th January 2024 were approved.

8. HARINGEY HEALTH AND WELLBEING STRATEGY

Will Maimaris presented this item to the committee. This was presented at the previous meeting but had been amended to reflect points that were made in the discussion.

The following was noted in response to questions from the committee:

- This strategy would be published on the Haringey Council website. Officers were thinking about alternative means around access, for example there was potential for the creation of a YouTube video. There would be varied options for

people to look at this and officers had engaged widely on this to help establish different routes of publication.

- This strategy would become the structure by which members would look at themed matters in this meeting.
- This strategy was discussed with the Overview and Scrutiny committee, they were keen to continue having ongoing discussions on this; specifically, to monitor what was taking place against the planned outcomes and actions. This also fitted alongside the borough vision.
- Cllr Das Neves thanked everyone who contributed to the document, especially community groups. Members were confident that this was a good production of real neighbourhood priorities.

RESOLVED

For noting revised document after discussions at last Health and Wellbeing Board and approval for publication.

9. BETTER CARE FUND UPDATE

Jo Baty presented this item to the committee. This was a collaborative piece of work with the ICB. This was a strategic initiative designed to support local systems in achieving the integration of health and social care services. There would be a draft policy framework available in mid-December.

Cllr Das Neves was pleased that officers had bought the Better Care Fund to the committee. She recognised the challenges and pressures both on the local authority side and the NHS. She noted she looked for more stability and confirmation of where the borough was going to be financially going forward. She also noted there had to be a relentless focus on what was most critical.

The following was noted in response to questions from the committee:

- It was flagged that as the policy framework drafts were completed, members would like this bought back to the committee.
- The funding envelope was shrinking, officers were working with an organisation called Red Quadrant who were helping the team establish a target operating model. Officers wanted the Red Quadrant to work with the service at pace.
- The localities model needed a lot more work because the mental health team was bought back in House last year, that was also at its early stages of development.
- It was noted that work needed to be done differently with commissioning in Haringey. The team were looking at securing an investor to save investment on growing the capacity of a small team for a large borough with complex issues.
- Members thought it was positive that there had been a discussion about private providers and children's services. It was noted that these discussions weren’t taking place in adult social care.
- Neighborhood work was imperative, but it required careful planning. The team were joining together with colleagues in the NHS and the voluntary community sector. The team were already working in partnership with Disability Action Haringey, who had employed independent living workers to help focus on giving

residents more choice and control. In the transformation as a Council the team were also looking to integrate with housing.

- Collaborative work was key and it was also important for residents to understand the parameters of each workforce.
- In the new year the team would begin to review of all of areas of the service. They were waiting for the CQC inspection outcome and associated action plan.
- Assurances were given that the experience around local processes would still remain, patient discharge was a local discussion that would be preserved. This would not change following the merger.
- The committee would bring back the discussions about the merger to a future meeting.
- Whittington Health were keen to be involved in the neighbourhood work and in the forming of the strategy around neighbourhoods.
- There was both primary and secondary prevention, secondary prevention was about making sure people received the reinforcement they needed in a timely way.
- The funding had been allocated according to how it was last year, this was not on a locality base. The locality model currently in phase one was a local authority model and the Better Care Fund was not about the local authority. Next year would be a transition year to start planning and look whether the health and well-being board would want to utilize the fund more on a locality base or a neighborhood base.
- It would be important to encourage a wider group of people to understand the issues the service was dealing with and receive intelligence back from those people.

RESOLVED

For the board to receive an update and approve allocations for 24/25.

10. HARINGEY BOROUGH VISION

Jess Crowe introduced the item; she noted that the aim was for partners to adopt the vision so it would not just be a Council document. There were initial priorities which came out of the discussions, it would be useful to have a conversation at a later board on the detail of how partners should go about actioning these priorities. The team wanted this be a live document as a means of being held to account for delivering, there could be potential to have an annual workshop, which would enable this.

Partners would be sent a copy of the borough vision document and were welcomed to bring comments back to the board on this.

11. NORTH CENTRAL LONDON POPULATION HEALTH AND INTEGRATED CARE DELIVERY PLAN - DELIVERING POPULATION HEALTH AND INTEGRATED CARE AMBITIONS IN HARINGEY

Tim Miller and Paul Allen introduced the reports for this item. The North Central London Population Health And Integrated Care Delivery Plan was endorsed by partners in April 2023, and that followed a significant amount of work with local residents and stakeholders. There were 5 key Risk areas for health and these were around childhood immunisation,

cancer, mental health, heart health and lung health. Sitting behind the strategy, there was a delivery plan which was identifying priorities to take forward because the population health strategy was comprehensive.

The following was noted following questions from the committee:

- The Haringey deal looked at understanding the communities in the borough and more work on that was important. A good example that was developing and emerging was the work with the mental health trust and the Bulgarian Roma community.
- The team had been working with the Council and were looking at health service transitions.
- In terms of the early year's foundation stage, Haringey came 5th in London and 8th nationally. This included all the areas of development with speech and language and if the Council carried on investing in these over the years, it would offset a lot of problems.
- It was important to work on vaccination take up, this was a challenge and was part of wider engagement process with children and families. There were school based vaccination programmes, for example the HPV vaccine. Haringey held the highest figures for this in North Central London, this was through working closely with the school's and the vaccination provider. This had to be extended into preschool vaccinations.
- The team were trying to work with public health colleagues locally to try and understand the inequalities aspects of core areas. They would be deep diving into some specific areas such as childhood immunisation and would report on this routinely to track some of that progress.
- Sharon Grant had recently set up a new charity for older people in the borough. The committee looked forward to engaging more with the voluntary sector and looking at the over 50s area generally**.**

RESOLVED

For the board to receive an update and for discussion.

12. NEW ITEMS OF URGENT BUSINESS

There were no new items of urgent business.

NHS
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General Practice update

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March 2025

North Central London
Integrated Care Board

Contents

North Central London
Integrated Care Board

Introduction

This report:

- Sets out the national and local context for general practice
- Describes the work we are doing to improve patient experience of access
- Describes how the ICB manages and monitors quality and performance in general practice
- Gives examples of key pieces of work being delivered by the ICB and general practice in Haringey

Summary:

Patient satisfaction with access to General Practice continues to receive attention nationally. Practices are providing more appointments than ever before and yet patient satisfaction with experience of access has declined nationally.

As the 'front door' of the NHS it is critical that patients can reach General Practice when needed. The NCL response to the *National Delivery Plan for Recovering Access to General Practice* has supported improvement (measured by patient surveys and other indicators) over the last 18 months. Work continues and we expect to see further improvement over time.

Major programmes of work are underway in NCL to support the transformation and sustainability of General Practice. These are all undertaken with the aim of improving experience, quality and outcomes for local patients.

We would be happy to establish an annual reporting cycle with the Health and Wellbeing Boards and Health Overview and Scrutiny Committees to enable sustained dialogue about developments in general practice.

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National and local context

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National strategic context

In the past two years, national and regional publications have described the many challenges and the potential future scenarios for general practice. We expect to see significant reform of the national General Practice contract in the coming years and increasing asks of ICB/ICS as the Government seeks to address the sustainability of the sector which has a critical role in its vision (the 'left shift' and neighbourhood health service).

Lord Darzi's Independent Investigation of the NHS in England highlighted:

- Increased demands, with GPs "…*expected to deliver an ever-wider range of services and to integrate care for more, and more complex, patients*"
- Rising productivity in general practice, reducing GP numbers, evident capacity constraints
- Reducing share of overall NHS expenditure (true locally and nationally)
- Premises that are not fit for purpose
- The "*extraordinary innovations*" embraced and delivered in general practice

The report noted increased capacity and infrastructure for general practice (and other community-based services) is the only way to help people to live well for longer and reduce reliance on hospital services.

NCL ICB has been selected by NHS England to work with them to test interventions to increase the sustainability of general practice and therefore inform future contract arrangements (see Appendix 1).

The national 24/25 GP contract (presented as an interim solution ahead of more significant revision) was poorly received. It did not address the acknowledged shortfall in funding and prompted the BMA to promote *Collective Action* across practices.

The national 25/26 GP contract commits to increased investment into general practice. We are currently working through the implications of the contract for our work plan for 25/26 and await some detail in the national service specifications.

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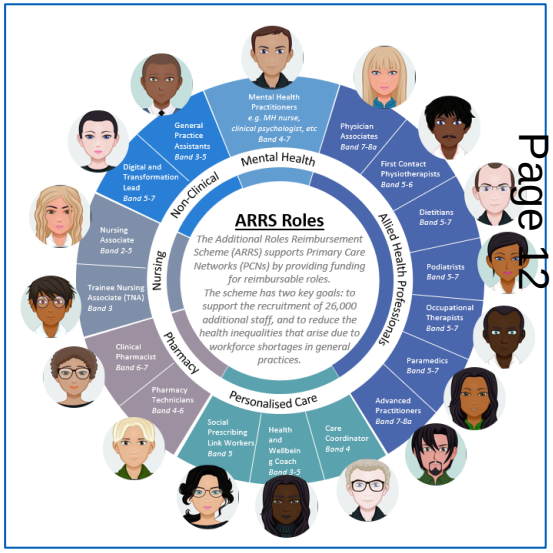
Haringey General Practice landscape

- There are **34 General Practices** in Haringey covering a registered list size of **345,516 patients**. Practices range from very large partnerships to small practices run by a single GP. The number of practices has reduced but overall capacity (staffing, appointments) has increased (see also Appendix 2).
- All Haringey practices are members of a **Primary Care Network (PCN)** – there are 7 in Haringey (East Central, N15/South East, North Central, North East, North West, South West and Welbourne). PCNs are groups of practices which work together, led by a named Clinical Director.
- PCNs now deliver additional services for patients including additional appointments outside 'core' opening hours (enhanced access), medication review & optimisation, support to care homes, early cancer diagnosis, social prescribing support, cardiovascular disease prevention and diagnosis, work to tackle health inequalities and care planning for those who need it.
- Reflecting the growth in both the offer from General Practice and the volume of work, new staff have been introduced to practice teams for example Pharmacists, Paramedics, Physiotherapists. This is funded through the national additional roles reimbursement scheme (ARRS). Newly qualified GPs have recently been included within the scheme.
- The **Haringey GP Federation** supports practices and PCNs. GP Federations are legal entities with local practice membership. They lead transformation and collaboration at Borough level, deliver services 'at scale', support back office and operations, provide a voice for primary care, and are engaged in the development of integrated care models.
- General Practice providers will be significant partners in the emerging 'Neighbourhoods' and already play a key role leading and staffing Integrated Neighbourhood Teams. In Haringey the MACC (multiagency care coordination team) already supports some of our most complex and frail patients with support from General Practice.



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Provision of appointments

General practices in NCL continue to respond to high demand despite constrained resources. Practice list sizes have grown by c15% over the last five years but appointment numbers by approximately 30% (noting variation between practices)

NCL Practices provide a total of circa 800,000 contacts per month (core appointments, online consultations, extended access provision).

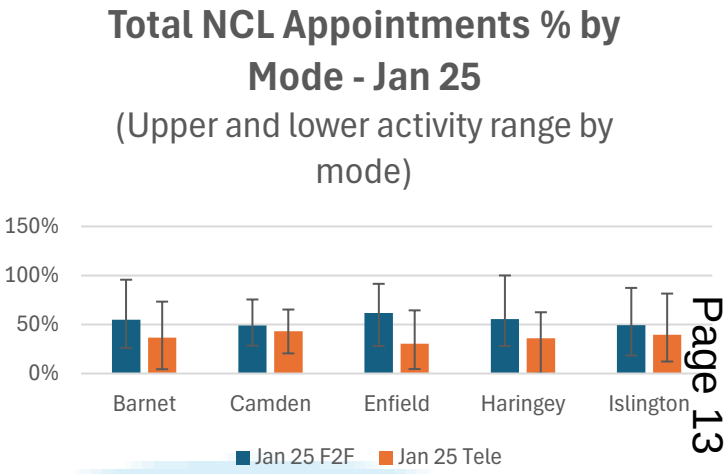
GP appointments data shows that the number of appointments provided across NCL in December 2024 was 11% higher than in December 2023.

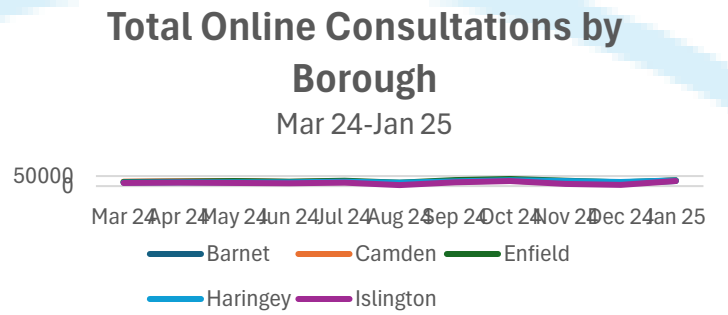
The year-to-date average number of appointments per month for 2024/25 is 8% higher than for 2023/24.

Of this total number of appointments, 54% were provided on-the-day (national average 46%), and 92% within two weeks of the request being made (national average 83%).

Fifty-five percent of appointments were face to face – this compares to a national average of 64.4%, and 60.1% for London, and may reflect the strong adoption of digital tools and remote consultations by practices in NCL.

We know, however, that there is large variation in appointment mode by practice, driven by variation in the operating models of practices.





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Workforce - Haringey

General Practice Workforce is split into roles **recruited for practice level working** and roles **recruited specifically for PCN level working**.

Practice Workforce
Haringey GP Practices employ 608 WTE staff. The NCL general practice workforce increased by 3.6% between December 2023 and December 2024. In Haringey this was higher at a 5.6% increase.

In Haringey the year-on-year increases included:

- Admin/Non-Clinical roles **up 5.7%** from Dec-23
- Direct Patient Care roles (making up the wider clinical MDT excluding GPs and Nurses) **up 2.3%** from Dec-23
- Nursing roles up **13.2%** from Dec-23
- GPs (excl. registrars) roles up **4.7%** from Dec-23

PCN Workforce
Haringey PCNs employ **179 WTE to support PCN working** excluding GPs.

There was no increase in core ARRS budget for 24/25 so this workforce remained largely stable between 23/24 and 24/25.

Newly Qualified GPs were introduced to PCN reimbursable roles from 1st October, recruitment to these roles is underway so not captured here but all Haringey PCNs have shown commitment to this opportunity and are recruiting into these roles during 24/25.

Primary Care Network roles	Haringey WTE Total
Clinical Pharmacist	55
Care Co-ordinator	49.4
Physician Associate	17.6
Social Prescribing Link Worker	14.8
General Practice Assistant	15.7
First-contact Physiotherapist	4
Advanced Practitioner	3.6
Pharmacy Technician	4.7
Digital & Transformation Lead	3
Community Paramedic	1
Trainee Nursing Associate	4
Health & Wellbeing Coach	2.6
Adult Mental Health Practitioner (AfC B7)	2.2
Adult Mental Health Practitioner (AfC B8a)	1
Nursing Associate	0.4
Enhanced Practice Nurse	0
Dietician	0
Occupational Therapist	0
Podiatrist	0

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We have heard from Londoners about their views on the future of general practice

With the other London Integrated Care Boards (ICBs) and NHS England London Region, we have undertaken public engagement to inform the future of primary care in London.

Over three workshops participants, representing Londoners in terms of gender, sexuality, age, ethnicity, varying levels of usage of primary care and caring responsibilities, learned about primary care and potential areas of change.

Participants shared experiences, exchanged ideas and reflected on what changes might mean for Londoners.

In a final workshop, participants formed a final set of expectations, to be used to shape local implementation and engagement plans.

Key messages and priorities among participants:

The need for, and openness to, change

Convenience, choice, continuity, consistency

Reducing health inequalities and addressing inequities with tailored solutions to reach marginalised communities, such as the homeless

Enthusiasm for opportunities offered by digital tools, though traditional access must be easily accessible for those who need it

Limited awareness of wider primary care roles may be a barrier to a shift away from a GP-first model

Understanding of the benefits and necessity of data sharing for improved healthcare but also the importance of robust security and privacy measures.

Large scale public education and communications, including national and local campaigns, to inform the public and build trust.

Local strategic context

- In April 2023 we began a series of Roundtable conversations about challenges faced in general practice and the ICB role in curating change to overcome these challenges. These brought together ICB Board members and other system leaders, including the lead Council Chief Executive for Health to consider future ambitions for general practice.
- The conversations resulted in draft ambition statements that we have tested with teams across the ICB and with front-line general practice staff, via focus groups with 60 individuals, and those in different leadership roles in general practice
- The process has been supported by the National Association of Primary Care and the NCL General Practice Provider Alliance.

Current draft ambitions are structured into 5 themes and 14 ambitions

- The ambitions statements are deliberately not presented in the form of a strategy – we expect the ambitions to provoke debate and to iterate over time – not least when the forthcoming 10-year health plan is published
- We are currently taking the draft ambitions through internal review and look forward to sharing these with partners for discussion in the coming months.

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Improving patient experience of access

North Central London
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National Primary Care Access Recovery Plan

As described previously, demand has increased significantly, and patients now find it more difficult to access General Practice. Work is underway to modernise access models to address this demand and support appropriate and timely access. We have delivered against all practice, PCN or ICB related aspects of the national Primary Care Access Recovery Plan.

1	**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy	
2	**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity	• Rapid assessment and response
3	**Build capacity**	• Growing multi-disciplinary teams	• More new doctors	• Retention and return of experienced GPs	• Priority of primary care in new housing developments
4	**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Reducing IIF indicators and freeing up resources	

North Central London
Integrated Care Board

NCL Delivery Plan

The ICB has taken a proactive approach to delivery of the national Primary Care Access Recovery Plan (see also Appendix 3)

As examples:

- We have used a data and soft-intelligence driven approach to assess likely support needs of practices in making the transition to Modern General Practice Access
- We have completed 58/60 initial diagnostic conversations with practices where data and soft-intelligence indicated a structured, clinically led conversation would better inform consideration of change support needs
- We have commissioned hands-on change support for a sub-set of practices where the likely support need was clear – this has then been agreed between the practice and change support provider at the outset of the work.
- 100% practices are using modern, cloud-based telephony systems and we are working with them to optimise functionality such as call-back.
- 99% have enabled ordering of repeat prescriptions via the NHS App and 90% have enabled booking and cancelling appointments. Patient use of the App has increased in NCL since the programme began. In March 2025 there were 928,418 logins to the NHS App by NCL patients.
- 94% percent of practices offer online registration for new patients
- 97% of community pharmacies are delivering the Pharmacy First service.
- 58% of residents are now registered with the NHS App and patient activity in the App continues to increase.
- Secondary care trusts have committed to implementing the four national commitments to reduce bureaucracy at the primary / secondary care interface – this is an ongoing programme of work and will have increased focus in 2025.

North Central London
Integrated Care Board

Your Local Health Team campaign

- We know optimising the impact of changes in the way patients can access healthcare requires breadth and depth of understanding across our 1.8m registered patients.
- Our locally designed 'Your Local Health Team' campaign - featuring local staff – conveys key messages and builds in outreach to key communities supported by the VCSE and community leaders (see appendix 4 for more details).
- Aim: to improve recognition and understanding of the breadth of local services on offer across Haringey, Barnet, Enfield, Islington and Camden. We want it to be local and resident focused, adaptable and distinctive.
- Phases: the campaign has five phases, and we are in phase two of the campaign (see more details in Appendix 4)
- Tactics: paid social media, out of home media e.g. bus shelters, community engagement events
- We have worked in partnership with all councils and Trusts to put together co-branded content

GP Patient Survey

Practices are beginning to see results from efforts to improve patient experience. The 2024 GP Patient Survey gives insight into where patient experience is already improving, and where more support will be required to help practices realise key benefits.

	NCL average 2024	National average 2024	London average 2025	NCL practice range 2024
% patients who had a **good overall experience of contacting their practice**	67%	67%	67%	23% - 100%
% patients reporting a **good overall experience of their GP practice**	72%	74%	73%	30% – 98%
% patients who find it easy to contact their GP practice ***on the phone***	52%	50%	53%	11% – 97%
% patients who find it easy to contact their GP practice ***using their website***	46%	48%	48%	8% – 96%
% patients who find it easy to contact their practice ***via the NHS App***	42%	45%	45%	7% – 82%
% patients who find the **reception and admin team at their practice helpful**	79%	83%	81%	42% – 99%
% patients who **knew what the next step would be** when they last contacted their practice	80%	83%	81%	52% - 100%

We did not expect to see significant changes, driven by the Access Recovery Plan, in the 2024 survey but there were some positive early signs:

- We are above the national average for satisfaction with telephone access and have closed the gap between NCL and national averages in some areas e.g. patient satisfaction with practice websites.
- Across NCL over 50 practices improved overall patient satisfaction by 10% or more. In Haringey this is true of 8 practices.
- 6 practices increased overall satisfaction by 20% or more.
- Conversely in 14 practices overall patient satisfaction dropped by 10% or more. In Haringey this is true of 1 practice.
- 7 practices saw a reduction in satisfaction.
- Practices that have recently moved to new premises show an increase in patient satisfaction with the overall experience of accessing primary care of between 3% and 24% (NB there are likely to also be other positive changes in service delivery that may have contributed).

NHS
North Central London
Integrated Care Board

Monitoring quality and performance

North Central London
Integrated Care Board

Quality & Performance

- We recognise and value the **range of priorities and functions** that general practice is being asked to prioritise alongside same day access and episodic care. These are explicit in national and local strategies and in the outcomes and 'core indicators selected in NCL. Priorities include:
  - **Long Term Condition management and continuity of care** – (see slide 19)
  - **Proactive Care** – for patients with complex needs (bio-psycho-social).
  - **Prevention –** screening, vaccinations, health messaging and coaching, outreach to key communities
  - **Integrated Neighbourhood Teams** - primary care will have a significant role to play in integrated care models, support to self care, the development of community-based provision and in work to engage with the wider determinants of health.
- KPIs and key data are monitored across all 176 practices and across wider general practice contracts. ICB teams support quality and performance day to day via:
  - Contract Performance Reviews
  - Practice visits
  - Medicines optimisation activity
  - Our formal 'caseload' – covering quality and performance concerns but also mergers, moves and more
  - Use of soft intelligence to capture rising risk, bringing together quantitative and qualitative information across teams including primary care, medicines, estates, IT, quality and complaints.
- We are building analytical models to help us identify practices that may benefit from additional support. We are using a national 'support level framework' tool to hold clinically-led structured conversations with practices to inform change management offers.

North Central London
Integrated Care Board

Primary Care Committee

- The ICB Primary Care Committee provides oversight, scrutiny and decision making for both core general practice and locally commissioned services, and ICB strategic development of general practice. The Committee makes decisions in relation to the commissioning and management of primary medical services contracts and has oversight of the quality and performance of primary medical services, and the primary care budget delegated from NHS England.
- The Primary Care Committee receives a Quality & Performance report which covers a range of indicators covering domains such as: access; patient experience and complaints; vaccination and screening; health checks; cancer and other clinical priorities; staffing; referrals and secondary care activity trends. This is published on the ICB website and is evolving to improve utilisation by the Committee and primary care team.
- The Primary Care Committee has recently approved commencement of a procurement process which will include St Ann's Road Surgery, following the Committee decision in June 2024 to not extend further the existing providers (AT Medics Ltd) contract. There are several GP contracts to be procured in 2025/26 so the full procurement process will be carried out over 18 months. The new contracts and providers will commence from 1 April 2026.
- The Committee meets in public, is open to questions and deputations from the public and ensures patient engagement informs decision making.
- The ICB works closely with the CQC and NHSE Medical Directorate informing inspection timetables and scope. Currently 2 practices are rated ‘outstanding’, 9 ‘requires improvement’ and 165 ‘good’.
- The ICB has delegated responsibility for managing patient complaints that are not resolved at practice-level and are escalated by the patient. In 2024 the ICB received 135 complaints about practices in Haringey. The most common themes related to Communication, Clinical Treatment, and Delay/Failure to refer.

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Long term conditions management

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NCL Long Term Conditions Locally Commissioned Service - Overview

- Since October 2023, General Practice across NCL has adopted a new model for managing Long Term Conditions through the implementation of a new Locally Commissioned Service (the NCL LTC LCS).

- Developed in collaboration with partners and stakeholders from across NCL, the service focuses on personalised, holistic care and treatment prioritising prevention, the early detection of LTCs and what is important to the individual. It aims to improve population health and wellbeing and help address health inequalities.

- The holistic approach to the conditions in scope (a range of metabolic and respiratory conditions) sees better patient experience, common outcomes, and better use of system resources, supporting the ambition to shift toward prevention, early intervention, and proactive care, while ensuring greater consistency across NCL.

- Patients who are living with one or more LTC, or who may be at risk of developing a LTC, will be invited into the practice for an appointment. If found to have one or more LTCs, they will be offered an annual cycle of proactive and personalised care – which includes being invited to a Check & Test appointment, a Discussion appointment, and a Follow-Up appointment, over the year. Patients will have relevant tests carried out and will be asked what's most important to them to feel well. This annual cycle repeats each year.

- Additional clinical and non-clinical support roles are in place in each borough, working closely with practices and offering support to any who are experiencing any issues, recognising that this is a new way of working for many.

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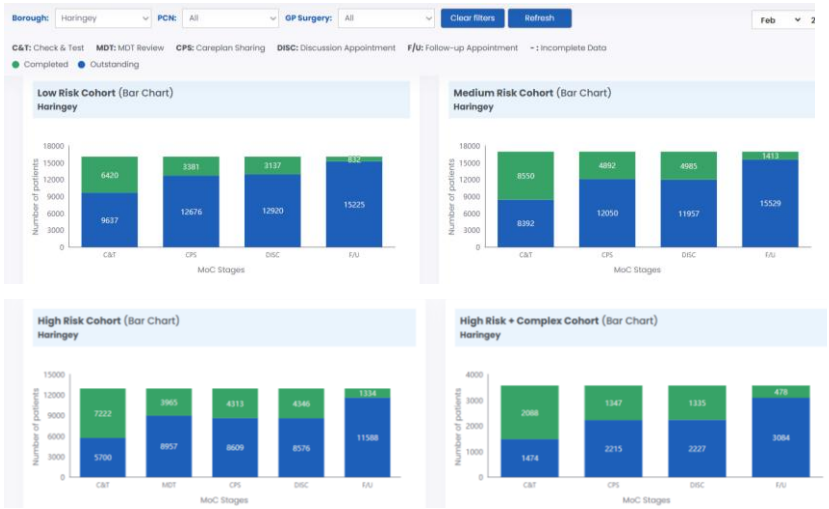
NCL Long Term Condition Locally Commissioned Service: Haringey updates

- All 34 Haringey practices have signed up to deliver the NCL Long Term Conditions Locally Commissioned Service (LTC LCS).
- Haringey practices have a good comprehension of the LTC LCS. Activity has increased steadily. A significant number of each of the Model of Care touch points with patients has been performed – the best examples being East Central, South West and Welbourne PCNs.
- There has been a positive correlation between Model of Care activity and outcome performance. Promising efforts have been seen across Haringey practices to continue improving their outcome achievement in 2024/25.
- One Haringey PCN in particular, South West PCN, is thinking creatively about how to approach their LTC work; whether through collaborating on administrative work or through adoption of third-party call/recall tools.

Up to five PCN outcomes will be incentivised for each year of the LTC LCS; two are being incentivised across all of NCL and three are at the borough level to reflect local priorities (see Appendix 5 for details).



Practices have access to a dashboard which helps them track progress in completing all parts of the model of care with eligible patients.

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Estates developments

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NCL ICB Primary Care Estate Development

- We are one of the first ICS in the country to start allocating 5% of system Capital to developing the local care estate.
- We have undertaken a deep-dive analysis of the approx. 200 primary care practice premises across NCL.
- We have a prioritised pipeline of development projects, which is taken forward in collaboration with the practices, PCNs and other providers.
- We are working closely with Council colleagues to identify suitable opportunities for relocation and where available to employ S106 and CIL funding to facilitate projects.
- We are pro-actively improving the primary care estate with the available funding.
- Where we are unable to relocate practices to new, fit for purpose premises, we are undertaking smaller, targeted investment programmes to improve existing estate for patients and staff. For example, by digitalising patients records and repurposing the storage space for patient facing clinical or clinical support space.
- The ICB's work has informed NHSE Planning Guidance which for the first time allocates capital to general practice.

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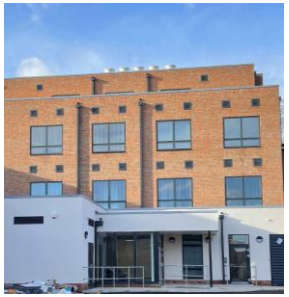
Investment in new Haringey GP Practice Premises

The Muswell Hill Practice – Opened 2022



Charlton House Surgery – Opened 2023

West Green Surgery – Opened 2022

Welbourne Health Centre – opened 2024

Current Active Projects - 25/26

- Rutland House Surgery – Muswell Hill – New surgery and colocation with its Queens Ave branch
- Hornsey Wood Green GP – Wood Green – New surgery
- Staunton Group Practice, Wood Green – Refurbishment project

Other Estates Activities – 25/26

- Hornsey Central, Crouch End – void reduction/space optimisation & utilisation.
- Laurel's Health & Wellbeing Centre - space optimisation & utilisation.
- Broadwater Farm Medical Practice – relocation.

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Other Investment Community Diagnostic Centres

NCL ICS operates **two Community Diagnostic Centres, both HSJ award** winners

1. **Larger hub** at Finchley Memorial Hospital in Barnet
2. **Spoke site** in Haringey's Wood Green Shopping City

- **@500,000 tests** have been conducted since opening
- Strong local engagement - **77% of patients** have been seen come from our **most deprived** communities
- **Strong links with GPs**, including referral dashboard & targeted communication to help increase footfall

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Next steps

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Next steps

This slide deck provides an overview of some aspects of the work being undertaken with general practice in North Central London. While access remains a high priority for the ICB and for patients and the population, we would ask the Health and Wellbeing board to NOTE that it is also important to protect the full range of functions of general practice, including proactive care for the more complex patients.

Our work plan for the coming year will include:

- Finalising the General Practice Ambitions and further development of the associated delivery plan
- Continued focus on improving the patient experience of accessing general practice
- Continued focus on proactive care and long term conditions
- Increased focus on continuity of care
- Increased focus on our structured approach to use of data and dialogue with practices to understand change support needs
- Review of the range of locally commissioned services commissioned by NCL ICB from general practice
- Support to general practice to engage in the development of neighbourhoods

We would like to develop an annual reporting cycle with Borough Health and Wellbeing Boards and Health Overview and Scrutiny Committees and as such would welcome comments from Haringey Health and Wellbeing Board on the aspects of the primary care work plan it would be most useful to understand and receive updates on.

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Appendices

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Appendix 1: NHS England Test Sites Programme

The PCN Test Sites Programme will be used at a national level to inform future GP contract(s) and should also inform local policy and commissioning. The National team hope detailed evidence will be collected to articulate the role and quantify the resources required to deliver modern general practice. The programme runs to 26/27 and will inform future proposals for the GP contract and funding envelope.

The programme seeks to understand the capacity gap in general practice and test solutions to close that gap. It audits met and unmet demand, staff capacity and the time required to deliver key functions, baselines investment (core and local) and takes a 'before and after' approach to identify the impact of interventions tested to narrow or close the gap. Participating PCNs have funding to take staffing levels to those described in the NHS Long Term Workforce Plan so these assumptions can be tested.

In NCL, 18 PCNs expressed an interest in participating in this programme, 14 submitted formal applications and 3 (max number) were selected:

- **Barnet PCN3** (Dr Nufar Wetterhahn); 7 practices; 69,334 patients (large elderly and care home population);
- **Camden Kentish Town South** (Dr Jonathan Levy); 2 practices; 29,870 patients (high burden of mental ill health); and
- **Camden West and Central** (Dr Rumshia Ahmad); 2 practices; 35,598 patients (large student population).

The programme formally launched in mid-September across 22 PCNs covering a population of just over 1m.

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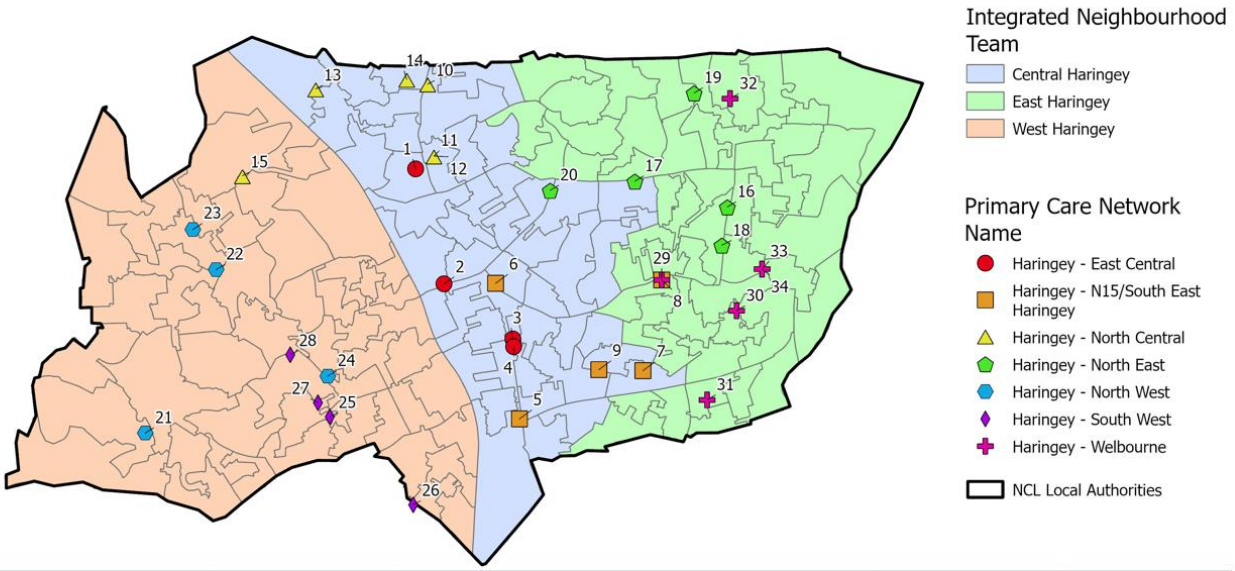
Appendix 2: Haringey Primary Care Landscape



Label	Practices Name	PCN Name	Label	Practices Name	PCN Name	Label	Practices Name	PCN Name
1	Staunton Group Practice	Haringey - East Central	13	Bounds Green Group Practice	Haringey - North Central	24	The Vale Practice	Haringey - North West
2	The Surgery (Hornsey Park Surgery)	Haringey - East Central	14	Cheshire Road Surgery	Haringey - North Central	25	The Christchurch Hall Surgery	Haringey - South West
3	West Green Road Surgery	Haringey - East Central	15	The Alexandra Surgery	Haringey - North Central	26	The 157 Medical Practice	Haringey - South West
4	The Old Surgery	Haringey - East Central	16	Charlton House Medical Centre	Haringey - North East	27	Crouch Hall Road Surgery	Haringey - South West
5	Bridge House	Haringey - N15/South East Haringey	17	The Morris House Medical Practice	Haringey - North East	28	Queenswood Medical Practice	Haringey - South West
6	Havergal Surgery	Haringey - N15/South East Haringey	18	Bruce Grove Primary Care Health C	Haringey - North East	29	Lawrence House (Dr Rohan)	Haringey - Welbourne
7	The Surgery (Grove Road)	Haringey - N15/South East Haringey	19	Somerset Gardens Family Health Ca	Haringey - North East	30	Tynemouth Road Health Centre	Haringey - Welbourne
8	JS Medical Practice	Haringey - N15/South East Haringey	20	Westbury Medical Centre (Steinberg	Haringey - North East	31	Fernlea Surgery	Haringey - Welbourne
9	St Anns Road Surgery	Haringey - N15/South East Haringey	21	Highgate Group Practice	Haringey - North West	32	Tottenham Health Centre	Haringey - Welbourne
10	Arcadian Gardens NHS Medical Centre	Haringey - North Central	22	The Muswell Hill Practice	Haringey - North West	33	The Surgery (Dowsett road surgery)	Haringey - Welbourne
11	The High Rd Surgery	Haringey - North Central	23	Rutland House Surgery	Haringey - North West	34	Tottenham Hale Medical Centre	Haringey - Welbourne
12	Stuart Crescent Health Centre	Haringey - North Central						

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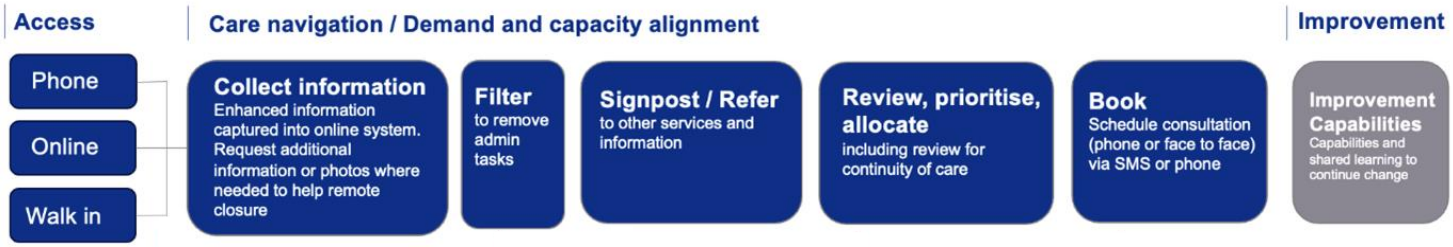
Appendix 3: Primary Care Access Recovery Plan - Modern General Practice Access model

The national Primary Care Access Recovery Plan describes a 'Modern General Practice Access' operating model, described as including the following elements:

- offering patient choice of telephone, online and in person access via highly usable and accessible practice websites, online consultation tools and improved telephone systems
- structured information gathering at the point of patient contact to understand what the patient needs
- using one process to assess and prioritise need safely and fairly, and to efficiently get patients to the right healthcare professional or service, in the appropriate time frame (including consideration of continuity of care) moving away from a 'first come first served approach'
- better allocating existing capacity to need, making full use of a multi-professional primary care team, community services and 'self access' options where appropriate, and helping GPs and practice staff to optimise use of their time to where it's needed most.
- building capability in general practice teams to work together and to access, understand and use data, digital tools and shared knowledge to lead, plan, implement, improve and sustain change.



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Appendix 3: Primary Care Access Recovery Plan
Support for practices to move to the modern general practice operating model 1/2

The ICB has taken a proactive approach to delivery of the national Primary Care Access Recovery Plan

Data driven review of likely support needs

At the outset of the programme we used data to initially stratify practices by likely need for change support to improve patient experience of access and successfully implement the modern general practice model.

We then tested the outputs of data analysis with ICB borough primary care teams and other stakeholders in the ICB incorporating primary care contracting, digital, estates, workforce to blend the quantitative view with soft intelligence that may explain why a practice's data looks the way it does. Where there were known reasons this informed the likely change management support that would be beneficial. MDTs have also reviewed practice requests for transition and transformation funding and made recommendations about when practices are most likely to benefit from accessing this.

Support Level Framework (SLF)

The General Practice Support Level Framework (SLF) is a national diagnostic tool for identifying a practice's own ambitions and any development and support needs, through a facilitated conversation between the practice team and external facilitators.

The SLF framework conversation covers six broad domains of general practice: Supporting access; Quality and safety; Leadership and culture; Stakeholder engagement; Workforce; Indicative data

The ambition is that over time all practices in NCL will take part in an SLF conversation. To date 59 practices across NCL have taken part in the clinically facilitated discussion. The SLF has helped the ICB work with practices to identify internal actions that may move a practice towards its goals and to co-design a change plan associated with the move to the modern general practice operating model.

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Appendix 3: Primary Care Access Recovery Plan Support for practices to move to the modern general practice operating model 2/2

Following the SLF discussion and depending on the practice action plan, there are two further offers of hands-on support that are available to practices.

Primary Care Access Recovery Plan (PCARP) change support

NCL ICB worked in collaboration with Islington GP Federation and NCL Training Hub to design and commission a supportive hands-on change management offer for practices who would most benefit, to help them improve patient experience of access and make the transition to modern general practice.

This offer has engaged with 53 practices for bespoke support and a total of 97 practices for a 'universal offer' of webinars.

The areas of support align with the six domains of support identified during the MDT meetings described above. Based on this work, IGPF have identified key recurring themes that have informed how they structure the support to practices. These themes include:

- Triage
- Website, Telephony & Digital Maturity
- Patient Engagement
- Understanding and using data - demand and capacity management

Case studies are also being produced to showcase the work of NCL practices.

General Practice Improvement Programme (GPIP)

The objectives of the improvement programme are to support practices and primary care networks to:

- Better align capacity with demand
- Improve the working environment
- Provide tools, guidance, resources to make the change easier
- Build on what other practices have learnt and developed

Hands on practice level support is delivered through weekly sessions in practice to enable practices to plan and deliver improvements.

To date 9 practices across NCL have taken part in the programme:

- 4 Haringey practices have participated and taken up this offer
- 1 Haringey PCN has taken up the PCN offer

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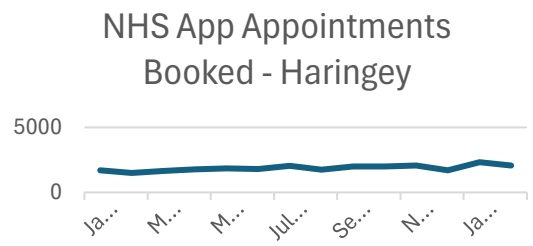
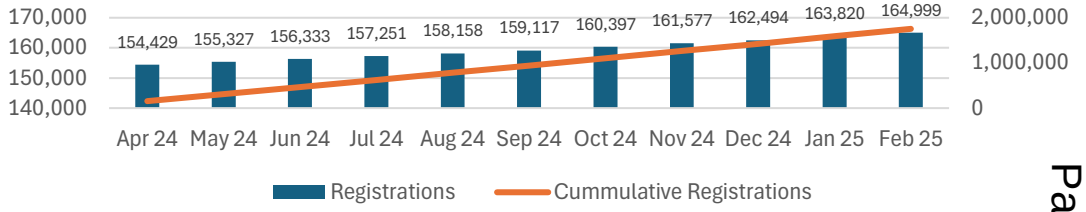
Appendix 3: Primary Care Access Recovery Plan
Use of the NHS App

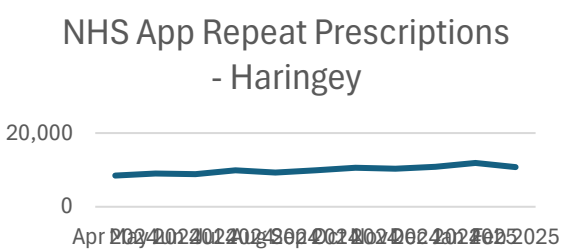
Appointment Booked



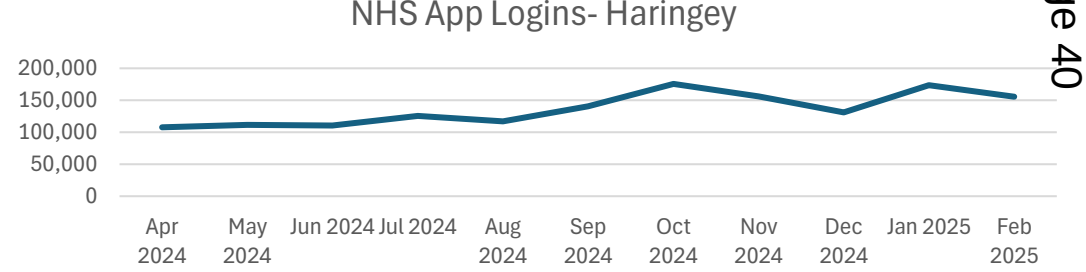
NHS App Registrations



Repeat Prescriptions



NHS App Logins



Key Insights

- **Steady Growth in Registrations:** NHS App registrations in Haringey have increased consistently, rising from **154,429 in April 2024 to 164,999 in February 2025**, demonstrating a positive adoption trend.
- **Appointments Managed via the App:** The number of **appointments booked** has remained stable with minor fluctuations,
- **Increasing Repeat Prescription Use:** The number of **repeat prescriptions ordered via the app** has grown steadily, indicating stronger patient engagement with digital prescription services.
- **Rising NHS App Logins:** NHS App logins have generally increased, peaking in **October 2024 and January 2025**, highlighting growing patient reliance on digital healthcare tools.

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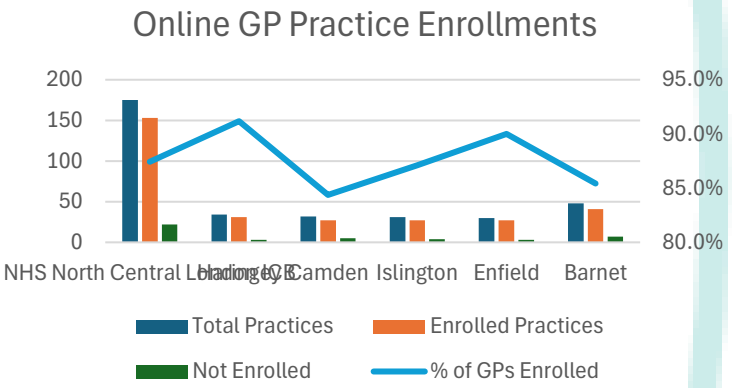
Appendix 3: Primary Care Access Recovery Plan Digital Access

Online GP registrations and enrolment:



- 31 of 34 Haringey practices have enabled online GP registration
- Haringey has the highest borough enrolment across NCL at 91%

Online Consultations:

The 2025/26 GP Contract requires practices to offer online consultations within opening hours (08:30 to18:30) Monday to Friday, from October 2025

There are a number of tools used to enable online consultations. Practices have a choice of tools and sometimes use a combination of tools to provide online consultations to their patients. Examples of these include:

- AccuRx
- eConsult
- Patches

The demand for online consultations, including Accurx and eConsult submissions, remains strong across North Central London boroughs. October 2024 saw peak usage, with a subsequent decline in November and December.

Haringey and Islington continue to show higher engagement, highlighting areas with sustained demand for online services.

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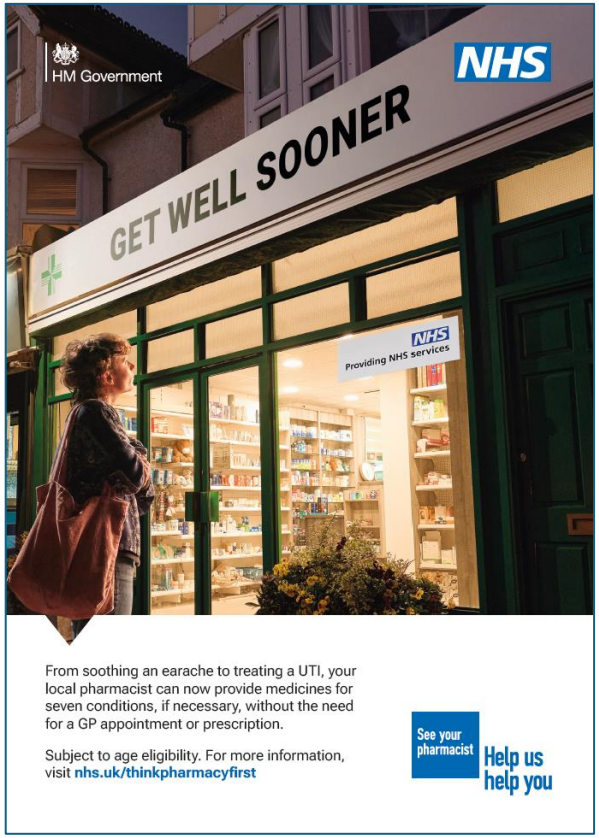
Appendix 3: Primary Care Access Recovery Plan

Pharmacy First service



- Almost all pharmacies now offer the Pharmacy First service, giving advice for minor ailments and conditions.
- If needed pharmacists can provide NHS medicines to treat seven common health conditions
- Walk-in service - removes the need for a GP appointment
- This service is available in 97% of pharmacies in NCL.
- Other pharmacy services include oral contraception and blood pressure checks.

PHARMACIES REGISTERED FOR PHARMACY FIRST	Yes	No	Grand Total
Barnet	70	2	72
Camden	59	2	61
Enfield	55	2	57
Haringey	52	3	55
Islington	44	1	45
Grand Total	280	10	290

Appendix 4: Your Local Health Team campaign 1/3

Phase 1 themes: October – December 2024

- **Get the care you need** – raising awareness of the three ways to contact general practice and equitable triage process that supports these
- **Get vaccinated, get protected** – encouraging eligible residents to get their flu, COVID-19, and respiratory syncytial virus (RSV) vaccinations
- **Stay well this winter** – sharing tips on staying well and encouraging people to seek help in the most appropriate setting and consider using the NHS App, and NHS 111
- **Meet your local health team** – introducing the different skilled professionals providing a range of services to increase trust and awareness

Phase 2 themes: December 2024 – April 2025

- **Meet your local health team** – creating new content and shining a light on the different skilled professionals providing a range of services to increase trust and awareness. New videos from Islington, Camden and Enfield have gone live on our YouTube and Website.
- **Pharmacy and self-care**– ensuring people are using the range of ways they can get the care they need, emphasising that many of these tools can increase the speed at which people get help.
- **Vaccinations in pregnancy** – highlighting the different vaccinations recommended during pregnancy, with content from trained healthcare professionals discussing the benefits of these vaccines and where to get them.

Phase 3 theme: April – July 2025

- **NHS App** – we have a core focus in Phase 3 on the NHS App, and are running a dedicated behaviour change campaign on encouraging people to download the app. Alongside this, we are working with GP practices to encourage them to 'turn on' the relevant functionality to allow patients to use a wider range of services on the App.
- **HPV vaccinations** – reminding people to get their HPV vaccines, using a variety of council created content such as the videos developed by Haringey Council.

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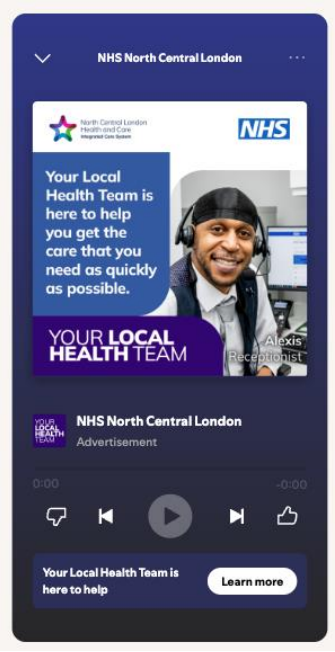
Appendix 4: Your Local Health Team campaign 2/3

Use of social media

We are using Spotify, Snapchat and Facebook to promote our messages. Our social media in February has been seen **over 1 million times. This is consistent with previous monthly performance.**



As well using a range of social media platforms, the campaign will be featured in outdoor advertising (bus stop adverts and digital screens) and adverts in some Council magazines.

The five NCL Councils and the NHS providers are all supporting the campaign.

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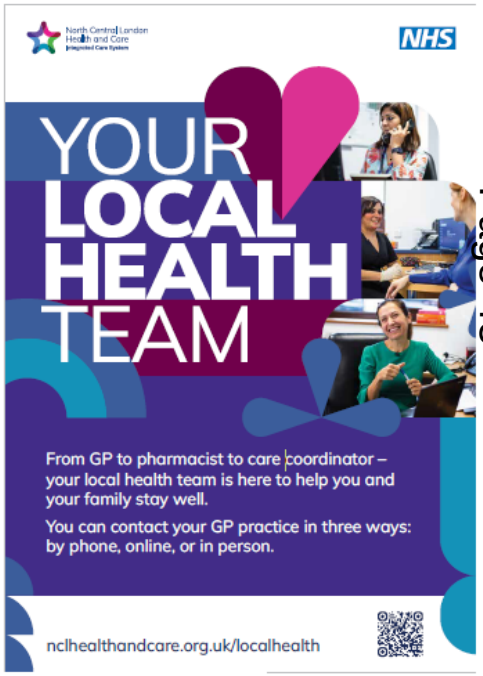
Appendix 4: Your Local Health Team campaign 3/3

Community engagement

- Advocacy approach via trained champion focussed on our most underserved communities, particularly around North Mid Hospital. In addition, Barnet has low satisfaction around general practice and aims will include changing this and building more trust with health services

Evaluation

- NHS App downloads
- Stakeholder feedback – from Councils and local community organisations
- Tracking QR codes
- Community Voices Panel survey – 1,000 local residents



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Appendix 5: NCL Long Term Condition Locally Commissioned Service (NCL LTC LCS): Outcomes

System / Borough level	PCN Outcome
NCL	Percentage of overall LTC cohort (which excludes CYP asthma only, low risk hypertension only, and low risk adult asthma only) with a completed personalisation outcome measure in the preceding 12 months at end of year (specific format for care plan and follow up forms provided)
NCL	Percentage increase in people on the hypertension register with well-controlled blood pressure (thresholds provided)
Haringey	Percentage of the LTC population referred to a lifestyle intervention service
Haringey	Percentage of people under 75 years of age who have a diagnosis of Non-Alcoholic Fatty Liver Disease, with a Fib 4 score (measure of risk of liver fibrosis) in the last 3 years
Haringey	Percentage of people on the diabetes register who have had all 8 care processes completed in the preceding 12 months at end of year.

- There is a suite of 32 outcomes in the LTC LCS outcomes framework.
- Practices/PCNs are working towards achieving all of them throughout the year, however for 24/25, there were 5 outcomes that were incentivised for Haringey practices to achieve.
- 2 were NCL-wide outcomes and 3 borough specific, which were selected by Haringey clinical leads and practices.

North Central London Health and Care
Integrated Care System

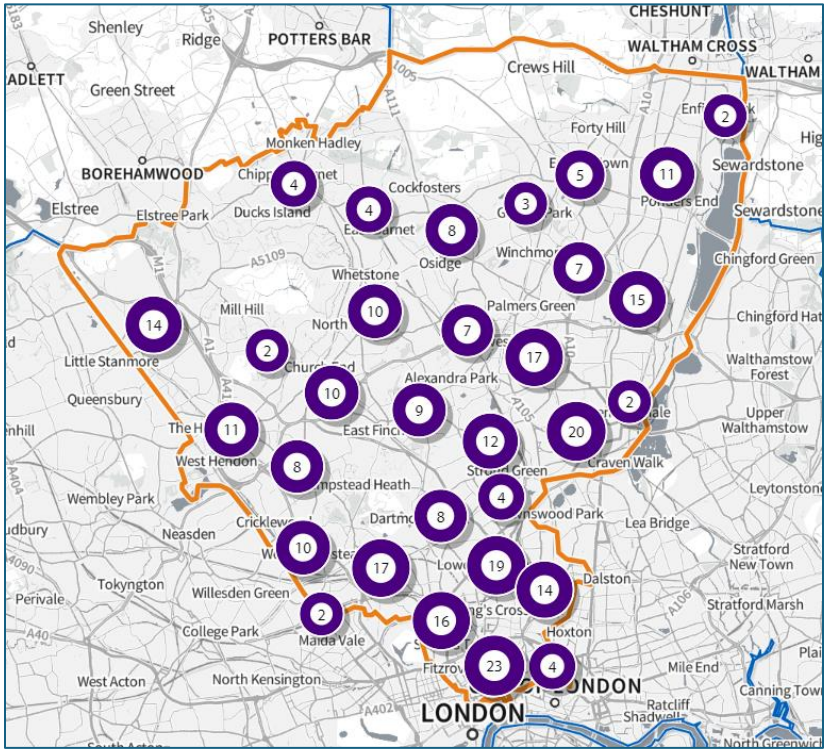
NHS

Community Pharmacy NCL update

Haringey Health and Wellbeing Board 27th March
Rachael Clark, NCL ICB Medicines Optimisation Team

North Central London Health and Care
Integrated Care System

Pharmacy – at the heart of our communities



Source: ShapeAtlas

- Haringey has 54 community pharmacies; 289 across NCL.
- Community pharmacies are accessible, and often in areas of higher deprivation.
- 89.2% of the population in England can access a community pharmacy within a 20-minute walk, and access is greatest in areas of highest deprivation.
- Community Connectedness and friendships – community pharmacy is an untapped resource for Haringey. For many communities their pharmacy is an informal resource for social and emotional support due to the accessibility of the pharmacist.

Community pharmacy services

North Central London Health and Care
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NATIONAL		REGIONAL	NCL ICB/PH
Essential Services	**Advanced Services**	**Enhanced Services**	**Locally Commissioned Services**
1. Dispensing Medicines 2. Repeat Dispensing and eRD 3. Dispensing Appliances 4. Disposal of unwanted medicines 5. Support for Self Care 6. Signposting 7. Healthy Living Pharmacies 8. Public Health (Promotion of Healthy Lifestyles) 9. Discharge Medicines Service (DMS)	1. Flu vaccination service 2. Pharmacy First 3. Hypertension case-finding service 4. New Medicine Service (NMS) 5. Appliance Use Review (AUR) 6. Stoma Appliance Customisation (SAC) 7. Smoking Cessation Advanced Service 8. Contraception service	1. London Vaccination Service 2. COVID-19 vaccination (national)	<u>Local Authority / Public Health</u> • Needle Exchange • Supervised self-administration • Stop Smoking Service • Emergency Hormonal Contraception (EHC) • Condom Distribution <u>ICB</u> • Supply of End-of-Life medicines (EoL) • Self-Care Medicines Scheme (SCMS) • Bank holiday rota

Community Pharmacy England https://cpe.org.uk/national-pharmacy-services/

Pharmacy First Service

North Central London Health and Care Integrated Care System

- The Pharmacy first service consists of three elements:

Pharmacy First (NHS referrals for minor illness)	Pharmacy First (urgent repeat medicine supply)	Pharmacy First (clinical pathways)
✓ Previously commissioned as part of community pharmacy consultation service (CPCS) ✓ Referrals from GP practice and NHS111	✓ Previously commissioned as part of CPCS ✓ Referrals from NHS111	✓ New element ✓ Referrals from GP practice and NHS111 or walk-in

- Contractors MUST provide all 3 elements (only exception is distance selling pharmacies do not need to do otitis media pathway due to need to use otoscopes).
- By 31st March 2025; any contractor wishing to provide Pharmacy First should also provide Pharmacy Contraception and Hypertension Case-Finding Service.

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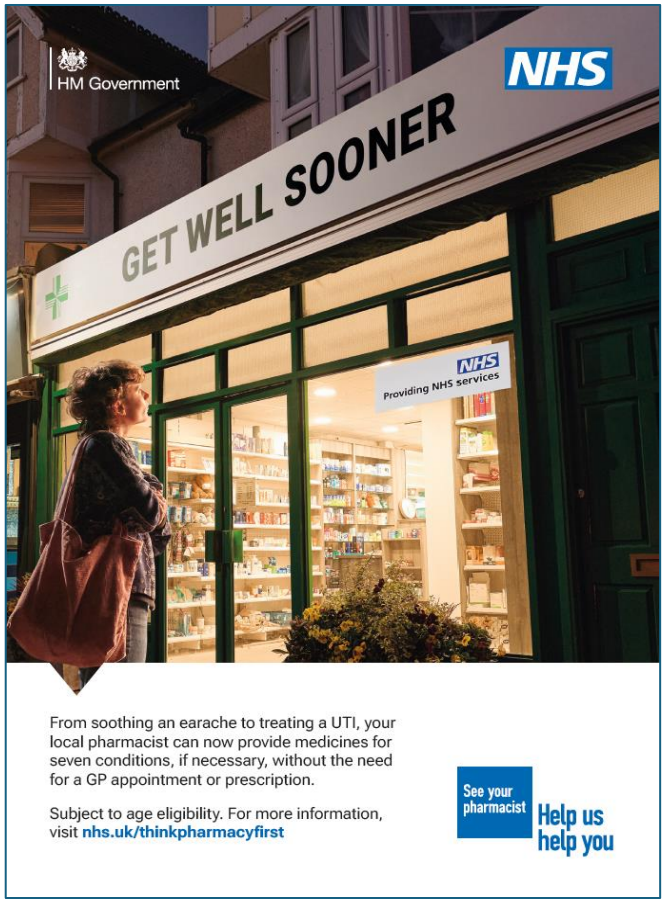
Pharmacy First Service



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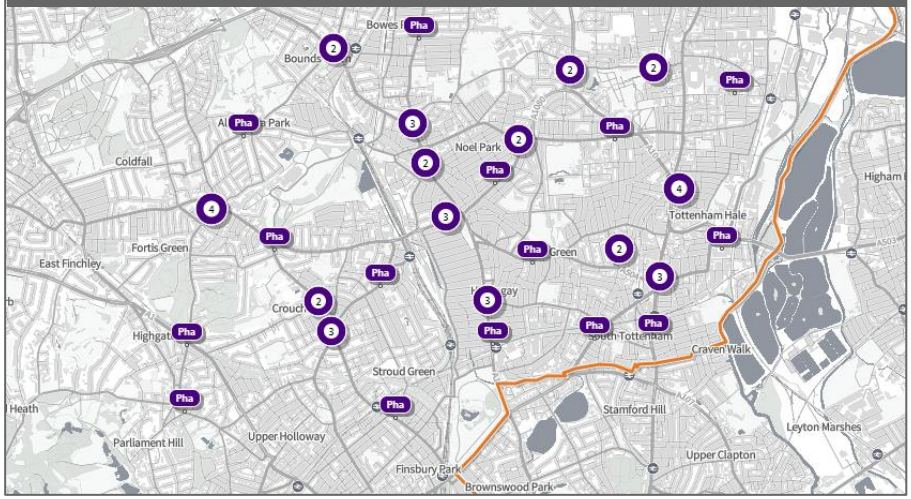
Haringey	52	2	54
Islington	44	1	45
Grand Total	278	11	289

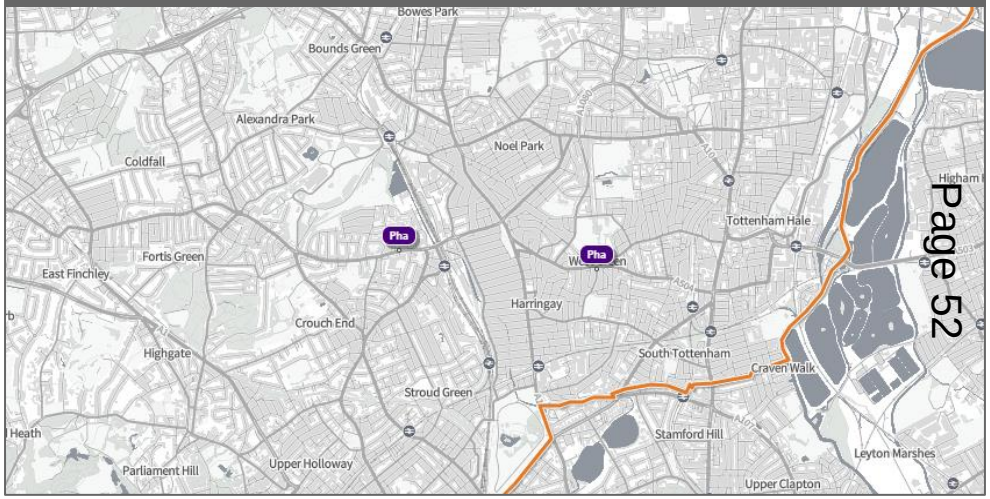
North Central London Health and Care
Integrated Care System

Pharmacy First: Haringey (Feb 25)

Haringey pharmacies offering Pharmacy First:



Haringey pharmacies NOT offering Pharmacy First:



Borough	No	Yes	Total
Barnet	2	70	72
Camden	3	58	61
Enfield	3	54	57
Haringey	2	52	54
Islington	1	44	45
NCL Total	**11**	**278 (96%)**	**289**

North Central London Health and Care
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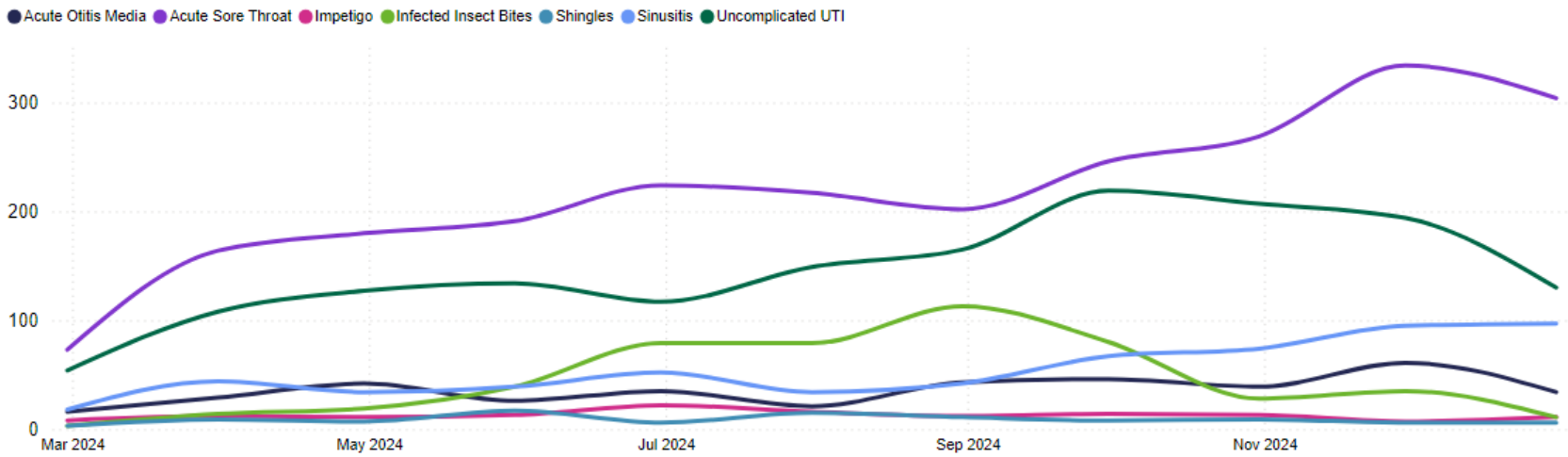
Pharmacy First conditions: Haringey



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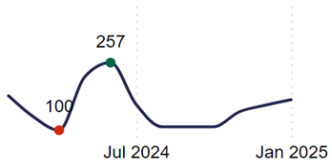
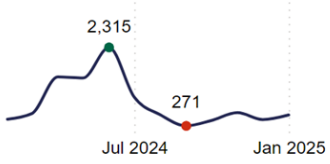
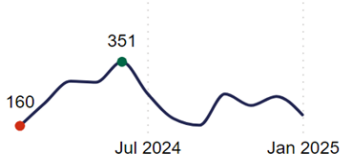
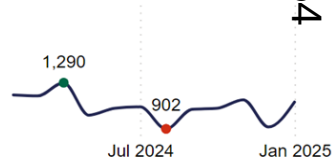
Pharmacy First activity

Barnet	Camden	Enfield	Haringey	Islington
6,235	1,849	10,289	2,839	13,074
Jan 2025: 550	Jan 2025: 171	Jan 2025: 556	Jan 2025: 193	Jan 2025: 1,128
Change from Dec 2024: -102 ↓	**Change from Dec 2024: 13 ↑**	**Change from Dec 2024: 119 ↑**	**Change from Dec 2024: -55 ↓**	**Change from Dec 2024: 210 ↑**
Percentage Change: -15.6%	Percentage Change: 8.2%	Percentage Change: 27.2%	Percentage Change: -22.2%	Percentage Change: 22.9%
Rate Per 1000*: 15.3	Rate Per 1000*: 5.3	Rate Per 1000*: 30.8	Rate Per 1000*: 8.7	Rate Per 1000*: 42.8
Practices without Referral in last three months: 33.3%	Practices without Referral in last three months: 40.6%	Practices without Referral in last three months: 38.7%	Practices without Referral in last three months: 58.8%	Practices without Referral in last three months: 9.7%

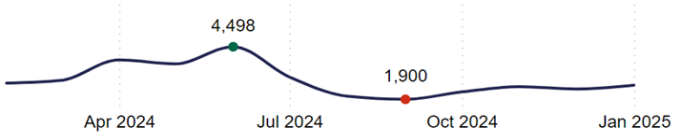








NCL has had 34,286 GP referrals with 2,598 in Jan 2025. This is an increase on Dec 2024 of 185 and a percentage change of 0.1%. NCL has a referral rate of 19.9 per 1000 with 36.4% practices without any referrals in the last three months.



59% of Haringey GP practices have not sent a referral in the last 3 months (highest in NCL).

*This is a general rate per 1000 and is not standardised for age or gender.

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NCL Self Care Medicines Scheme (SCMS)

Who can use this service…
Patients aged under 16 years who have at least one parent who would be eligible for this service
Patients who are receiving Universal Credit and whose income is at a level where theyare eligible for free prescriptions. Patients receiving any other benefits which give them eligibility for free prescriptions: • NHS Low Income Scheme and are in possession of a valid HC2 certificate. • Income Support (IS) or Income-related Employment and Support Allowance (ESA) • Income-based Jobseeker's Allowance (JSA) • Tax Credit exemption certificate • Pension Credit Guarantee Credit
Young people aged 16,17 or 18 years **and** • in full-time education, part-time education, or undertaking an accredited level 1 apprenticeship • Homeless and in possession of local authority 'Letter of homelessness'

Further info: https://fepe.org.uk/dispensing-and-supply/prescription-processing/receiving-a-prescription/patient-charges/exemptions/

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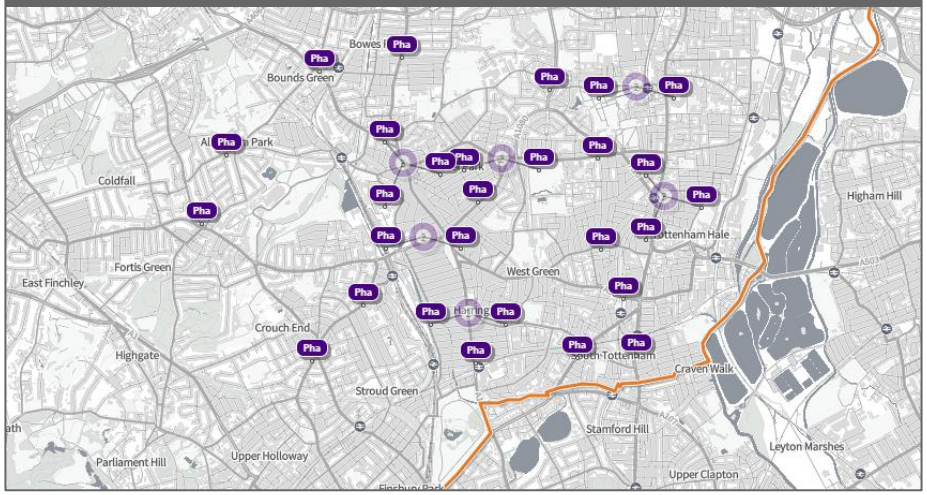
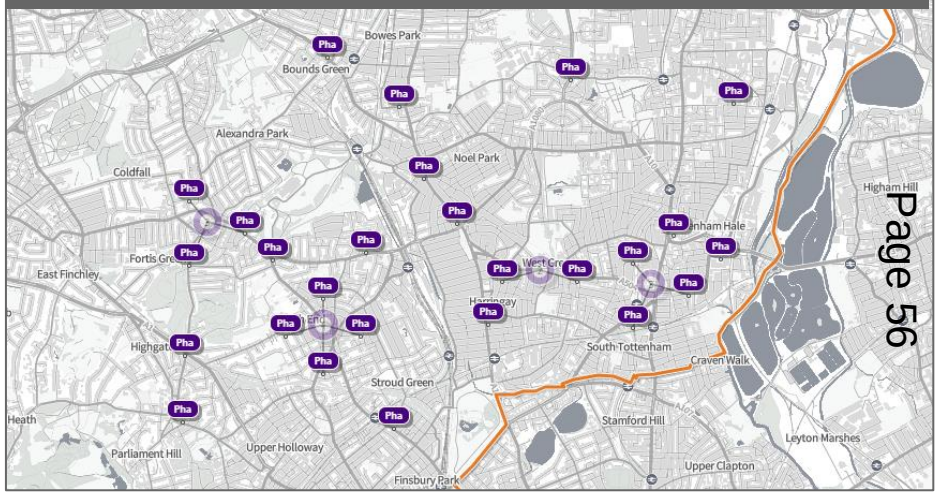
Self Care Medicines Scheme: Haringey

(Feb 2025)

Haringey pharmacies offering Self-Care Medicines Scheme:



Haringey pharmacies NOT offering Self-Care Medicines Scheme:



Borough	SCMS Consultations (Jun 24- Feb 25)
1. Islington	4353 (56%)
2. Camden	2128 (27%)
3. Haringey	777 (10%)
4. Enfield	565 (7%)
5. Barnet	8 (0.1%)

Borough	Registered	Not registered	Total
Barnet	21	50	71
Camden	29	32	61
Enfield	24	33	57
Haringey	29	25	54
Islington	35	10	45
NCL Total	**138**	**151**	**289**

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NCL SCMS activity: June 24 – Feb 25

7831 consultations June - Feb 2025

87% of patients would have gone to GP

83% of consultations were self-referred

56% consultations were in Islington

47% patients under 16

8 patients required onward referral

Source: PharmOutcomes claims data for 1/6/24 – 28/02/25, accessed March 2025.

Healthy Living Pharmacies

- **23 pharmacies in Haringey are commissioned by Haringey Council Public Health Team to be Healthy Living Pharmacies**
- **These pharmacies provide a range of free services**
  - **substance misuse services** – needle exchange, naloxone and supervised consumption
  - Smoking cessation services
  - Healthy start vitamins
  - Sexual health services – STI testing and treatment, HIV point of care testing, Emergency contraception, Free condom schemes for young people and for adults

START • LIVE • AGE
WELL
HARINGEY BOROUGH PARTNERSHIP

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Haringey Health and Wellbeing Board

Neighbourhoods & Integrated Neighbourhood Teams

March 2025

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Context

Neighbourhoods are the third pillar of our ICS. Reinforced by Fuller, Darzi & the three shifts and government focus on a *'neighbourhood health service'* expected in the10 Year Plan. London is collaborating on a case and outline model.

Neighbourhoods pivot to integrated, proactive & community-oriented models. Multidisciplinary input, population health management techniques and innovation are essential. Individuals & VCSE are critical partners.

They are a key vehicle for integration and for public sector sustainability plans, which consistently focus on community-based support, mitigating complexity and building individual & community assets.

There has been a lot of work locally and progress. However, a significant gap still exists between vision and delivery. Despite efforts we have struggled for the step change our patients/residents want to see and we want to achieve. Services are struggling to support more complex needs; interdependent teams work in parallel for the same people & communities; staff do not have time for prevention and continuity; beyond the individual very few see the 'whole picture'; and outcomes are a struggle & inequalities persist.

Major reform delivered largely via existing resources needs shared focus, appetite and widespread sponsorship.

We need to set priorities, agree '*what needs to be true*', point assets at this approach (workforce models, infrastructure, data, financial flows), and mobilise at scale. We need system support for enduring change.

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NCL has strong foundations

There is growing consensus around **three key focus areas for neighbourhoods: targeted prevention, proactive care for chronic and complex needs, and fostering strength and resilience in individuals & communities.** In NCL:

- The Population Health Strategy & Outcomes capture agreed priorities to anchor the neighbourhoods.
- Borough Partnerships are bought into neighbourhood working as a model for population health improvement.
- Major programmes and service developments in NCL give us key building blocks:
  - Long Term Conditions – core offer, vertical integration with secondary care, innovation
  - Core offers for community & mental health and strong relationships with council teams
  - CYP integration and Family Hubs
  - Hyper-local prevention offers (vax, screening, pharmacy) with outreach and health on the high street, partnering the VCS
  - Work Well – providing a vehicle through which employment outcomes for those managing complexity and LTCs can be improved
- We have a highly engaged VCS providing services, voluntary capacity and routes to partners with our diverse communities and community leaders.
- We have active and innovative Primary Care Networks willing to work on broader geographical footprints to enable integration with other services.
- We have a mature and innovative approach to infrastructure and estate across health and local government.

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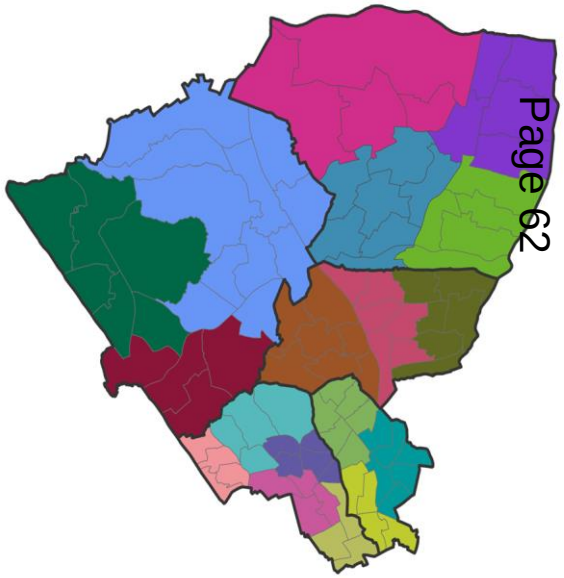
Neighbourhoods in NCL

- Neighbourhoods are footprints on which teams integrate, services work together, and local infrastructure and community assets are developed. There is emphasis on prevention, proactivity and local care, underpinned by shared infrastructure, data and insight, technology and workforce reform.
- Integrated Neighbourhood Teams (INT) build on MDTs and include NHS providers, council teams and the VCS. Specialists support. Patients an residents are key partners.
- Borough Partnership work to date suggests at least **18 neighbourhoo in NCL** with populations of 60,000–130,000.
- We would expect each to have:
  - ✓ **Leadership and management capacity** to support caseloads, systems, processes, training & development, and accountability – including an '*integrator function*' as per recent London work
  - ✓ **Shared infrastructure** (IT, co-location where possible but flexi spa & networked models where necessary, population health data)
  - ✓ **Wider delivery capacity** (including high street services)
  - ✓ **Strong relationships with local communities and the VSC –** stability for VCS partners, expertise in person-centred care and strengths-based approaches

18 NCL Neighbourhoods identified by Borough Partnerships



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The change sought

System

- Health & local government challenged by complex & episodic need
- *'Failure demand'* – silos, disjointed provision, inefficiencies
- Unwarranted variation and inequity in outcomes
- Resources reducing with inflation

System

- ✓ Finding and supporting target populations – risk stratify, engage & learn, close prevalence gaps, reduce disparities
- ✓ Dedicate capacity to proactivity, continuity, and prevention
- ✓ Integrate provision– efficacy and efficiency in patient journey and outcomes
- ✓ Optimise statutory *and* individual & community assets

Patients & residents

- Complex bio-psycho-social needs; wider determinants impact motivation, engagement & outcomes
- Services seen as unresponsive and disjointed
- Confusion around access (statutory & wider support)
- Social isolation - sense of community challenged
- Lack of trust and confidence in offers made

Patients & residents

- ✓ Recognition that services talk to each other and problems get solved
- ✓ Equipped to stay well for longer & have more control
- ✓ Relevant and effective offers from professionals
- ✓ Clarity about steps to avoid illness & where to access help

Staff

- Struggling to provide the care they want to/may not see a future
- Thresholds for support increasing, gaps in pathways emerging
- Capacity for proactivity and continuity is squeezed out
- Struggling to arrange support for the most complex people

Staff

- ✓ Work together to avoid handoffs and unnecessary red-tape
- ✓ More focus on multi-morbidity, complexity & wider determinants
- ✓ Can leverage a diverse range of assets to help address drivers of poor health outcomes – which may not be about medical care at all

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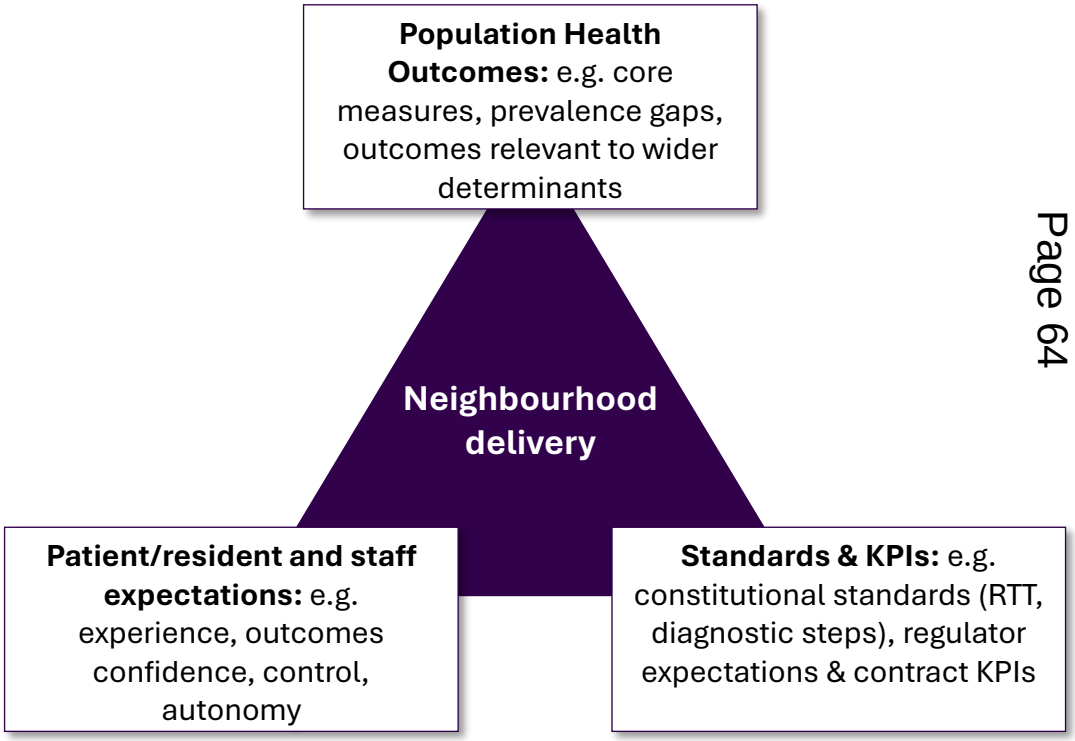
Impact

We believe neighbourhoods can help tackle three core sets of measures:

- Popultion health outcomes – the opportunity to deliver health & care differently and purposefully improve population health
- Standards – addressing core and statutory requirements to support operational needs and wider credibility
- Patient/resident and staff expectations – neighbourhoods will be rooted in communities, understanding or responding to their needs

Significant work is needed around benefits realisation including defining the range of potential benefits and impacts, monitoring and attribution.



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Examples of work to date

Camden:
- Five established localities/neighbourhoods
- East INT team fully established in dedicated space at Kentish Town Health Centre supported by ICB
- Two years to land - council & CNWL formally consulted staff and moved into neighbourhood teams
- GP leadership & engagement
- Brings together housing and safety as well as health and social care
- Civic and community powered work a key feature
- Initial focus is alignment of existing caseloads but LTCs, older adults and tenants experiencing complexity are a priority
- Opportunities in the West and North being developed

Islington:
-Three established localities/neighbourhoods
Whittington community staff aligned to locality
MDTs fortnightly on smaller footprints - general practice, social care, community matron, mental health, VCS navigator
Paediatric MDTs now set up
Council access hubs in each locality for early help and support
Nascent leadership teams keen to build clear roles and responsibilities

Haringey:
- Three established localities/neighbourhoods
- Social care, community mental health and community services (therapies and DNs) aligned to neighbourhood footprint
- GP leadership & engagement
- Online MDTs
- Council community hubs (e.g. *Northumberland Park Resource Centre)* for early help and support & NHS on drop-in basis
- Council Community Coordinators and GP Fed sponsored clinical leads but funding reducing
- Looking at how services can operate fully on neighbourhood footprint
- MACC team an exemplar early-stage INT – good practice being shared with London region drawing on evaluation of impact, and cited in Chris Witty's report on Cities and Health

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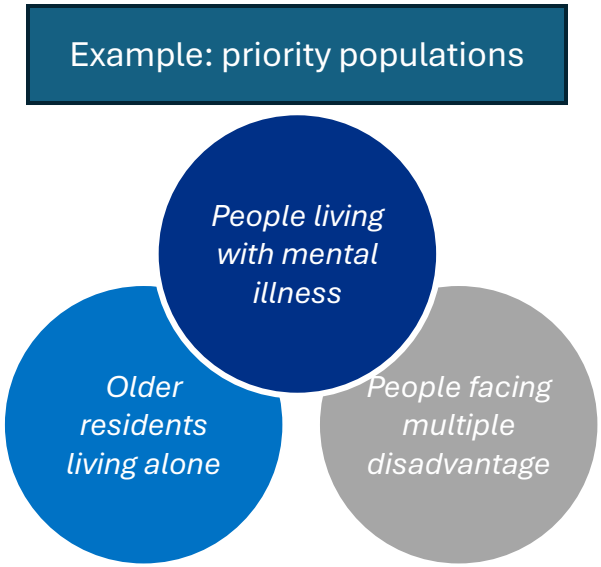
Integrated Care System

Population cohorts

- The model should be **relevant to multiple population cohorts** and there is a clear link to the population segmentation work being discussed.
- **Each Borough Partnership has a view on its priorities**, informed by their understanding of the local population, gaps in outcomes and service pressures.
- We expect government to seek a **neighbourhood health offer 'for all'** – accelerating our integrated and proactive approach to **prevention** through each neighbourhood could provide such an offer. The impetus and levers for this will deepen again with future delegation to ICBs of specialised commissioning and Section 7a immunisation services.
- However, transformation at scale and pace benefits from some focus and consensus. We expect policy may point to those living with **multiple and complex long-term conditions** and have a very strong platform on which to build in NCL.



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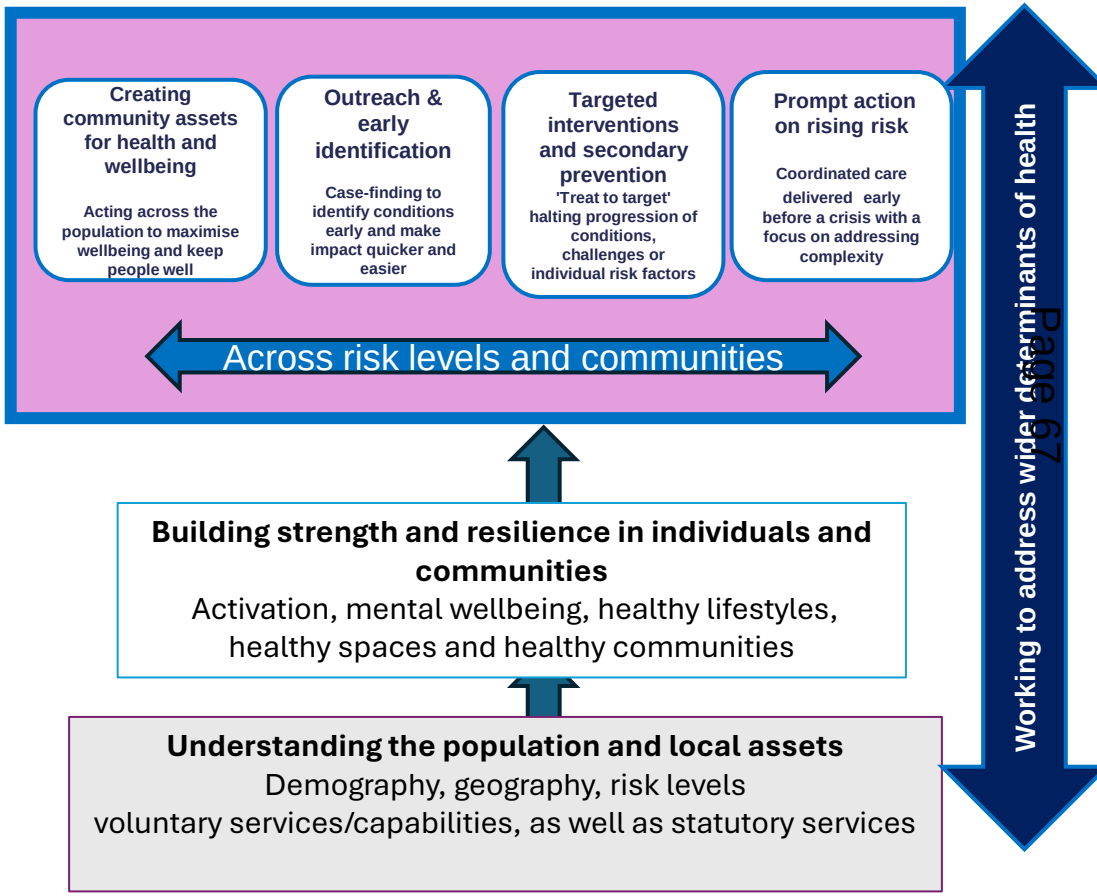
Key features

- The distinctive feature is the **purposeful and consistent connection between the context of people's lives and the support offered** to increase efficacy and achieve improved outcomes.
- The **link between statutory and voluntary services** is also fundamental. Voluntary services are the bridge to communities and offer hyper-local, trusted support for those most in need.
- This is a **person-centred and asset-based** approach to generate individual and community strength and resilience.
- Action is rooted in a more **sophisticated understanding of the population and drivers of variation in outcomes**. Population health data + qualitative insight + co-production.
- **Can be applied to a range of population groups and priority cohorts** and works meaningfully across the life course (Start, Live, Age Well).



A day in the life...

North Central London Health and Care
Integrated Care System

Scoping the difference – how integrated neighbourhood teams are going to look and feel

- ✓ **Ring-fenced time** to focus on prevention, early intervention and proactive care – weekly at minimum – to focus on the four pillars
- ✓ **Coordinated acute input** to reduce duplication and provide specialist input (e.g. geriatrician, LTC consultant)
- ✓ A **leadership team** made up of statutory services across housing, employment, public health, community care, primary care, and nominated VCS
- ✓ **Act as a place to problem solve**, unblock or take additional action
- ✓ **Able to connect with the Borough Partnership** to discuss gaps or strategic need

- ✓ **Links to local services** to coordinate action
- ✓ **Teams that know each other and know local resources**
- ✓ **Insightful integrated data** linked to each of the pillars which can be seen in aggregate to understand trends and at individual level to build targeted lists; risk stratified and segmented
- ✓ **Neighbourhood Manager** to facilitate and coordinate
- ✓ A growing **network of traditional sites moving toward becoming holistic, MECC-focused neighbourhood hubs focused on proactive care and early intervention**

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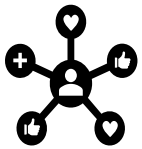
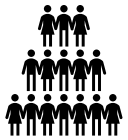
Integrated Care System

Team features (*draft*)

Borough Partnership: owns the local implementation plan, priorities and outcomes. Oversees efficacy. Hosts the **'integrator function'** – accountable for development of the model, senior managerial/operational, technical support, analytics, estates planning, training, reporting. Shares learning and understands variation. Supports the community development effort. Key role in assessing VfM. Connections to innovate and optimise local assets



Integrated Neighbourhood Team (INT): core team of health, local government and VCS. Expect 80/20 rule to apply on offer and roles, e.g. expected membership from General Practice, Community Pharmacy, Adult Community, Mental Health, Social Care, Housing & Repairs, Public Health, VCS. Will link to wider NHS services (e.g. Specialist) and Local Government (e.g. economic development, early help, children and families). Works with more complex caseload and supports proactive outreach, prevention and earlier intervention. Patient/resident is a partner in their care.



Neighbourhood network of services & support: local care capacity & capability strengthened and aligned to the neighbourhood model as part of the 'left shift'. Includes teams from core services above. At least in short term will still deliver a large % of care episodes. Will interface with INT and be mobilised to support outreach, prevention, and earlier intervention via a population health approach.

System support (including role for provider alliances):

- Connects to policy
- Strategic commissioning for the neighbourhood model – aligning principles, pathways, incentives
- Learning from borough-level implementation
- Tackling key enablers once where possible (data sharing, data products, workforce planning, estates principles and plans, HR framework)
- Streamlining route into specialist support.
- Helps unblock key issues that can't be resolved by teams
- Coordinates formal decision making where system-wide
- Seeks income, assets & innovation to support the effort

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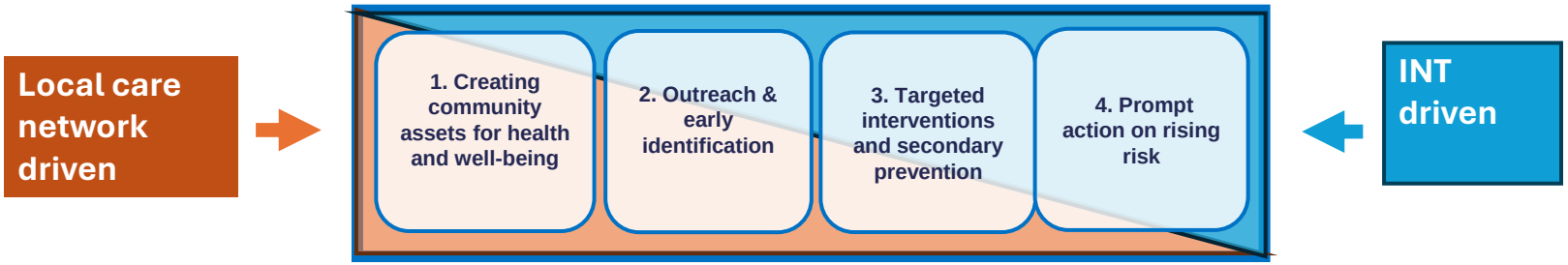
Neighbourhoods and INTs

Across the four pillars of proactive care, the INT will play a specific role within the wider neighbourhood's local care network (i.e. the statutory and voluntary services and partners that make up the neighbourhood), with greater input and leadership in pillars three and four.

At every point, person-centred and strengths-based approaches, patient activation, personalisation and holistic support are at the heart.

In **pillar one: creating community assets for health and well-being**, local government, VCS and Public Health leadership is strongest, creating the context for **thriving communities** and an improving context for health and wellbeing.
In **pillar two: outreach & early identification,** primary care drives case-finding, the local care network plays an increased role in closing prevalence gaps, underpinned by common data insight and coordinated by the INT leadership. Work with communities, supported by trusted VCS and others, to tailor the offer and outreach, reaching individuals and communities not engaged by existing offers.
In **pillar three: targeted Interventions,** the focus is on close working to ensure that all local resources are mobilised to support targeted work to close treatment gaps and provide early help. MECC strategies and coordination across the local care network is key.
In **pillar four: rising Risk,** INT leadership is most comprehensive, where the need for individual care coordination or case management is greatest. This could be to manage bio-psycho-social complexity, where multi-agency input is most needed to address rising risk or as part of the step-down from acute care where ongoing support for risk is needed. Coordinated primary, community and secondary care input is streamlined. There is a case-load and accountability needs to be clear and unambiguous.



North Central London Health and Care
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Neighbourhood teams

Proactive and preventative care and support

- Building a picture of our existing caseloads and increasing the efficacy of our support
- Finding people before their needs deepen or intensify and/or those who are at rising risk
- Provide early support to get ahead of future needs
- Person-centred planning and support

Supports innovation in local care

- Creating space for teams to identify, plan for and respond to hyper-local needs
- Innovation in workforce and delivery models
- Person-centred, asset based & inclusive of VCS groups and patients/residents
- Shaping and adopting innovation (technology, new roles, alternate methods & modes of delivery)

Integrated delivery teams

- Comprising **primary care, community, mental health, local authority (social care and wider services), VCS, pharmacy**
- Majority of their time working together
- More integrated leadership and management capacity
- Support from Place and System to overcome the barriers to proactive and integrated working

Connects processes, tools and models of practice

- Brings caseloads together, reorganises the working week
- Risk stratification & care planning - optimising intervention and support offers
- Aligning around outcomes & standards
- Adopting a new approach to risk
- Sharing data and intelligence. Culture of continuous improvement and willingness to learn by doing

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Workforce implications of neighbourhood working

Mobilising neighbourhoods across NCL implies profound change in the way that staff are employed, deployed, developed, and supported:

Supply

- Scoping/deploying new roles (e.g. Neighbourhood Manager, Health Coach, vaccinators, health and wellbeing workers)
- Supporting patients and residents to overcome health-related barriers to employment
- Integrated workforce planning between INT partners (coordinated at 'place')
- Promoting opportunities to work across statutory, non-clinical and voluntary roles

Development

- Supporting new roles
- New learning & development packages – embedding skills to lead/work in partnership
- Joint development pathways within INTs (including rotations)
- Testing whether INTs foster joy at work by providing a collaborative and creative environment - tracking staff experience on this

Transformation

- Joint workforce planning and oversight across partners – data, modelling
- Creating 'team of teams' culture through new INT 'rhythms & rituals'
- Developing new models of practice through population health data and tools
- Fostering innovation in ways of working/models of care through dedicating staff time

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Where are we now in Haringey?

Some activity mapped against the four pillars

Creating community assets for health and well-being Acting across the population to maximise wellbeing and keep people well	Outreach & early identification Case-finding to identify conditions early and make impact quicker and easier	Targeted interventions and secondary prevention Halting progression of conditions, challenges or individual risk factors	Prompt action on rising risk Coordinated care delivered early before a crisis with a focus on addressing complexity
• VCS grassroots projects • Parks and leisure • Culture and arts • Public health programmes • Anchor institutes • Public realm and regeneration • Community centres (NRC) • Welfare and related advice	• GP's LTC model with case-finding • Health-checks • Community outreach from NHS/VCS partnerships • Schools in-reach and health visiting • Haringey Health Champions • 4 x Family Hubs • Data-led identification of financial strain • Responding to rent arrears	• GP's LTC model with care plans • Community NHS team delivery • Social care services to sustain independence • Housing related support and advice sector	• MACC team – INT exemplar • GP teleconference • Multi-agency solutions forum (LBH) • Rapid Response team • Roger Sylvester Centre • MASH hub and adult safeguarding • Incident response arrangements

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Question for HWBB

How can we utilise the neighbourhoods' agenda to impact positively on health and wellbeing in Haringey?

Adult Social Care CQC Inspection Outcome Health and Wellbeing Board

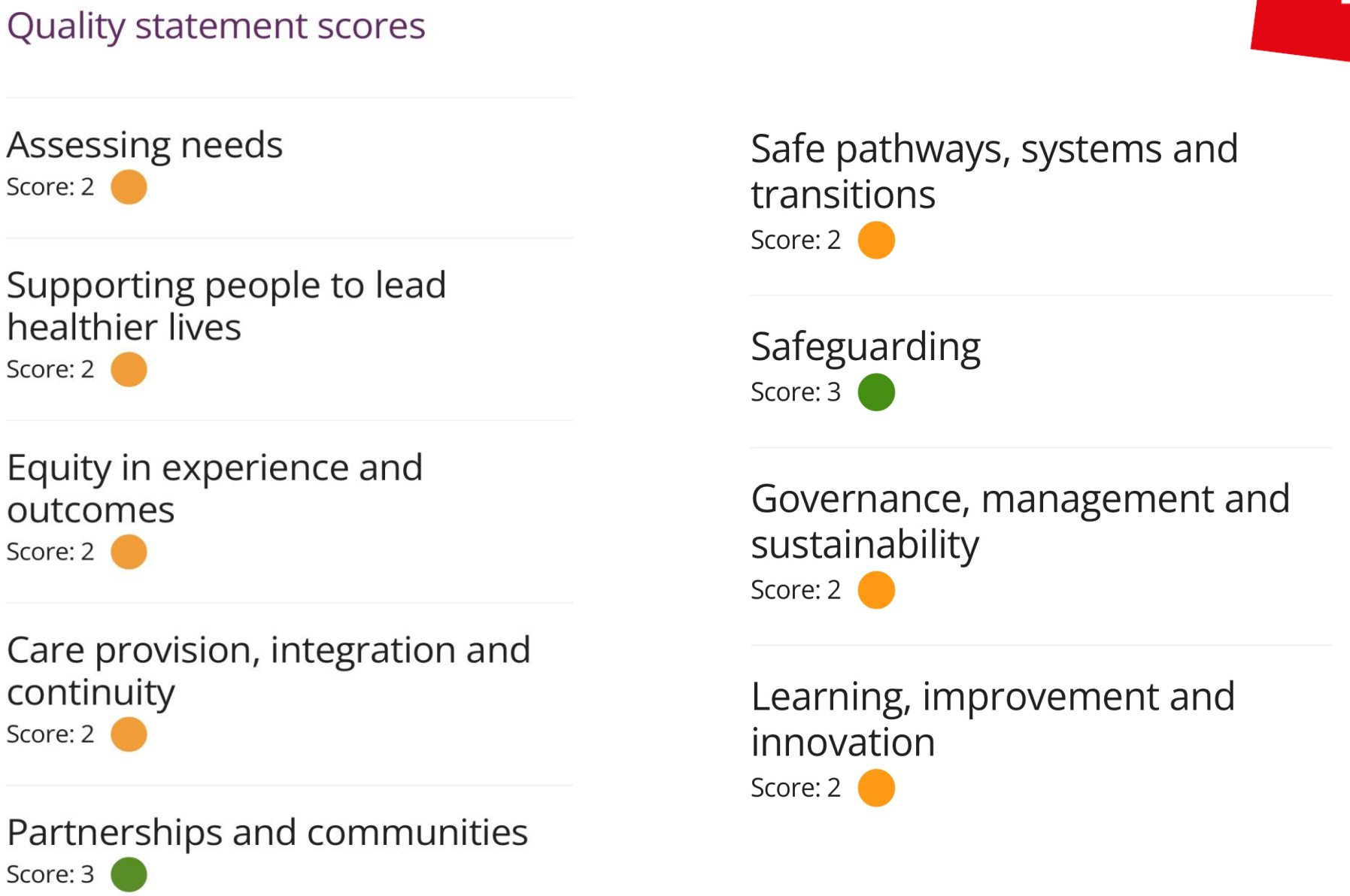
March 27th 2025

Overall score

London Borough of Haringey

Requires improvement

Quality statement scores



Overall score

Overall Summary

Local Authority rating and quality statement scores
Requires Improvement: Evidence shows some shortfalls

Summary

1. Experience of care and support was mixed
2. Most feedback from unpaid carers was negative and related to the availability, quality and outcomes of assessments
3. Carers will access to support fedback that staff were responsive and supported them
4. Assessments were broadly person-centred, strength-based and reviewed people's needs but
5. Timeliness of assessments and reviews were a barrier for people
6. Contacting the local authority was also a barrier, with information not always being accessible
7. People had positive experiences of being supported by multi-agency integrated teams which enabled people to access services and stay independent
8. There were mixed experiences of transitions between services such as Children's to Adult's services
9. Most people who used services felt safe but contact with people and partners following safeguarding referrals was not always consistent.
10. People were receiving increased engagement through coproduction activities such as carers and coproduction groups.

Theme 1. How the Local Authority works with people

Assessing Needs

Strengths

- people who already had an allocated worker told us their workers were contactable and responsive to them.
- The local authority had adopted their own model of strengths-based practice to support person-centred assessments and deliver outcome focused support for people and staff teams told CQC they used a person-centred and strength-based approach.
- Referral pathway arrangements supported co-ordinated approaches across different agencies and services. For example, the learning disability service had multi-disciplinary pathways to support co-ordination, including a complex physical health needs pathway and a dementia pathway.
- As part of their new localities model, the local authority's front-door for social care was also being transformed. Leaders and staff felt this would improve the local authority's responsiveness to those requiring support from adult social care services.
- The local authority had systems to mitigate risk across their waiting lists. Referrals were being screening and prioritised to ensure people with the most urgent needs were contacted more quickly
- Senior leaders told us they had acted to make improvements to their unpaid carers offer, which included an improvement plan. This included improved systems to support staff with completing carers' assessments; drop-in services for carers to access assessments and support; a further commissioned partner who supported with information and advice, and the creation of a carers coproduction group
- A team consistently referred to by other staff teams was the Connected Communities team. This team provided bespoke support for people until they had access to the services they needed
- Other services within the borough which supported people with non-eligible needs included the autism hub, which supported over 500 autistic people
- A further example was the Haynes dementia hub, which was a local authority run service providing dementia support and awareness to the wider community.
- Frontline staff gave examples of when advocacy was used to support people and accessed support from the commissioned advocacy provider to develop understanding and support referral decision making.

Theme 1. How the Local Authority works with people

Assessing Needs

Areas of development

- Access to assessments and reviews was limited due to challenges contacting the local authority.
- People and partners told us contacting the local authority over the phone to request assessments or support was time consuming as it was difficult to get through to speak with staff.
- Assessments and care planning arrangements were not always completed in a timely manner
- Some relatives felt their loved one's needs had not been holistically assessed, and long-term goals and support for independence had not been considered. A person-centred approach was not always consistent.
- Care providers gave mixed feedback about their involvement in reviews. Some providers told us they were consulted when reviews were taking place, but others felt they were not involved with the process
- Some carers told us support for their wellbeing could be improved. These carers reflected support had not had a positive impact on their lives and their health and wellbeing was declining.
- Accessibility of information, assessments, reviews and services were a barrier for some carers
- Some carers told us they were waiting prolonged periods to access assessments, reviews and decisions on commissioned support.
- The local authority had a significant backlog of financial assessments
- People did not always have timely access to advocacy. Some frontline teams told us delays in accessing advocacy could lead to delays in processes such as assessments and reviews.

Theme 1. How the Local Authority works with people

Supporting people to live healthier lives

Strengths

- Adult social care was embedded into wider local authority plans and strategies to support prevention.
- The current housing strategy, a coproduced Rough Sleeping Strategy (2023-2027), and plans for a new coproduced homelessness strategy, were targeting prevention of homelessness and supported people to reduce risks to their health and wellbeing.
- The local authority worked with partners to fund prevention activity, such as the mental health wellbeing network.
- The Multi-Agency Care and Co-ordination Team (MACCT) was an integrated service which supported adults living with frailty and/or multi-morbidity concerns to maintain or improve their health, independence and well-being.
- The Connected Communities team also supported a prevent, reduce, delay approach.
- The local authority's website had a range of resources which supported prevention. For example, information was available for ageing well, including an ageing well guide for people which was produced with partners.
- There had been an ongoing transformation of reablement services - reablement pathways had become more efficient, with the service completing 99.2% assessments within 28 days
- The local authority had expanded staffing within the OT team through recruitment. The team used screening and prioritisation to triage referrals based on risk. OTs on duty review referrals and where there was urgent need, assessments were completed within 48 hours. Frontline teams were trusted assessors which supported people to access low-level aids and equipment in a timelier manner and reduced workload on OTs.
- The local authority also had an assistive technology offer to support people to remain independent and frontline staff teams were passionate about supporting people with their independence using aids and equipment

Theme 1. How the Local Authority works with people

Supporting people to live healthier lives

Strengths continued

- The local authority incorporated adaptations and equipment into their future planning
- The Connected Communities team supported access to information and advice - a positive example of proactively supporting people to access information.
- A dementia co-ordinator supported people with dementia and their relatives with accessing information. A partner told us this role had a positive impact for the community as the role supported knowledge of services and they also held events to promote understanding and dementia awareness across the borough.
- There was no waiting list for direct payments and carers who did access direct payments were positive about their experience. They told us the direct payment was manageable and allowed them to take their relatives into the community and take part in activities.
- The local authority understood barriers to accessing direct payments and was taking steps to remove them

Areas of development

- There was a significant waiting list for people accessing occupational therapy (OT) assessments and this impacted on people getting timely access to equipment
- People could not always easily access information and advice on their rights under the Care Act and ways to meet their care and support needs
- A key issue highlighted was people not being able to get through to speak with the local authority and some partners told us the local authority website was difficult to navigate and understand for people which prevented them accessing information easily.
- Some carers felt it was difficult to get information and advice directly from the local authority and unpaid carers were not consistently signposted to commissioned information services and would have to source information themselves.

Theme 1 – How the Local Authority works with people

Equity in experience and outcomes

Strengths

- Senior leaders understood the impact of inequalities across the borough, with identifying and listening to seldom-heard groups a priority for the local authority and worked closely with key partners to better understand and reduce local health inequalities.
- Example; 'Community Voices' used researchers who represented their own community groups to speak with a range of people from different ethnic backgrounds to understand their experiences of the cost-of-living crisis.
- Haringey commissioned a range of health inequalities projects, with 17 projects overseen by a Neighbourhoods & Inequalities Board.
- local authority had also supported the introduction of community health champions and proactively approached to engage communities such as the Gypsy, Roma and Traveller community.
- People and staff gave examples of staff having a good understanding of cultural diversity
- Frontline teams told us how they received training to support communication with people with learning disabilities, autism, neurodivergence and hearing impairments. This supported staff to make conversations more accessible for people.
- The local authority had a rehabilitation officer who supported people with sensory needs, such as those who had a sight and/or hearing loss

Weaknesses

- Support for unpaid carers from ethnic minority communities was an area for development.
- Partners told us there was a lack of information available in other accessible formats and said the local authority's website did not include information in different languages

Theme 2 – Providing Support

Care provision, integration and continuity

Strengths

- Haringey had launched a commissioning coproduction board and there was some evidence the board had begun to influence processes such as quality assurance of services
- partners were positive about the provision of the local Autism Hub, which was coproduced and described as an exemplar service
- People told us they were supported to access homecare support, which was flexible, person centred and of good quality.
- The local authority worked closely with the NCL system to retain oversight of residential and nursing care provision across the system.
- A partner told us a specialist provision which offered high quality services and advice was the Dementia Hub
- The local authority had clear arrangements to monitor the quality and impact of the care and support services being commissioned for people and it supported improvements where needed
- Care providers told us quality assurance processes supported them to improve their systems and practices
- The local authority was focused on improving people's voice in improving quality of services. For example, the Commissioning Coproduction Board had developed a methodology to support people's voice in contract management and quality reviews of services
- The local authority had identified the need to increase personal care services for people using direct payments and commissioned a partner to promote the role of becoming a personal assistant to support people's choice in services

Theme 2 – Providing Support

Care provision, integration and continuity

Areas of development

- People's access to a diverse range of local support options which were effective, affordable, and high-quality was inconsistent
- partners told us about gaps in service provision in the area. This included care homes, dementia-friendly services, specialist accommodation for autistic people, complex placements and mental health provision
- People and partners were not always included in market shaping activity
- Capacity for care and support within the borough was limited and as a result, a large proportion of care and support was commissioned out of the borough.
- There was not a clear process for reviewing the quality of people's placements outside of the NCL system – and the backlog and delays of people's statutory Care Act annual reviews highlighted a potential risk of concerns about people's care services not being known to the local authority

Theme 2 – Providing Support

Partnerships and communities

Strengths

- The local authority was developing strong partnerships and worked collaboratively with partners to agree and align strategic priorities, plans and responsibilities for people in the area
- The Haringey Borough Partnership helped strengthen internal and external relationships with Children's services, Public Health, Housing and senior health partners.
- the Integrated Reablement team were undergoing a transformation and had seen improvements in its performance, working closely with a health Rapid Response team
- a positive working example of a multiagency drugs and alcohol team who supported people to achieve better outcomes
- Staff told us they had received support and training to take part in joint funding discussions with health colleagues
- The local authority used pooled resources, such as the Better Care Fund, to deliver positive outcomes for people through integrated services. This included the reablement pathway and the MACCT.
- People told us adult social care and housing had worked closely together to support them to get support.
- A commissioned VCSE partner was also part of the carer's coproduction group, and a staff member told us links with this partner were strong. The partner told us they were hopeful their membership of the group would support outreach to new carers
- The local authority also worked with the ICB to fund VCSE-led projects. For example, a senior leader told us about 'Tottenham Talking'

Theme 2 – Providing Support

Partnerships and communities

Areas for development

- Partnership working to facilitate agreement of funding splits was an area for development. Data showed the local authority had a disproportionate level of health funding for complex care packages as compared to other areas and this impacted on the local authority financially.
- JPB - there was mixed feedback from partners on whether they felt listened to or had opportunities to inform strategies and projects
- Still scope for improvement of integration of adult social care and health services
- Where Section 75 agreements were not in place, such as with the Mental Health Trust, teams worked with health partners to support people, but approaches could be inconsistent. There was mixed feedback from staff on how well these processes worked.

Theme 3 – How the Local Authority ensures safety within the system

Safe pathways, systems and transitions

Strengths

- Staff spoke about cohesive partnerships within the local authority which supported safe, secure, and timely sharing of information to enable people to move safely between services.
- The local authority understood the importance of safety and the risks people faced across their care journey. They identified and mitigated risks to safely manage peoples' care.
- There were clear, person-centred pathways and protocols to help prevent risk to people's continuity of care
- Pathways for identifying, assessing, and allocating complex and non-complex cases for people moving between children and adult services were well-understood by the local authority

Areas of development

- some inconsistencies with how care and support was planned and organised with people, together with partners and communities to support safe transitions.
- the local authority could improve communication and timeliness of hospital discharges.
- Leaders, staff, and people identified safe, effective transitions from Children's to Adult services was an area for development and people's and carers' experiences of transitions between Children's and Adult services were mixed
- However, details around how they planned with carers to minimise risk when they could not fulfil their caring duties were vague

Theme 3 – How the Local Authority ensures safety within the system

Safeguarding

Strengths

- Staff also told us the safeguarding systems and processes were person-centred and reflected peoples' wishes to support them to remain safe.
- there was a clear procedure for triaging urgent police referrals and the actions leading to a protection measure being implemented
- Safeguarding concerns which did not meet the statutory referral criteria were processed in appropriate ways which informed internal colleagues and community health partners of the risks to people
- SAB chair told us there had been successes in transitional safeguarding
- Local authority staff were supported to access training and learning from SARs and partners were supported to improve practices to keep people safe
- Effective processes were in place to respond to Deprivation of Liberty Safeguards (DoLS)
- There was no waiting list for concerns or s.42 enquiries
- There was clarity on what constituted a s.42 safeguarding concern and when s.42 safeguarding enquiries were required, and this was applied consistently
- Staff we spoke with demonstrated a strong understanding of a personalised approach to safeguarding and this was reflected in examples they gave

Theme 3 – How the Local Authority ensures safety within the system

Safeguarding

Areas of development

- While there were processes to support staff to raise safeguarding concerns, these were not always followed.
- Care providers were not always supported to learn from safeguarding investigations
- Partners told us they did not always receive updates, outcomes and responses when making safeguarding referrals
- However, staff told us statutory advocacy was not always readily accessible, and it took up 36 to 6 weeks to get an advocate for people

Theme 4 – Leadership

Governance, Management and Sustainability

Strengths

- There was a stable adult social care leadership team with clear roles, responsibilities and accountabilities
- Leaders were visible, capable and compassionate
- Governance structures supported internal working relationships
- Senior leaders told us they undertook, along with managers and senior practitioners, a range of audits and supervisions including monthly case file audits and thematic audits

Areas of development

- There was not an up-to-date Carers Strategy, with the previous strategy running between 2020-2023
- Use of agency/locum staff was significant, making up 26% of the adult social care workforce (full time equivalents) as of July 2024 and turnover of staff also impacted people receiving services
- Systems to support leaders accessing data were not always consistent.

Theme 4 – Leadership

Learning improvement and innovation

Strengths

- The local authority had committed to improving relationships with communities and to work with people to support them to have a say in decision making. This approach was beginning to embed, with new strategies taking a coproduced approach
- The local authority had introduced carers and commissioning coproduction groups. These processes were still being developed but a partner told us people felt more listened to with this approach, and it was more representative of communities
- The local authority worked closely with peers to support and improve their practice (e.g. LGA Peer Review)
- 'Technology for our Ageing Population: Panel for Innovation' (TAPPI) project
- Staff told us of a positive working culture which supported continuous learning and improvement
- Good progression opportunities, PSW, DASS, ASYE, Locality Team opportunities as examples
- Establishment and collaboration with Disability Action Haringey
- 7 Min Briefings

Areas of development

- Partners told us coproduction was not well embedded, and this was recognised by the local authority
- Other concerns included the local authority not investing in supporting people to take part in coproduction which created barriers for people
- Taking forward recommendations of review of Joint Partnership Board

Communications and engagement

Assurance is also about keeping our colleagues, partners and importantly carers, people in receipt of care and support are engaged through existing governance and co-production opportunities such as the commissioning co-production group, JPB and carers co-production group.

To date this has included:

- Staff briefing Sessions
- Communications sent to Haringey Borough Partnership Executive, Safeguarding Adults Board and Joint Partnership Board (JPB)
- All Member briefing
- Meetings held with Healthwatch Advisory Board, LD Carers Forum, Carers Reference Group and JPB
- Health and Wellbeing Board
- Adults & Health Scrutiny agenda item 31st March

Assurance and oversight

- Adults Improvement Board (AIB) established, chaired by Chief Executive, Andy Donald and with cross-party member representation on the board
- First meeting of the AIB was held on 10th March 2025 and future meetings will be held every 8/9 weeks
- Draft Adults Improvement Plan is currently in development
- Improvement plan will be monitored at the AIB
- Regular updates will be presented to Adults and Health Scrutiny panel

Any Questions?

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Health and Wellbeing Board

27th March 2025

Better Care Fund Q3 24/25 Update

Reason for the decision

- A condition of the Better Care Fund is that The Health and Wellbeing Board is required to confirm the Plan meets national BCF Plan and provide oversight for the successful delivery of the plan.

- The BCF Plan was initially presented to the Health and Wellbeing Board on 17th January 2024 to confirm a two-year strategy for the BCF plan for 23/24 and 24/25. Approval received at that time. This is the second year of this plan and has remained unchanged, except for some adjustments related to the reallocation of funding to new or existing schemes and the redistribution of additional funding obtained. This update was provided to the Board in November 2024

- The Board is invited to note the progress reported in quarter three

- 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 considering local and national strategies and plans, such as NHS Long-Term Plan, Haringey Deal and Haringey's Ageing Well Strategy.

Better Care Fund Background

The Better Care Fund (BCF) is a strategic initiative designed to support local systems in achieving the integration of health and social care services. Its primary objectives are to deliver person-centered care, ensure sustainability, and improve outcomes for individuals and carers. The BCF promotes integration by mandating that integrated care systems and local authorities enter into pooled budget arrangements and agree on a comprehensive integrated spending plan.

The BCF has been crucial in supporting people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by 2 core objectives.

Objective 1: to enable people to stay well, safe and independent at home for longer

The priorities for health and social care are to improve quality of life and reduce pressure on UEC, acute and social care services.

Objective 2: to provide people with the right care, at the right place, at the right time.

The priorities for health and social care are to tackle immediate pressures in delayed discharges and demand for hospital attendances and admissions, bringing about sustained improvements in outcomes for people discharged from hospital, and wider system flow.

Quarter 3 Reporting Highlights and Exceptions - Expenditure

- The data from the quarter 3 submissions indicate that Haringey is currently on track to meet the minimum spend requirement from the Better Care Fund (BCF).
- Most schemes have achieved 75% or more of the required spend allocation, by Q3 and full expenditure is anticipated for all schemes.
- At the last HWBB it was reported that the Disabled Facilities Grant was at 12% this was because the spend had been reported on completed schemes and not committed spend. At Q3 this was at 68% and work in progress will see the full expenditure.
- It was also previously reported that the discharge funding for home care was slightly lower at 31% and this was due to the recent implementation of the localities model over the past three months. An action plan was implemented with the Locality teams to raise awareness among individual teams in the service about avoidable hospital admissions. This includes service users receiving home care and reablement packages of care via the ASC Front Door, not just those transitioning from the hospital. This is supportive of admission avoidance and as a result of the activity it has increased and expenditure levels is back in line for the year end, currently 72%.
- The iBCF home care and domiciliary care has increased in quarter 3 as previously reported as a result of the winter period as during this time there is an increase in numbers of people requiring care on discharge and a higher conversion rate of reablement packages to long term packages. This is in line with forecasts.

Quarter 3 Reporting Highlights and Exceptions - Metrics

Metrics Overview for 2024/2025

- The Better Care Fund (BCF) for 2024/2025 focuses on four key metrics: Avoidable Admissions, Discharge to Normal Place of Residence, Falls, and Residential Admissions. For the Quarter 3 submission, we provided an update on our progress against the metric plan.

Avoidable Admissions

- Avoidable admissions pertain to unplanned hospitalisations for chronic ambulatory care-sensitive conditions. Quarter 3 data indicated that we were not on track to meet the target, with the borough missing the BCF Q3 target by 3%. (162.9 against target of 158)
- It has been determined that there were data issues (merging virtual ward and LA data), causing inaccuracies.
- Haringey's virtual ward (at NMUH and Whittington) faces several challenges, including a lack of carer support, medical cover issues, and difficulties in recruiting HCAs for interim care, although recruitment plans are underway.
- To address these issues, steps have been taken to separate Haringey's data and correct coding discrepancies, providing a clearer picture of virtual ward and SDEC performance.
- Given the reliance on accurate data for decision-making, ongoing improvements include refining data reporting to ensure precise and reliable data is captured moving forward.

Quarter 3 Reporting Highlights and Exceptions - Metrics

Discharge to Normal Place of Residence

- Discharge to normal place of residence focuses on the percentage of people discharged from acute hospitals to their normal place of residence. Quarter 3 data revealed that were not on track to meet the target, with the borough missing its BCF Q3 target by 2.21%. (92.9% against target of 95%)
- Although the target has not yet been met, the incremental progress observed from Q1 to Q3 is encouraging.
- The decreasing percentage difference over the quarters indicates that efforts are showing positive results, and Haringey remains optimistic about achieving the target in Q4 as several key improvements are underway.
- This optimism is due to the development of a new systemwide P2 digital solution, which aims to enhance our data set by reflecting variations at the acute site, borough, and unit levels.

Quarter 3 Reporting Highlights and Exceptions - Metrics

Falls

- The Falls metric relates to emergency hospital admissions due to falls in people aged 65 and over. BCF Q3 data showed that we were not on track to meet the target, with the data showing a 15.63% deviation above the target amount. (346 against target of 300)
- Despite not meeting the targeted metrics for falls this quarter, the work around the Community MDT Falls Clinic has made notable progress.
- Previously there were no falls clinic in Haringey, whereas now there are regular clinic sessions being held.
- Key challenges have been the initial capacity to meet all demand, especially with non-urgent falls assessments and waiting times, which have not been fully alleviated despite the service's growth.
- The recruitment of the Band 7 Nurse role, which is essential for managing falls, is still in progress, impacting service delivery and metrics achievement.

Residential Admissions

- Residential Admissions focus on the rate of permanent admissions to residential care per 100,000 population. Quarter 3 data highlighted that we are on track to meet this target. Investment in home-first and reablement-based care as the first approach have been key contributing factors to enable better wrap-around care, facilitating residents staying at home to meet outcome 2 of the national conditions.

25/26 BCF Submission

The BCF 2025/26 policy objectives focus on two overarching goals: supporting the shift from sickness to prevention and supporting people living independently and the shift from hospital to home

These objectives are designed to enhance the integration of health and social care services, ensuring that people receive the right care at the right time and in the right place. The key elements of these objectives include:

1. **Shift from Sickness to Prevention**: This objective emphasises the importance of preventive care to reduce the incidence of illness and the need for acute care services. By focusing on prevention, the BCF aims to improve overall health outcomes and reduce the burden on healthcare systems.
2. **Supporting People Living Independently and the Shift from Hospital to Home**: This objective aims to enable individuals to live independently in their own homes for as long as possible. It includes initiatives to improve discharge processes, enhance community-based care, and reduce the reliance on hospital and long-term residential care

25/26 BCF Submission

The metrics that will be focused on for 25/26 are: Emergency Admissions, Discharge Delays, Residential Admissions.

- The total funding for BCF 25/26 has increased by £721,803 compared to 24/25.

- The breakdown of the funding changes is as follows:
- Disabled Facilities Grant (DFG) increased by £402,061.
- Adult Social Care services spend from the NHS minimum allocations increased by £319,742 which was a 3.93% uplift which has been primarily allocated to cover increased costs of staffing.
- Improved Better Care Fund (IBCF) has been renamed and merged with the Local Discharge Funding, the funding remains static for these at £12,097,8022.

To note whilst the Local Discharge Funding is no longer ringfenced there is a clear stipulation that its original intended purpose remains a priority, and the commitment and ambitions clearly stated.

25/26 BCF Submission

The approach being adopted is primarily an extension of the 23/24 – 24/25 plan. With minor adjustments under consideration.

The deadlines are challenging and there has been much concerned raised across all authorities about effectively meeting this.

A joint working group has been established to coordinate and develop the plans and submissions to meet the requirements.

Key submission Deadlines

3rd March 2025 - Draft Narrative and planning template submitted.

31st March 2025 (midday) full submission.

30th September 2025 – Section 75 must be in place

A change to the sign off process is that in addition to Health and Well Being Board sign off, Chief Executives are also required to sign off.

Due to timing of the Board and paper submissions we are asking for HWBB Chairs sign off and will bring to the next meeting for information.

Conclusion

- The Board is invited to note and agree the changes and note the progress reported in quarters three.

- To note the 25/26 BCF submission key requirements and deadlines.

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