

NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

Thursday, 26th February, 2026, 2.00 pm - George Meehan House, Woodside Room, 294 High Road, N22 8JZ (watch the live meeting [here](#), watch the recording [here](#))

Councillors: Ibrahim Ali, Lucia das Neves (Chair) and Zena Brabazon

Quorum: 3

1. **FILMING AT MEETINGS**

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

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

2. **WELCOME AND INTRODUCTIONS**

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 12).

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 1 - 2)

To confirm and sign the minutes of the Health and Wellbeing Board meeting held on 6th November 2025 as a correct record.

8. DEMENTIA IN HARINGEY (PAGES 3 - 34)

9. BETTER CARE FUND UPDATE WITH FOCUS ON METRICS (PAGES 35 - 46)

10. UPDATE ON ICB TRANSITION TO NEW STRUCTURE - VERBAL UPDATE

11. NEIGHBOURHOODS UPDATE INCLUDING PARTICIPATION IN DHSC/LGA NEIGHBOURHOODS SUPPORT PROGRAMME - VERBAL UPDATE

12. NEW ITEMS OF URGENT BUSINESS

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

13. FUTURE AGENDA ITEMS AND MEETING DATES

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

To note the dates of future meetings are to be confirmed.

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

Wednesday, 18 February 2026

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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

Apologies for absence were received from Cllr Brabazon.

4. URGENT BUSINESS

There were no items of urgent business.

5. DECLARATIONS OF INTEREST

Cllr Das Neves declared an interest as she was a governor for North London Foundation NHS Trust

6. QUESTIONS, DEPUTATIONS, AND PETITIONS

There were none.

7. MINUTES

It was noted that as mentioned in the minutes that the ICB approved the consultation.

RESOLVED

The minutes of the meeting held on 18th September were approved.

8. NEIGHBOURHOOD HEALTH AND CARE UPDATE

Will Maimaris, Director of Public Health introduced the report for this item. The following was noted in response to questions from the committee:

- Cllr Das Neves thanked the team for neighbourhood working, she acknowledged the change and restructure to the NHS and systems of resource. She encouraged further work on the vision and structure for how to engage with communities and deeply related to the voluntary community sector. She would like to see a structure which set out how grassroot organisations were recognised.
- The referral system from GP services to hospital services currently took too long and was not centralised, which created challenges for residents.
- Better comms between hospital discharge teams and GP practices was imperative.

- Teams were struggling for new funding and hoped that central government and the NHS would provide this. Officers relied on time and enthusiasm to drive improvements, and it was key to find investment for this.
- Officers needed to use accessible language to describe the changes. There was a partnership board with several groups, this could provide the ability to bring more resident groups together and enable them to have a more strategic voice and input into the neighbourhoods work.

9. HARINGEY TOBACCO CONTROL STRATEGY

Will Maimaris, Director of Health introduced the report for the item:

Comments from the board included

- It was noted that the tobacco control, work could be delivered through neighbourhoods at a very local level, linking back to the previous item on the agenda.
- The smoking cessation service goes out in the community, there were recent engagements in northumberland park, bruce castle, north middlesex hospital. There was service provision available from Monday to Thursdays 8-7pm, Friday from 9-5, Saturday 10-1pm. This service could be accessed on the phone.

10. LOCAL PLAN

Bryce Tudball, Head of Spatial Planning introduced the item:

Comments and discussions points raised

- The differing sections of the plan were useful; they contributed to conversations around neighbourhoods and long term planning.
- There were issues with disabled accessibility in buildings in Haringey, specifically Tottenham hale.
- From 2027 onwards, the Council were looking to redevelop Alexandra house and the bus station in Wood Green, there were various opportunities on Wood Green High Road.
- As part of the new London plan there would be revised housing targets, which would be closer to 20,000.
- The team had launched 20 consultation events which residents could attend to comment on the plan.

11. FUTURE AGENDA ITEMS

Members suggested items revolving around children and young people.

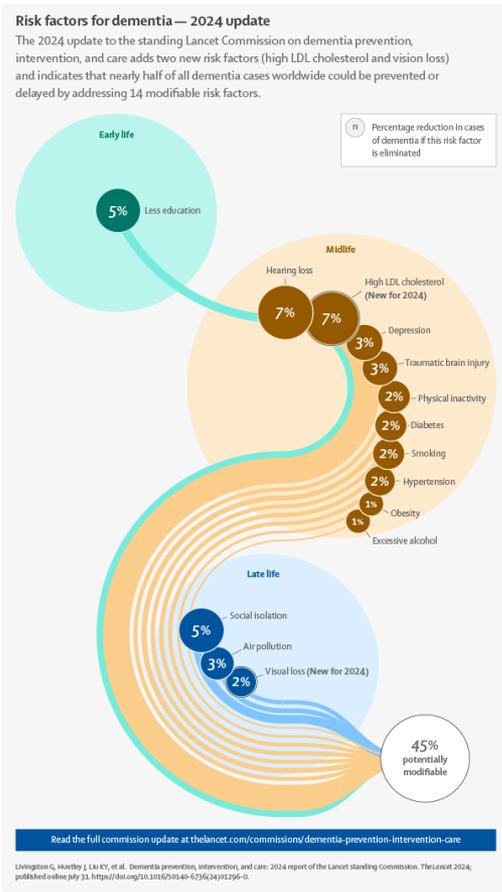
Dementia in Haringey Public Health

Jan 2026

Dementia: Definitions and National Picture

- Dementia is a term used to describe a range of cognitive and behavioural symptoms, including memory loss, problems with reasoning and communication, changes in personality, and reduced ability to carry out daily activities.¹
- The most common types of dementia are: Alzheimer's disease, vascular dementia, mixed dementia, dementia with Lewy bodies and frontotemporal dementia.¹
- The Alzheimer's Society estimates that there are 982,000 people over the age of 65 with dementia in the UK. This is expected to rise to 1.4 million by 2040.²
- Mild Cognitive Impairment (MCI) is characterised by objective cognitive impairment (but not severe enough to merit a diagnosis of dementia), and without a predictable pattern of progression. In general, over a period of three years, one third of people with MCI spontaneously improve, one third stay the same, and one third progress to dementia.³
- In 2023 1.3% of all people aged 65 and over registered with primary care had a diagnosis of MCI, which equates to 142,319 people.³

The Lancet Commission in 2024 highlighted that nearly half of all dementia cases worldwide could be prevented or delayed by addressing 14 risk factors across the life course



14 dementia risk factors

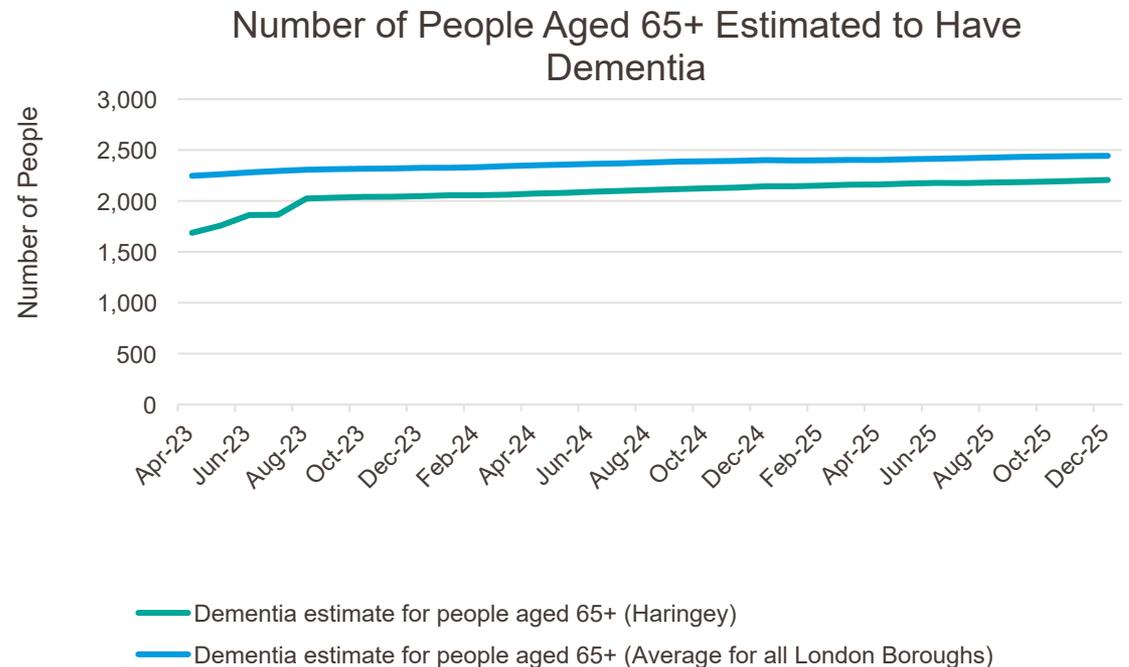
1 Physical inactivity	2 Smoking
3 Excessive alcohol consumption	4 Air pollution
5 Head injury	6 Infrequent social contact
7 Less education	8 Obesity
9 Hypertension	10 Diabetes
11 Depression	12 Hearing impairment
13 High LDL cholesterol	14 Vision loss

Dementia: Key Information in Haringey

- The risk of acquiring dementia increases with age. Dementia mainly affects older people. The likelihood of developing dementia roughly doubles every five years after the age of 65.¹
- 2,206 people aged 65 and over were estimated to have dementia in Haringey in December 2025.² This includes people without a formal diagnosis of dementia.
- 65% of people aged 65 and over living with dementia in Haringey in 2025 were estimated to have a formal diagnosis.³
- By 2045, projections suggest a 61% rise in people over 65 living with dementia - increasing to 3,156 people in Haringey.⁴

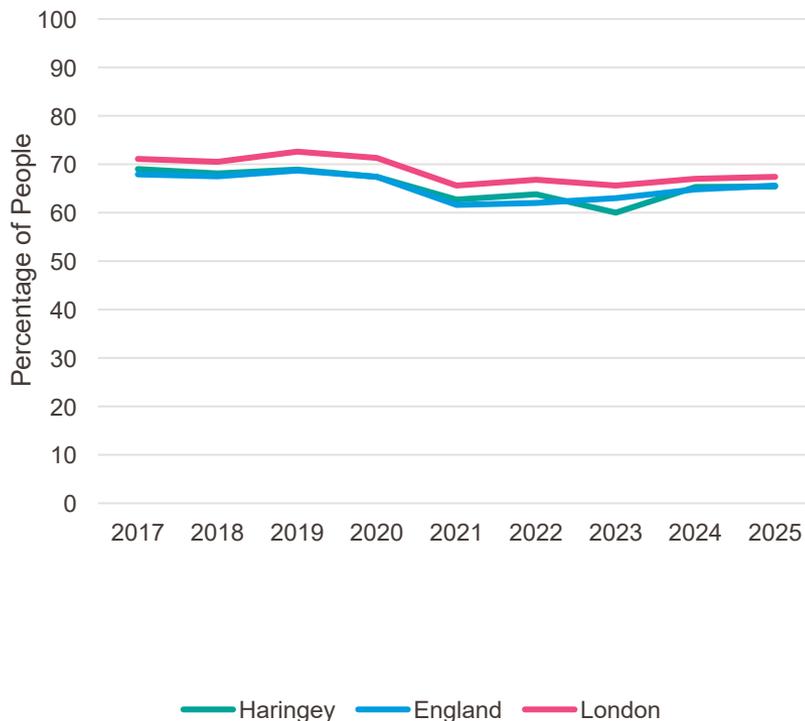
2,206 people aged 65 and over were estimated to have dementia in Haringey in December 2025.

- This includes people without a formal diagnosis of dementia.
- The number of people aged 65+ estimated to have dementia increased from 1,687 in April 2023 to 2,206 in December 2025, which equates to a 31% increase during this period.
- This reflects the impact of an ageing population on dementia prevalence.



65% of people aged 65 and over living with dementia in Haringey in 2025 were estimated to have a formal diagnosis.

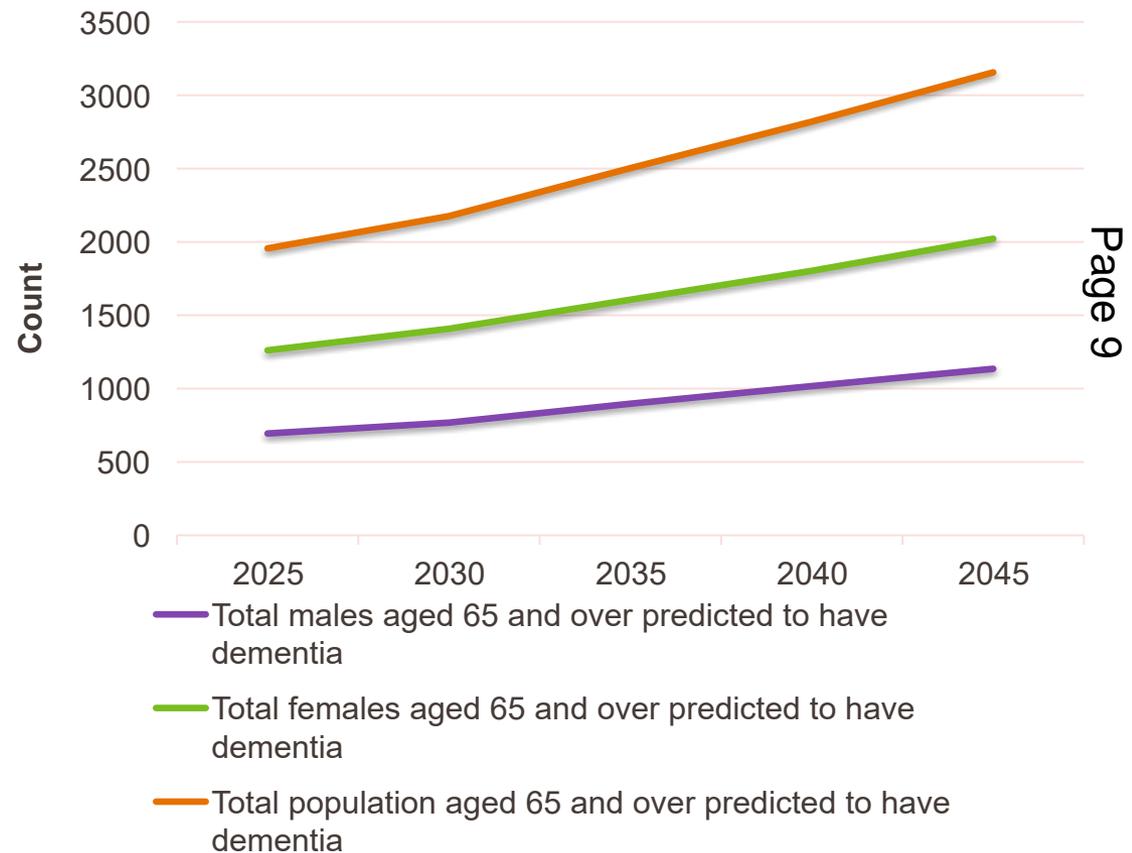
Proportion of People Aged 65+ Living With Dementia Estimated to Have a Formal Diagnosis



- This did not vary significantly from the dementia diagnosis rates for London and England.
- The proportion of people 65 or over living with dementia in Haringey who have a formal diagnosis has remained similar from 2017 to 2025.
- The number of people diagnosed is amenable to change - highlighting the importance of access to diagnostic services to enable early detection and access to support to live well with dementia.

By 2045, projections suggest a 61% rise in people over 65 living with dementia - increasing to 3,156 people in Haringey.

- As Haringey will see an increase in the number of older people over the next decade, the number of people affected by dementia is also expected to increase.
- The figure opposite shows that in 2045, 1,135 males are projected to have dementia compared to 2,022 females.

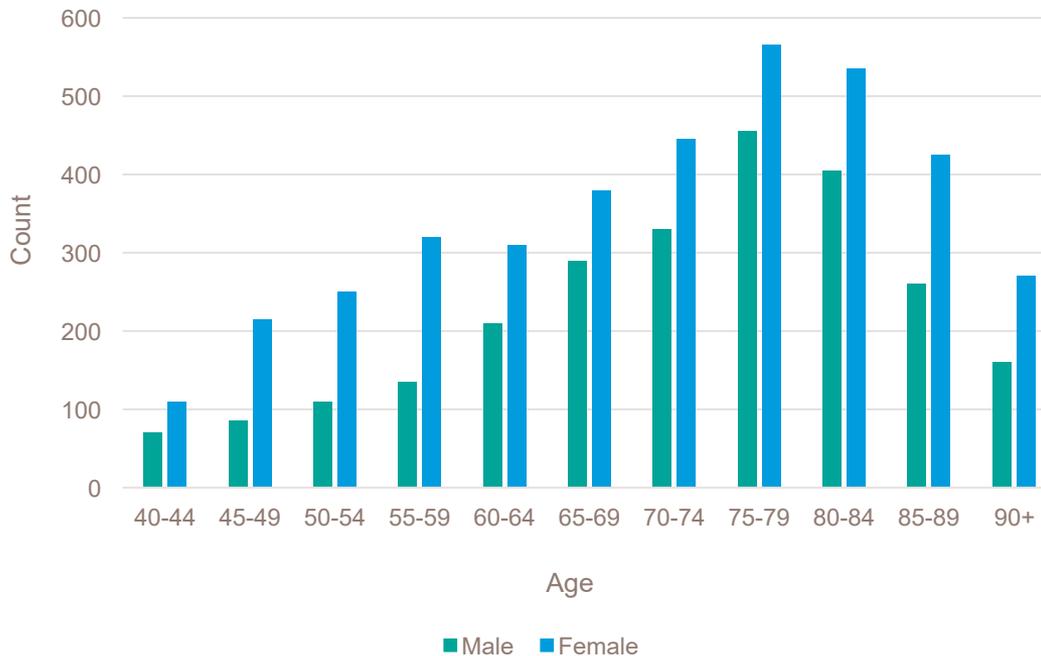


Why this matters for Haringey now!

- Dementia prevalence in Haringey is already increasing, driven by a growing older population, with a 61% projected rise by 2045.
- Dementia is a system-wide issue, impacting adult social care, primary care, community health services, voluntary sector support and unpaid carers.
- Later diagnosis is associated with higher levels of crisis, unplanned hospital admissions and increased reliance on formal care.
- Dementia has a significant impact on families and carers, with increased emotional, physical and financial pressures.
- Haringey's population profile means dementia intersects with inequalities, deprivation and long-term conditions, influencing outcomes and access to support.
- Early identification, coordinated pathways and community-based support are critical to helping people live well with dementia and reducing avoidable escalation.

Mild Cognitive Impairment: North Central London GP Practices

Mild Cognitive Impairment prevalence broken down by age and gender for North Central London ICB, December 2025



- GP practices also record the number of patients who have a diagnosis of mild cognitive impairment (MCI) without a recorded diagnosis of dementia.
- This information has been available for patients aged 40 and over since April 2024.

- Mild Cognitive Impairment (MCI) describes measurable changes in memory or thinking that do not yet meet the threshold for dementia.
- MCI is a key early intervention point:
 - Some people remain stable
 - Some improve
 - Some progress to dementia
- Early identification of MCI enables monitoring, prevention activity and timely support, rather than crisis-led responses.
- Evidence shows that addressing modifiable risk factors (e.g. physical activity, cardiovascular health, social connection) can delay or reduce progression.
- MCI aligns strongly with the prevention and “ageing well” agenda, linking public health, primary care and community services.
- Focusing on MCI supports earlier planning, better outcomes for residents and reduced long-term system pressure.



Dementia Friendly Haringey

Clare Davies, Dementia Coordinator



DFH Overview

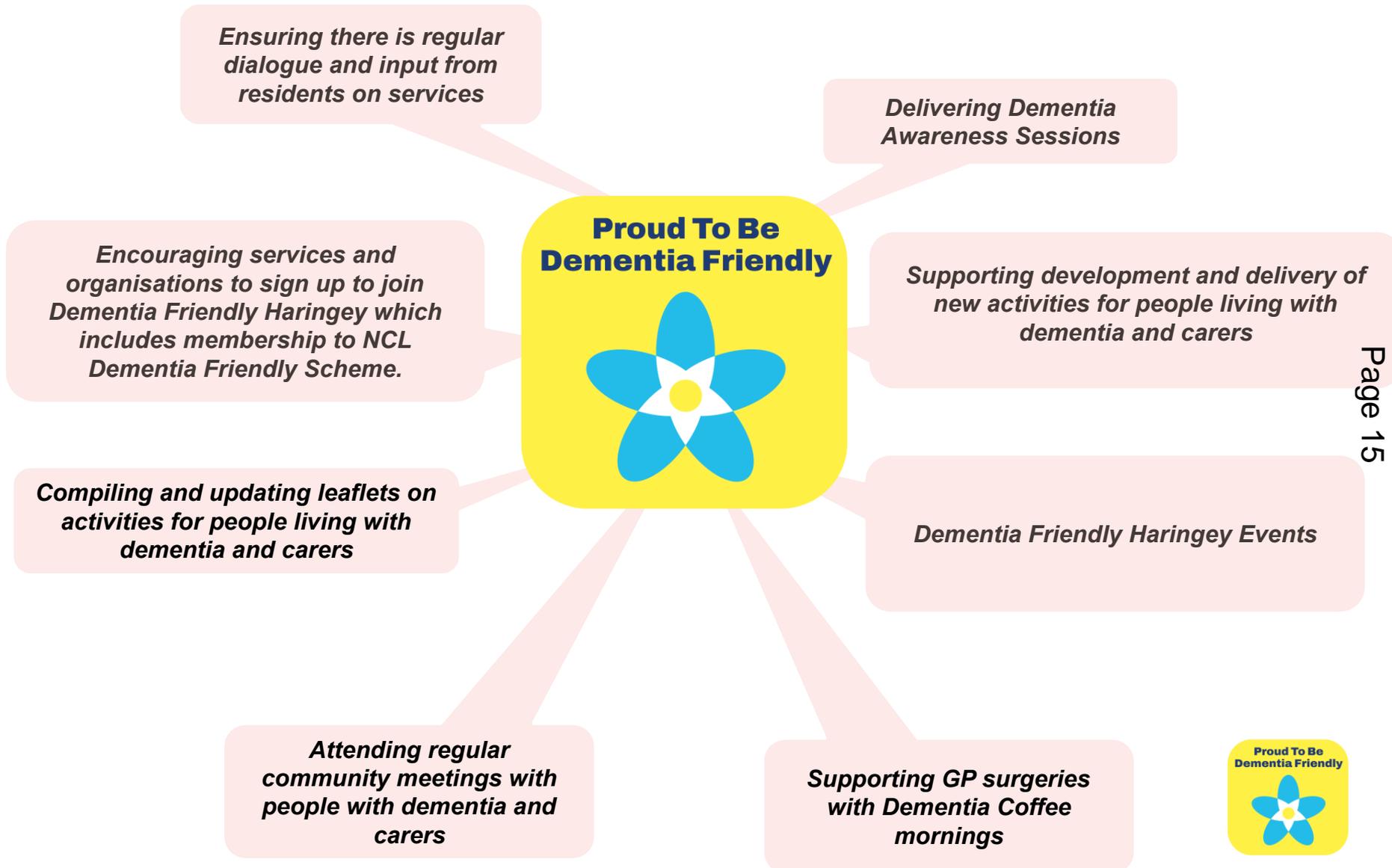
Dementia Friendly Haringey aims to make Haringey a place where people with dementia are understood, respected and supported.

Dementia-Friendly Haringey brings together people from across the council, health services, voluntary and community sector as well as residents committed to making the borough a friendly and accessible place for people living with dementia and their carers.

Dementia-Friendly Haringey's priorities are to create a place where people with dementia and their carers will:

- Be respected and experience a greater level of dementia awareness in the community
- Have greater access to health and social care support services
- Have access to a range of local social activities

How this is delivered





WEST

Tom's Club
Haynes

Hildene Court
Memory Cafe

Park Theatre
Dementia Friendly
Groups

Dementia Friendly
Wellbeing Walk

CENTRAL

Cognitive
Stimulation
Therapy
Cypriot Centre

TWPA Dementia
Awareness Group

Winkfield Memory
Cafe

EAST

Tom's Club
Chestnuts
Community
Centre

Singing for the
Brain
at Spurs

Sensing A Place
Bruce Castle
Museum



Dementia Friendly Haringey



Events,
Coffee mornings,
Meetings &
Activities

Further Information

Dementia Friendly Haringey Leaflets: Please see below links to our leaflets with full listings on groups and services for Dementia Activities, Dementia and Carers Support and Safeguarding and dementia.

[Dementia activities leaflet](#)

[Dementia and carers support leaflet](#)

[Safeguarding and dementia leaflet](#)

Dementia Reference Group Update for Health & Wellbeing Board Feb 2026

020 3196 1900
info@publicvoice.london
www.publicvoice.london

Dementia Reference Group – Who We Are

- The Dementia Reference Group (DRG) brings together:
- People living with dementia, mild cognitive impairment, or memory concerns
- Carers of people living with dementia
- Admiral Nurses and Memory Service staff
- Community Mental Health Teams and Specialist Dementia Service
- Haringey Dementia Co-ordinator and Haynes Dementia Hub Manager
- Dementia Lead Nurses from the Whittington and North Mid
- Reach & Connect Community Connectors
- Voluntary and community partners including the Cypriot Centre, Grace Centre and Community Hub
- Carers First and the Age Well team at the Integrated Care Board
- Spurs Foundation – Active Memories Team

- The DRG was established in 2022 and initially co-chaired by Paul Allen.
- Early objectives focused on improving dementia services and strengthening support for patients and carers following diagnosis.
- Initial priorities included:
 - 1. Early diagnosis and tackling social isolation through improved awareness.
 - 2. Developing community support including Carers' Coffee Mornings with Carers First.
 - 3. Encouraging self-care and positive lifestyle changes.
 - 4. Raising housing concerns including welfare checks for older residents.

- Key areas of focus beyond diagnosis include:
 - Strengthening early diagnosis pathways and reassessment support via district nurses
 - Establishing the Living Well Group for post-diagnosis support (Memory Service & Reach & Connect)
 - Expanding Memory Service support from diagnosis to end-of-life
 - Accelerating assessments for access to day services at Haynes Hub, Grace and Cypriot Centres
 - Rolling out Cognitive Stimulation Therapy (CST) and CST Maintenance sessions across Haringey

- The DRG has also worked on:
 - Safeguarding: addressing risks highlighted by carers, leading to a multi-agency meeting and new safeguarding leaflet
 - Providing feedback on the Dementia-Friendly Parks Audit
 - Suggesting improvements to primary care dementia reviews
 - Raising the need to fast-track joint tenancy processes for people with dementia

Dementia Reference Group – Current Issues in Care

- Carers now face increasing challenges with loved ones in hospital and care homes.

Hospital Care:

- Worked with Dementia Lead Nurses at Whittington and North Mid to highlight patient needs
- Staff shortages and inconsistent training contribute to poor patient experiences
- A DRG carer produced a report on poor A&E experience with recommendations

Care Homes:

- - Concerns over quality of care and activities offered
- - Quality Assurance team will attend next DRG meeting to discuss monitoring

Outstanding issues include:

- Following up on the NCL Dementia Review and borough-level disparities
- Increasing Admiral Nurse provision in Haringey
- Improving access to home adaptations and tenancy support
- Developing a Dementia Charter
- Improving support for Mild Cognitive Impairment (MCI)
- More support for young-onset dementia, including rare early cases
- Proposing a dementia hotline and support option on Social Services phone lines

**Haringey
Older Peoples
Dementia Services**

Victoria Unit
St Ann's Hospital

Haringey Memory Service

- The memory service accepts referrals for those over 65 for the assessment and diagnosis of dementia.
- Mainly a clinic-based service with some provision for home visit assessments if required.
- Most assessments are completed by doctors with some home visit assessments completed by the clinical specialist nurse.
- Mild Cognitive Impairment – discharged though contacted in a year and re-referral to service facilitated if appropriate.

Haringey Older Peoples Community Mental Health Team (CMHT)

- Referrals for people with a diagnosis of dementia and behavioural and psychological symptoms of dementia are seen in the CMHT.
- Specialist dementia service within the CMHT support patients with dementia with complex difficulties both living at home and in care homes.

Diagnosis to end of life model

- Camden and Islington have a diagnosis to end of life model in their memory service providing support to people with dementia living at home until the end of life. Service for those in care homes only includes assessment and diagnosis without longer term follow up.
- Work has been taking place since 2024 to provide longer term support for people with dementia within Haringey memory service.
- Quality Improvement project commenced in July 2024 with a target to have 50% of people with dementia living at home on the memory service caseload by April 2026. This target has been met.

Memory Service Transformation

- There has been a review of caseloads in the OPCMHT and some patients with dementia living at home requiring low level support have been moved to the memory service.
- Using existing funding, B7 clinical specialist nurse role created for the memory service and transfer of some B6 nurse time from OPCMHT to the memory service alongside movement of dementia caseload.
- Since August 2025, patients with dementia are no longer being discharged from the memory service and any dementia patients ready for discharge from OPCMHT are being transferred to the memory service rather than discharged to GP.
- Referrals also being taken from MACCT and SALT at point of discharge.

Post Diagnostic Reviews

- Telephone follow up 6 weeks post dementia diagnosis. If taking cognitive enhancer, further reviews arranged according to need until medication dose stabilised.
- Referrals made for cognitive stimulation therapy and other post diagnostic support (Toms Club, START, carers sessions)
- Patients on antipsychotics or with high need are offered a 3 monthly review with a nurse.
- Offer of nurse or OT led 6 monthly or annual reviews either face to face or on telephone, in clinic or at home according to patient and carer choice being offered. Some families supported by Admiral nurse.
- Patients will be stepped up to the specialist dementia service in Older People's Community Mental Health Team or in the future to the Older Adults home treatment team if unable to be managed within memory service due to increasing needs and risk and crisis.

Post Diagnostic Support

- One dementia navigator working in the memory service prioritises providing practical support to the most vulnerable with high social needs.
- No dementia advisors available through Voluntary Community Sectors for routine signposting is a gap in Haringey compared to other boroughs in North Central London.
- Expectation of the model would be for the annual reviews to be carried out by dementia navigator/advisors rather than qualified staff.
- Currently one B4 mental health practitioner available to carry out these reviews.
- 3-4 additional B4 level dementia advisors would be required to provide a similar service to Camden Memory Service.
- Insufficient capacity to support all patients living at home with dementia in Haringey without additional staff.

Post Diagnostic Interventions

- Toms Club – drop in for person with dementia and carers.
- Cognitive Stimulation Therapy – 10 weekly sessions running 3 to 4 times a year
- Living Well with Dementia Group – 2 introductory sessions for carers.
- Living with Memory Changes Group – for early dementia.
- START – 8 sessions for carers with psychology team
- Post diagnostic adjustment sessions with psychologist

Q&A

Haringey Better Care Fund 2025/26

Metric & Performance Update
(Q1 – Q3)

Health and Wellbeing Board
20th February 2026

Better Care Fund

The Better Care Fund (BCF) is a national programme designed to support the integration of health and social care services, enabling local systems to work together more effectively. Its core purpose is to deliver person-centred, sustainable care, and to improve outcomes for residents and carers.

In Haringey, the BCF underpins a partnership between the North Central London Integrated Care Board and the London Borough of Haringey supported through a Section 75 agreement.

This arrangement helps drive integration and maintain the borough's commitment to delivering health and social care aligned with national and local strategies.

BCF Objectives

The BCF 2025/26 policy objectives focus on two overarching goals:

- supporting the shift from sickness to prevention
- 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:

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.

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

Headline BCF Metrics for 2025/26

The BCF for 2025/26 focuses on three headline metrics:

Emergency Admissions (65+)

The metric measures Emergency hospital admissions for people aged 65+, per 100,000 population. This includes unplanned admissions through A&E, GP referrals, or other urgent pathways.

This metric matters because high rates indicate gaps in prevention, frailty support, or urgent community care. Reducing avoidable admissions relieves hospital pressure, supports independence, and aligns with the BCF shift from hospital to home.

Discharge Delays – DRD to Discharge

The metric measures how efficiently patients leave hospital by tracking

- (1) the percentage discharged on their Discharge Ready Date (DRD)
- (2) the average days delayed for those not discharged on time.

This metric matters because reducing delays improves patient outcomes, prevents deconditioning, frees up beds, and supports the BCF goal of faster, safer transitions from hospital to home.

Admissions to Long Term Residential or Nursing Care (65+)

The metric measure the number of people aged 65+ whose long-term support needs lead to permanent admission to residential or nursing care, per 100,000 population.

The metric matters because lower admissions signal strong prevention, early intervention, and independence-focused support. It directly reflects the BCF aim of helping people stay well and live at home for longer.

Supporting BCF Metrics for 2025/26

The supporting BCF measure for 2025/26 focus on:

Avoidable Admissions (65+)

The metric measures unplanned hospitalisations for chronic ambulatory care sensitive conditions (ISR rate per 100,000 population).

This metric matters because high rates indicate gaps in prevention, long-term condition management, and community support. Reducing avoidable admissions lowers hospital pressure and improves independence and outcomes.

Falls 65+

The metric measure emergency hospital admissions due to falls in people aged 65+, measured per 100,000 population.

The metric matters because falls lead to loss of independence, long stays, and higher long-term care demand. A high rate signals gaps in prevention, mobility support, home adaptations, and timely clinical intervention.

Summary of progress against Metrics (Q1 – Q3)

Headline Metric	Target	Q1	Q2	Q3
Emergency Admissions (65+)	<p>Monthly target range of admissions is between 415 to 504.</p> <p>Admissions per quarter: Q1 - 1328, Q2 - 1350, Q3 - 1317</p>	<p>✓ On track</p> <p>Admissions remained lower than plan in April and May however higher number of admissions in June.</p>	<p>✓ Mostly On track</p> <p>Higher admissions in July however August showed improvement with admissions falling, slight increase in September</p>	<p>✗ Not on track</p> <p>Admissions increased into Oct however remained steady in Nov before spiking in Dec linked to winter pressures</p>
Discharge Delays (DRD → Discharge)	<p>92% discharged on Discharge Ready Date</p>	<p>✓ On track</p> <p>Performance was above target for all months across the quarter.</p>	<p>✓ On track</p> <p>Performance was above target for all months across the quarter.</p>	<p>✓ Mostly On track</p> <p>Performance was above target for Oct, and was slightly below target in Nov and Dec linked to winter pressures</p>
	<p>Avg Days from DRD to Discharge ≤ 7.5 delay days</p>	<p>✓ On track</p> <p>Delays remained below the target for all months across the quarter.</p>	<p>✓ On track</p> <p>Delays remained below/on target for July and August with Sep slightly above target.</p>	<p>✓ On track</p> <p>Delays remained below target for Oct and Nov with Dec above target.</p>
Residential Admissions (65+)	<p>36 per quarter → 144 annually</p>	<p>✓ On track</p> <p>Placements remained below the target for all months across in quarter.</p>	<p>✓ On track</p> <p>Placements remained below the target for all months across in quarter.</p>	<p>✓ On track</p> <p>Placements remained below the target for all months across in quarter.</p>

Emergency Admissions Narrative

Quarter 1 - On Track

Emergency admissions remained below the planned threshold in April (434 vs 440) and May (444 vs 474), demonstrating a strong start to the year.

However, June showed a noticeable rise to 482 against a plan of 415, reflecting a +67 variance, signalling the early impact of seasonal illness and increased frailty presentations.

While Q1 sits on track, the increase in June indicates emerging pressure that required monitoring into Q2.

Quarter 2 – Mostly On Track

Quarter 2 began with higher-than-planned admissions in July (511 vs 504), continuing the upward trend seen at the end of Q1.

August then showed improvement, with admissions falling to 435 vs a plan of 439.

In September, admissions rose again to 431 vs 408, indicating fluctuating demand linked to late-summer illness and increased acuity.

Performance across the quarter was therefore variable but still aligned with expectations for Q2.

Quarter 3 – Not on Track

Quarter 3 reflects winter pressures. October admissions rose to 569 vs a plan of 456, creating early winter strain across urgent care pathways.

November remained above plan 476 vs 476 plan, before peaking again in December at 519 vs 480 reinforcing known seasonal trends of viruses, increased frailty, and higher acuity.

Overall, Q3 indicates the performance was not on track, this was driven by a spike in flu cases which led to increased emergency admissions which was reflected in both local and NHS data.

Discharge Delays Narrative

% Discharged on Discharge Ready Date:

Quarter 1 - On Track

Performance remained consistently above the 92% target, with April at 93.5%, May at 92.1%, and June at 92.1%.

Quarter 2 - On Track

Quarter 2 maintained strong performance, with rates of 93.7% (Jul), 93.1% (Aug) and 93.6% (Sep) all comfortably above the 92% threshold.

Quarter 3 – Mostly On Track

Quarter 3 started with strong performance, with rates of 93.6% in Oct however then fell to 89.6% (Nov) and 87.9% (Dec) which were below the target. This due to an increase in hospital activity related to winter pressures and flu outbreak.

Average Days from DRD to Discharge:

Quarter 1 - On Track

Delays remained well below the 7.5-day target, with April at 4.4 days, May at 4.9, and June at 6.5.

Quarter 2 - On Track

Results were mixed but still near or below target: 7.5 days in July (on target), 4.1 days in August, 7.6 days in September (slightly above target). The slight rise in September reflects early seasonal pressures.

Quarter 3 - On Track

Results were mixed but still near or below target: 6.8 days in Oct, 6.7 days in Nov, 8.6 days in Dec (s). The rise in December reflects winter pressures and flu outbreak.

Issues Affecting Performance (Q2 – Q3)

1. Data Quality Issues within the NHS - Coding problems caused the Q2 emergency admissions performance to appear better than reality. These issues were resolved by mid Q3.
2. Staff Shortages & Recruitment Efforts - Gaps in staffing across the system were causing slower responses and some rejected referrals. LBH are recruiting additional therapists to support Discharge to Assess (D2A)
4. Lack of NHS System Access – Not all LBH staff have had NHS email access to speed up the process of sending documentation this is being progressed to resolve.
5. Referral Criteria - Delays caused by rejected referrals so planning on having training to improve the overall quality of referral content.
6. Seasonal Flu & Winter Pressures - Significant spike in flu activity, matched by national UKHSA data. This led to increased emergency admissions, particularly in older people.
7. Increased Patient Acuity - More severe underlying illness in presenting patients. Despite good admission avoidance, total admissions increased due to clinical acuity, not pathway failure.
8. Complex Discharge Cases - These cases drove discharge delays: Patients waiting for care home placements, Mental health–related delays, Court of Protection cases and Housing and homelessness delays

Q1 – Q3 Accomplishments

Emergency Admissions

- Avoidable admissions kept at lowest levels (Q1–Q2).
- Admissions Avoidance Workshop delivered (Q2).
- Winter vaccination & infection control guidance shared (Q2).
- UCR digital tool (Docobode), escalation process, Virtual Ward step-up acceptance (Q2).
- SPOA/ICC pathways reducing conveyance (Q2).

Discharge Delays

- Exceeded 92% DRD discharge target (Q1–Q2).
- Improved ward visibility speeding up interventions (Q3).
- Recruitment of therapists + workforce expansion (Q2–Q3).
- Referral criteria training completed (Q3).
- Staff given NHS emails to improve integration (Q2–Q3).
- Hoarding & deep clean framework improving discharge flow (Q2).

Current Risks Areas and Planning for Q4

Risk Area / Action	Timescale	Lead / Partners
Early Discharge planning on admission, with estimated discharge dates (EDDs)	Ongoing	ASC / Health
Increased capacity for 7-day working	To be finalised in Q4	ASC / Health
Escalation: Daily joint operational calls between ASC, hospital discharge teams, and brokerage. Platinum every Tuesday, Wednesday, Thursday. Weekly escalation across the Localities.	Ongoing – Daily	ASC / Health
Community Reablement Service (CRS), urgent discharges within 4–6 hours, supporting both hospital flow and community recovery	On-going into Q4	ASC
System-Wide Winter Flow Monitoring: Working with NCL	To be finalised in Q4	NCL Partners
Step-down flats to provide short-term accommodation for people who are medically fit for discharge but not yet ready to return home	Ongoing	ASC
Ensuring reablement and homecare capacity sufficient to meet the demand	Current	ASC Ops and Commissioning
Scoping the options for residential and nursing capacity for over the winter	Current	ASC Ops and Commissioning
Social Care Workforce planning	Complete	ASC

Next Steps

Progress

- Haringey meets daily with the Integrated Discharge Team huddles improving communication and shared decision-making.
- Earlier recognition of patients likely to face complex or prolonged discharge.
- Senior escalations are working well and presence at the Long Length Of Stay focus weeks.
- Brokerage providing strengthened advice on market conditions, provider suitability and interim options.
- Planned face to face workshop on the 12/02/2026 to discuss specific areas that need enhanced collaboration.

Next steps

- Implement agreed escalation triggers.
- Maintain daily IDT focus on longest-stay patients.
- Hold Whittington–Haringey–CHC alignment session.
- Strengthen early Haringey involvement at Emergency Department and admission.
- Work on specific areas of focus following workshop that is planned in February.
- Integrated Front Door with rapid triage of new referrals